time, which contrasts with a finding of an earlier study by them of similar duration, which indicated that the slope of the fall in glomerular filtration flattens if antihypertensive treatment is continued for a long time.⁵

Because of possible hidden biases in observational studies it is premature to recommend special treatment for patients with diabetic nephropathy who are homozygous for the deletion polymorphism until prospective randomised studies have been carried out.

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Course on basic surgical skills is being run by all surgical colleges

EDITOR,—A recent press release produced by the Royal College of Surgeons of England about the launch of a new course on basic surgical skills for surgical trainees gives the impression that the course has been derived and promoted solely by the Royal College of Surgeons of England.¹ This is inaccurate. This mandatory course has been derived from an intercollegiate basis and not solely by the Royal College of Surgeons of England. Its content has been formulated with input from all four royal surgical colleges, and the teaching format is standardised, such that skills acquired from proscriptive exercises during one course held in a particular college or region are identical with those acquired during a course held in another college or region.

The item about the course in *Medicopolitical Digest* is correct in stating that this is the first mandatory course for any specialty and must be completed to a satisfactory standard before a doctor is eligible to take the new AFRCS examination or the MRCS examination at the Royal College of Surgeons of Edinburgh, England, Glasgow, and Ireland.¹ The item is inaccurate in saying that the groups will be limited to 18: the Edinburgh college, for example, intends to increase participants to at least 20 per course, to deal with the expected heavy demand for participation. Another inaccuracy is that, although various courses on anastomosis have been piloted by the Royal College of Surgeons of England for two years, they have also been piloted by its sister colleges.

Furthermore, final intercollegiate agreement on the format of the course was agreed only last May. Subsequent changes to the content of the course and assessment of candidates will be reviewed in 12 months' time by all four colleges.

It is vitally important for surgical trainees to realise that they can attend courses on basic surgical skills not only at the Royal College of Surgeons of England and in its associated regions but also in Dublin at the Royal College of Surgeons in Ireland, in Glasgow at the Royal College of Physicians and Surgeons, and in Edinburgh at the Royal College of Surgeons. The emphasis throughout the formulation of the course has been the major step forward in intercollegiate agreement and cooperation. The press release from the English college seems to undermine this fundamental philosophy.

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Conflict of interest

Conflict of interest statement should be abolished

EDITOR,—Since the *BMJ* introduced the requirement that authors should declare any conflict of interest at the foot of papers and other articles¹ such conflicts have rarely, if ever, been admitted. I wonder whether this reflects the truth.

The purpose of scientific publication is to present the results of observations or experiments in such a way that readers can assess their veracity and importance in terms of scientific knowledge. In the case of a medical journal, this includes their relevance to clinical practice in cost-benefit terms in their widest sense, and hence their relevance to the allocation of resources. Only when there are absolutely no outside influences or pressures that might modify the presentation of results in such a way as to compromise their interpretation can there be said to be no conflict of interest. Scientists must be objective to a saintly degree if they can truly state that their wish to justify a substantial proportion of their life's work or what they regard as their most brilliant innovation has never influenced the mode of their presentations. This might merely be to emphasise those results that prove their theory or to press harder for publication of those things that they feel most deeply about. Indeed, it could be said that it is the innovator's duty to do these.

If an author has accepted funding from any pressure group or from any charity that restricts itself to funding particular diseases or groups of the population, let alone any money from a government agency for its own agenda, then it is difficult to avoid conflict of interest. This might arise from an agency's funding policy or, where a "popular" charity has particular ease in raising money, from distortion of the perceived need, because the greater the funds available the more the publications about that particular subject.

A change in the wording to "no undeclared conflict of interest" would solve the second group of problems but not the first. Perhaps it would be better to end the charade altogether and return to the old fashioned virtue of trusting the integrity of authors. This might allow a few

charlatans to get away with it, but one should not forget that mistrust, like other forms of pessimism, is a self fulfilling prophecy.

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- 1 Smith R. Conflict of interest and the BMJ. *BMJ* 1994;308:4-5.

Does the *BMJ* attempt independent ascertainment?

EDITOR,—A colleague and I recently wrote a letter about two papers on alcohol consumption and the risk of heart disease.¹ We were critical of the message that these articles gave, which, in simplistic terms, was that alcohol is good for you. I have since been informed that the research reported by Eric B Rimm and colleagues² was funded by some of Europe's leading producers of alcoholic beverages (through the International Life Sciences Institute).

The authors' paper ends with the statement "Conflict of interest: None." I assume that it is primarily for the author of an article to decide what constitutes a conflict of interest, but I wonder whether the *BMJ* has any guidelines on this. In addition, does the *BMJ* attempt any independent ascertainment of potential conflict of interest? Specifically, does a conflict of interest arise when research is funded by a company or companies whose profits may be appreciably affected by the outcome that is reported? Clearly, major drug companies often fund clinical trials of their products, but this is usually evident in the reporting of the work.

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- 2 Rimm EB, Klatsky A, Grobbee D, Stampfer MJ. Review of moderated alcohol consumption and reduced risk of coronary heart disease: is the effect due to beer, wine, or spirits? *BMJ* 1996;312:731-6. (23 March.)

*We are currently reviewing our policy on conflict of interest and will soon be suggesting some changes. We have learnt that authors often have conflicts of interest that they do not declare. One reason that authors don't declare conflicts may be the idea—epitomised by C K Connolly's letter—that there is something mendacious about a conflict of interest. This is not so. Conflicts of interest are common, and there is nothing wrong with having a conflict of interest. What is more of a problem is not to declare a conflict of interest.

A second reason why authors may not declare conflicts of interest is that they are confident that their judgment has not been influenced by the conflict. There is considerable evidence that conflicts of interest do influence judgment,¹ but this influence will usually be subconscious. We cannot know if a conflict of interest has influenced our judgment.

Our policy is not to try to eradicate conflict of interest. Rather, we want simply to disclose conflicts. Readers can then make up their own minds on whether authors' judgment has been influenced.

In answer to Luke Whitaker's questions, the *BMJ* does have guidelines on what constitutes a conflict of interest. These guidelines are sent to authors. Authors are asked to declare a conflict of interest or to sign to say that they do not have one. We do not—and could not—independently verify these statements. A conflict of interest clearly does arise when research is funded by an organisation whose business may be affected by

the results, and such conflicts should be made explicit.—EDITOR

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Summative assessment in general practice

Scheme is essential to protect public and train doctors to required standard

EDITOR,—We were pleased to see the subheading “Much to learn from new scheme” in Douglas Carnall’s editorial on summative assessment in general practice.¹ However, several of Carnall’s statements require correction and others require challenge. Firstly, the practical work on which registrars will have to submit a written report must be an audit, and the method developed by our team has now been shown to be valid and reliable.^{2,3} The scheme has been running in the west of Scotland for four years now, and only in the first year was it a pilot system; it has been operational since August 1993. Carnall reports opposition to the system and concern about validation and communication about the system but does not quote our rebuttal of this.⁴

The editorial questions whether summative assessment will enhance education in general practice. Summative assessment is not about education: it is regulatory, assesses the competence of doctors for independent practice, and protects the public from doctors whose performance is inadequate. This process has an effect on education, and we have found that formative assessment is being used much more rigorously in our region.

The editorial suggests that summative assessment should be optional. We tried this in our pilot year, with trainers being able to stop the assessment process for any registrar whose performance was identified as being of concern. Seventeen such registrars were identified, and 16 of the 17 trainers exercised this power. Subsequent review by our panel of assessors showed concern over the competence of four of the doctors. Our finding that 5% of registrars do not reach minimal competence¹ means that the scheme must be compulsory, because as a profession we must protect the public and train doctors to the required standard.

The introduction of summative assessment has been long and hard; it is universally favoured by the medical profession, but a number of them have nevertheless obstructed the process. An editorial in the *Lancet* about the proposed academy of medicine could also apply to summative assessment: “One sure sign of an inspired idea is the resentment that it elicits from those who should know better.”⁵

A considerable body of information about summative assessment is now in the public domain. No test has yet been devised that predicts future performance, but we believe that we have made some contribution to the process and that the scheme will benefit patients’ care.

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1 Carnall D. Summative assessment in general practice. *BMJ* 1996;313:638-9. (14 September.)

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3 Lough JRM, McKay J, Murray TS. Audit and summative assessment, system development and testing. *Med Educ* (in press).

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Scheme has to be compulsory for proper evaluation

EDITOR,—Douglas Carnall is correct in pointing out the lack of evidence to show that there has been any improvement in patients’ care as a result of summative assessment in general practice.¹ This is hardly surprising, given the longstanding difficulties in deciding on reliable measures of practice performance and the achievement of Professor T Murray and his educational team in the west of Scotland in presenting a practical, validated assessment tool in so short a period.

Carnall’s demand that participation in summative assessment should be optional until there is “decent evidence” of improvement in patients’ care cannot, however, be justified and, indeed, would be self defeating. The corollary of Carnall’s admission that higher performing candidates are more likely to enter the examination for membership of the Royal College of General Practitioners is that poorer performers would be less likely to submit themselves to optional summative assessment. If the scheme were optional and less satisfactory registrars did not participate then the possible effects of assessment on their patients’ care would remain unknown.

Having raised doubts about summative assessment as a result of this absence of evidence, Carnall then spoils his argument by making two unsubstantiated assertions of his own—namely, that “trying to cut off the tail at the other end of this performance distribution is a futile exercise” and that “general practice educators would do better to concentrate their efforts in shifting the entire distribution of performance upwards.” Apart from the General Medical Council’s procedures, there has been no formal attempt to identify poorly performing practitioners in the United Kingdom and to improve their performance, and so there is no evidence for the futility or otherwise of such an exercise. Furthermore, even if it is accepted theoretically that clinical performance and patients’ care can be shown to have a normal distribution there is again no evidence to show that education results in universal improvement: the curve might merely be flattened, with a greater spread of performance, leaving the tail unchanged.

Of course summative assessment must itself be assessed. This will involve addressing the need for robust outcome measures, including clinical performance. The most discriminant aspects of the assessment process should be identified and enhanced; this should allow for the complexities and costs to be reduced in due course. For this to happen, all potential principals will have to participate.

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Procedure is too complex and intrusive

EDITOR,—Douglas Carnall’s courageous editorial on summative assessment in general practice should be taken seriously by the educational and regulatory establishment. I share Pereira Gray’s concern at the poor performance of a small minority of doctors after “satisfactory” completion of their training,² but I question whether this poor performance will necessarily come to light in the summative assessment now being implemented. The assessment tests are

measures of what a candidate can do (competence) rather than of what he or she does do (performance). Unfortunately, there is no evidence, either, that the new style trainer’s report will be completed any more objectively than the previous one, especially if there is no guarantee that a registrar who fails the assessment will obtain good counselling and the necessary further training.

I could perhaps accept the new scheme as a starting point were it not for my worries about the side effects. I have just received the latest bulletin on summative assessment from my region. The clear language cannot hide the overwhelming complexity and the intrusiveness of the whole procedure. Each component has a different closing date and a different application procedure. Just understanding the procedures and making the necessary applications is going to take up an appreciable portion of the precious year in general practice. More worrying still are some of the hidden agendas implied by these procedures:

- vast areas of the work of general practice are less important because they are difficult to measure
- recruitment into general practice needs to be made more difficult
- education ends with summative assessment
- the core of training in general practice is not assessed by summative assessment because most registrars could pass the current procedures before they start training
- a substantial portion of the education budget should be spent on testing.

I cannot believe that those responsible for instigating summative assessment had these agendas in mind. I believe that all that was necessary was to give the trainer’s report more teeth, though not necessarily more objectivity. I hope that the registrars will persuade the establishment to think again.

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2 Pereira Gray D. Assessment at last. *Br J Gen Pract* 1993; 43:402-3.

More registrars are being trained in consultation skills now

EDITOR,—Douglas Carnall attacks the new arrangements for summative assessment as being “potentially educationally deleterious.”¹ Some years ago, as a young course organiser, I made a similar attack on the fact that trainees were able to take the examination for membership of the Royal College of Practitioners at the end of vocational training.² My proposed solution was a more clinically based assessment at the end of vocational training, which would encourage the learners to focus more on essential skills in general practice, such as consultation skills.

Experience from the west of Scotland already indicates that far more registrars are having regular training in consultation skills as a result of summative assessment. The argument for ensuring adequate clinical performance before registrars go on to unsupervised practice is undeniable. As yet the tests are unproved, but at least they are focusing the learners in the right direction.

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