

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 MRCP 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 MRCP 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 MRCP 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 MRCP 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.

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### 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.

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### 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