LETTERS

Doctors and the Pharmaceutical Industry

Sir,

The ideal relationship between the pharmaceutical industry and the medical profession will never be static nor easily defined and we can only welcome our College's recognition that the debate about this should be continuous and open.

Dr Donald (September *Journal,* p.599) is surely right to believe there must be a partnership and he has usefully reminded us of the many ways in which general practice has benefitted from using pharmaceutical industry finance and goodwill for academic investment. Dr Schofield (September *Journal,* p.601) is equally right to warn us of the substantial risk of squandering professional respectability by accepting inducements—even if these do normally differ in scale (although not in principle) from those crudely displayed in the recent 'Orient Express' affair. Colleges, University departments and individual doctors have to make their own decisions about where the line should be drawn, remembering that the closer that marketing penetrates to the 'academic centre' the less obvious its promotional techniques need to be.

However, the main purpose of this letter is to express concern over the Medicines Surveillance Organization (MSO) 'multicentre clinical appraisal' of a new analgesic, which was brought to the attention of College members during August.

The first stated objective of the study is to 'record the clinical indications' for which the drug concerned is used in general practice. This is naive. The drug is only likely to be being used because it is being studied (regrettably for payment, albeit modest). This problem, of course, mirrors a tactic already well established in marketing repertoires. The second objective is to investigate 'efficacy, safety and overall acceptability . . .'. Any attempt to comment in any clinically useful way about efficacy and acceptability on the basis of a study which does not use a standard alternative preparation and is not double-blind must again be suspect, and is again reminiscent of the kind of research logic more associated with promotion than true evaluation.

The third objective '. . . to record the incidence of clinical events . . .' overlaps with the safety component of the second objective and seems, on the surface, wholly proper. Many believe, however, that it is unsafe to rely on the chain of events which will be necessary in this study. Patients must recognize side-effects as being separate from the symptoms of their illnesses (often difficult when pain is present) and must then report their complaints to doctors who must recognize the symptoms or signs for what they are.

We feel that surveillance can only be effective if it is substantially more active than that being proposed in this study. If it is argued that this is 'not how general practice is' in real life, then either general practice is not the place to undertake drug surveillance or general practitioners are not the proper agents to undertake it.

We sympathise with the desire of MSO to launch itself sooner rather than later but greatly regret the structure and quality of this present proposal. We also fear that the apparently impeccable credentials of MSO will lead to its being seen as a prime facilitator for the backdoor launching of unnecessary and otherwise unsellable new products. Has the concept of MSO been adequately thought through?

J. G. R. HOWIE,
Professor, on behalf of the Department of General Practice
University of Edinburgh
Levinson House
20 West Richmond Street
Edinburgh EH8 9DX

Sir,

I write in support of Dr Theo Schofield, whose recent thoughtful argument against the use of drug company funds was published in the September *Journal,* (p. 601). General practitioners bring themselves into disrepute; at the simplest level by accepting drug company food and drink, at a more complex level by taking part in dubious 'trials' mounted purely as a marketing exercise; at the highest level by accepting drug company sponsorship for such posts as the Stuart Fellowship. As long as this continues, the profession will have no answer to the argument that its prescribing habits are manipulated more by drug companies than by reasoned thought or by use of such publications as *Drug and Therapeutics Bulletin.*

I would agree with Dr Schofield that if sponsorship is necessary, perhaps disinterested companies could be asked to donate funds, or if drug companies are to donate funds, that this money should go into a central pool to be used at the College's discretion, and not to be used as an indirect form of advertising.

G. B. TAYLOR
Guide Post Health Centre
Choppington
Northumberland NE62 5DD.

The Format of the College Examination

Quite a few trainers in the Birmingham area have gained experience from the use of videorecordings in the assessment of trainee performance during consultations. Surprisingly, there has been little protest from patients about invasion of privacy, and the resulting tapes have served as an excellent source of teaching material.

Could this method not be utilized in the oral section of the MRCGP examination? The candidate could have the option of producing a videorecording of four or five consultations to be forwarded to the College prior to the examination. The examiners would view the tape, isolating relevant sections, and at the *'viva'* it would take but a few seconds to identify the particular section for consideration. I am sure that with frequent use this would introduce the patient element missing from the present format (September *Journal,* p. 604).

DAVID R. AYLIN
4 Ferndown Road
Solihull
West Midlands B91 2AY.

Sir,

Dr Davey's comment (September *Journal,* p.604) represents a view of the validity of the examination without sufficient consideration of the equally important constraints of reliability and feasibility.

Validity is the relevance of an examination method to the subject being assessed. The reliability of a method relates to the accuracy, repeatability and fairness of the instrument of measurement. Any method of assessment is of little use unless it is reliable as well as valid.

In all examinations in primary care, the problems of reliability (and feasibility) are more difficult to resolve than are those of validity because the introduction of an instrument of measure-

ment so often interferes with the validity. The vagaries of role players are an excellent example of this.

Dr Davey says that 'one can pass the examination by reading the right books and presenting the correct attitudes'. Is there evidence that the methods used by the Australian and Canadian examinations resolve this dilemma of inference more reliably than the College examination?

One reason why we have retained the flexible, nonstructured oral is that skilled direct questioning by trained examiners (as all experienced general practitioners know) is still one of the most effective methods of making correct inferences about someone else's attitudes and motivations.

In the last few years those responsible for the MRCGP examination have spent much time and effort improving the reliability and validity of the format as well as assessing the methods used by the Australian and Canadian Colleges. A postgraduate examination for approximately 750 candidates twice a year creates considerable problems of feasibility, as well as aggravating those of reliability and validity.

A summary of our conclusions may be of interest to those who, like Dr Davey, have considered validity without raising the equally important problems of reliability:

- *A practical examination* (using x-rays and ECGs) as developed by the Australians and mentioned by Dr Davey is valid, reliable and feasible for large numbers. It is being developed for use by the College in a possible part I MRCGP examination.
- *Use of short answer management problems* (SAMP) as developed in Leeds and Canada is valid and reasonably reliable. It too is to be used in a possible part I examination.
- *Formal or structured role play by examiners* has the following disadvantages:

  Candidates say that validity is decreased not increased—for example role players are of the wrong age or sex. Candidates rightly claim it is unreliable (unfair) because examiners vary greatly in their role playing skills. Examiners tend to concentrate on the role play instead of on the candidate's performance. Neither the role player nor fellow examiner can interrupt to explore a candidate's thinking without confusing the candidate.

Role play is a satisfactory teaching tool but inappropriate as a method of assessment because it is neither valid nor reliable.

- *Use of real patients and actors.* If the consultation is videotaped and played back so that examiners can question the candidate, then this method is reasonably valid and can be made reasonably reliable. The disadvantages are:

  Variability and reliability: the procedure is very difficult to standardize. As the number of candidates increases, the variables increase rapidly, and reliability becomes impossible to maintain. It is impossible to interrupt and explore a candidate's thinking unless the consultation is videotaped. It is very expensive in time and money even for small numbers of candidates.

This technique is inappropriate for the MRCGP examination but is being developed for assessments such as the 'What sort of doctor?' exercise.

The methods (format) of all examinations by their nature have limitations and imperfections which must be monitored constantly and corrected wherever possible. Adjustments to the MRCGP examination are being made constantly. Changes of content to keep the examination up to date are continually introduced. The College is receptive to changes in the instruments of measurement once improvement in the reliability and validity of the new methods has been demonstrated.

The considerable time and effort put into preparation of material, and the training and selection of examiners probably has a much greater impact on both validity and reliability than the introduction of a new format of unproven reliability.

KEITH HODGKIN

94 Marwood Drive
Great Ayton
Middlesborough
Cleveland TS9 6PD

Primary Health Care in Industrialized Countries

Sir

Dr W. J. Stephen claims (March *Journal,* p. 188) that in my article on primary health care in industrialized countries (December *Journal,* p. 729) I perpetuated a myth concerning the Swedish health care system.

Which myth is he writing about and what exactly is he claiming? Does he maintain that the outpatient departments of hospitals are the backbone of the Swedish primary health care system? (Stephen: 'In 1978 it was estimated that just over 60 per cent of all primary care took place in hospital outpatient departments without any referral from a primary care physician') Or does he suggest that the general practitioners constitute this backbone? (Stephen: 'To state that in the Scandinavian system [Finland and Sweden] the focal point of provision of care is not the general practitioner but a health centre run by the local administration is simply not true for Sweden'.)

The section of my article that prompted Dr Stephen's comment dealt with the official health care system as defined and planned by the national health authorities. The official Swedish plans clearly state that the health centre (vårdcentral) is the focal point of the system and set the goal that by 1985 there shall be at least one health centre in each community. This goal has been fairly well achieved; out of the 775 health centres planned for 1985, 734 already exist.

Dr Stephen is, however, right in pointing out that the system does not yet function as planned: in 1981, still 55.8 per cent of all primary care visits took place at hospital outpatient departments. This deficient functioning—or rather abuse—of the system does not, however, change the simple truth that the health centre is the backbone of the official primary health care system both in Sweden and in Finland.

HANNU VUORI
Regional Officer for Primary Health Care, Europe
World Health Organisation
8 Scherfigsvej
DK-2100
Copenhagen
Denmark.

Quality of Care in General Practice

Sir,

I read in the August *Journal* of the policies that have been proposed by Council to improve the quality of care in general practice. The basic premise upon which the policies were founded is that doctors and patients are 'either content with, or relatively uncritical of, general practitioners' services'. Is this really true?

A recent editorial (January *Journal,* p.5) did not agree. Studies involving a complete cross-section of the population were quoted showing that patients were critical of doctors who were relatively inaccessible, and of those who did not communicate enough with their patients. Patients say too that they like to be examined by