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

their doctors (implying that often they are not) and are keen to be involved in decisions about their health and treatment. These criticisms have been made of some teaching practices. So to aim at bringing the general standard up to the present best is not good enough.

I believe it is because patients, and some doctors, are not satisfied with current NHS general practitioner services that they are voting with their feet and are turning to private or alternative medicine.

One way of enabling doctors to improve their services is to increase their consultation time with each patient. This would mean a radical change in the pattern of work for most general practitioners, involving the delegation of some work and an increased number of ancillary staff.

With a safe basic income from a large list there is no financial incentive to change the pattern of work. A simple service payment system, such as that used by doctors for private patients, instead of the capitation fee may introduce a healthy element of competition betwen doctors and transfer the responsibility for health care from the doctor back to the patient.

I am saddened that Council has not suggested any major changes for the future. Attending to minor details will not adequately improve the quality of care. We need to establish what would be the best possible service for patients and doctors, and then work towards it.

SALLY JOBLING
Dubai Trade Centre Residences
Building 1
Apartment 6
PO Box 11748
Dubai
UAE

Out-of-hospital Cardiac Arrest

Sir,

In your editorial (May *Journal*, p. 259) you imply that ambulancemen should be the people to be given the apparatus and training to correct ventricular fibrillation.

The main reason why general practitioners do not routinely carry defibrillators is that of cost—over £1,000 each. Most younger general practitioners are trained and experienced in their use.

My paper[1] demonstrated that on many occasions cardiac arrest occurred in the presence of the general practitioner and only comparatively rarely in the ambulance. The problem is one of equipping general practitioners first, and equipping and training ambulance personnel should be the second consideration.

If a doctor buys a defibrillator his income for that year is diminished by £1,000. Unless the cost of a defibrillator is drastically reduced, or another way of equipping interested general practitioners is found, ventricular fibrillation in the community will usually continue to be fatal.

D. C. RAWLINS
The Surgery
Anchor Road
Coleford
Bath BA3 5PG.

Reference

1. Rawlins DC. Study of the management of suspected cardiac infarction by British immediate care doctors. *Br Med J* 1981; **282:** 1677-1679.

General Practice Diabetic Care

Sir,

I recently attended a conference on diabetic care services throughout the UK, during which I learned of the British Diabetic Association's geographical survey of consultant physicians. This, basically, was a questionnaire about the services they provided.

The results did not take into account any organized independent services that general practitioners are providing. It did note the areas where general practitioners ran clinics for patients discharged from the local hospital diabetic clinics.

I suspect that there are some general practitioners, like myself, who provide a service for their patients completely separated from the local hospital diabetic clinic. In order that the survey should be entirely accurate, I would be grateful to hear from any general practitioner who runs an independent clinic for his diabetic patients.

P. R. W. TASKER
St James' House Surgery
County Court Road
Kings Lynn
Norfolk PE30 5EL

Epidemiology and Research in General Practice

Sir,

The College and Mrs Jill Pereira Gray deserve congratulation for their pioneer venture in publishing the epidemiological researches of the late Dr G. I. Watson for whom I had a profound respect and admiration (April *Journal*, p.243). His premature passing was a grievous loss to world medicine as well as to the College.

I have recently returned from a busman's holiday in East Africa where I had spent most of my working life and where malaria remains a major problem—especially now that the emergence of resistant strains of plasmodia has eroded faith in traditional prophylactic regimes. Ronald Ross's discovery of the malaria parasite in 1897 is immortalized in his own words:

> "This day relenting God
> Hath placed within my hand
> A wondrous thing; and God
> Be praised. At His command
> Seeking His secret deeds
> With tears and toiling breath
> I find thy cunning seeds
> O million murdering Death."

This is taken from his book of poems *In Exile* which was presented to me long ago by Ian's distinguished father Sir Malcolm Watson. This letter is accompanied by the book* as a small but heartfelt personal tribute to Sir Malcolm's illustrious son.

A. L. CRADDOCK
48 Bear Croft
Weobley
Hereford HR4 8TA

**The book is now in the College library—Ed.*

Smoking and Schoolchildren

Sir,

I was interested to read the article on smoking habits in Dublin school children (September *Journal*, p. 569).

I did a survey on smoking habits of fourth formers in Spring 1983 with the help of a sixth form group. A confidential (✓ only) questionnaire was completed by 256 out of 257 pupils, 55 per cent boys; 45 per cent girls.

My findings were similar and may be of interest:

- Of 52 pupils taking 'O' levels only, 10 per cent smoked; of 204 pupils taking CSEs and 'O' levels or CSEs only, 30 per cent smoked.
- Of 89 pupils whose fathers were smokers, 38 per cent smoked; of 167 pupils whose fathers were nonsmokers, 19 per cent smoked.
- Of 88 pupils whose mothers were smokers, 36 per cent smoked; of 168 pupils whose mothers were nonsmokers, 20 per cent smoked.
- Of 95 pupils whose 'best friend' was