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Summative assessment

Sir,
Lennox attempts to trivialize the message conveyed in our paper[1] in his letter to the editor (August *Journal*). Far from 'undetected sophistry', the Joint Committee, as a result of its regulatory reaccreditation visits to all regions in the United Kingdom, recognizes that there is a major problem in the profession's acceptance of audit as a routine mechanism to practising quality care.

Our published works are the only academic studies describing the reality of audit in training practices, warts and all. It gives us little pleasure to highlight such findings, except for the hope that serious debate about rectifying this dire situation will ensue.

Audit, as part of summative assessment, and in particular of a critical attempt to analyse such audits through an objective assessment tool, has given some insight into the scale of the problem of implementing audit. Consider the facts shown in Table 1.

The fact that 15% of registrars required two attempts at their audit project, and that even after this 3% still could not achieve minimum competence, is worrying indeed. One-to-one interviews with these registrars implicated their trainer's advice.

Quoting from the Christmas issue of the *BMJ*, noted for its light-heartedness, will not deflect from the seriousness of our profession's ambivalence towards assessing quality of care.

If there is a better way, let's see it.

Published or be damned.

J R MURRAY LOUGH
T STUART MURRAY

West of Scotland Postgraduate Medical Education Board
1 Horselethill Road
Glasgow G12 9LX

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1. Lough JRM, Murray TS. Training for audit: lessons still to be learned. *Br J Gen Pract* 1997; **47:** 290-292.

Table 1. Results of summative assessment.

Year	Registrars finishing summative assessment	Audits requiring resubmission	Audits failing after resubmission
1995	102	10	4
1996	103	24	5
1997	98	12	1
Total	303	46 (15%)	10 (3.3%)

Training for audit

Sir,
I write regarding the conclusions of a recent article by Lough and Murray entitled 'Training for audit: lessons still to be learned' (May *Journal*).[1] I have much experience in research and research methodology and have concerns about how summative assessment is being assessed.

This article, which sends out a warning to GP trainers, concludes that 'trainers are failing to recognize basic audit methodology using a marking schedule they themselves help to design.' This does not fill me or my GP registrar colleagues with confidence in trainers' teaching and in those marking audit projects submitted as part-fulfilment for summative assessment. How can a GP registrar, having submitted an audit project, accept the decision of trainers marking the project in whom knowledge of audit methodology has been assumed[2] as first being accurate (whether the project is passed or referred), and secondly as being fair in light of the findings presented by Lough and Murray?[1] Moreover, accuracy and fairness become even more important if, as Lough and Murray point out, the trainers marking audit projects are unaware that they are deficient in recognizing basic audit methodology and, if I might say, the differences between evidence-based audit and research.

I also wonder to what degree such inadequacies apply to the assessment of consultation skills when videotaped consultations are submitted for summative assessment.

I and my colleagues feel that urgent action is required to ensure that only trainers with proven expertise are used as assessors to guarantee accuracy and fairness in marking, Otherwise there is indeed a risk of the much criticized summative assessment becoming a farce rather than a test of so-called competence.

SHAHID ALI

33 Heaton Grove
Bradford
Yorkshire BD4 6DU

References

1. Lough JRM, Murray TS. Training for audit: lessons still to be learned. *Br J Gen Pract* 1997; **47:** 290-292.
2. Baker R, Thompson J. Innovation in general practice: is the gap between training and non-training practices getting wider? *Br J Gen Pract* 1995; **45:** 297-300.

Sore throat

Sir,
Howe's paper regarding the use of penicillin in sore throats (May *Journal*)[1] has a flaw that can be found in all similar studies when applying them to general practice.