I hope) to 'reduce the number of poor or marginal candidates', a multiple choice questionnaire (MCQ) paper seems to be the most obvious choice. Its reliability and validity are beyond doubt and, in terms of 'feasibility' and 'examiner time', this method is least demanding. It also happens to be the commonest form of Part I examination used by our sister colleges, and they have been examining a lot longer than we have.

J. BAHRAMI

Bradford Vocational Training Scheme
Field House Teaching Centre
Bradford Royal Infirmary
Bradford
West Yorkshire BD9 6RJ

Sir,

I welcome the lively correspondence on the MRCGP, which appeared in the January issue of the *Journal.* The same issue contained a report by Stanley and colleagues (January *Journal* p.9) on the development of tools for formative assessment during vocational training. There are three aspects of this work on which I would like to comment: first, the nature of the assessment tool itself; second, its possible future use; third, the further light which this throws on the debate about the MRCGP examination and College membership.

The report reveals the work of the examiners at its best. Educational need has been identified, and tackled in a properly rigorous way. The 11 areas of assessment seem to be highly relevant to the practice of medicine, and no doubt reflect an analysis not only of examination performance, but of the experience of the researchers as teachers of medical students and vocational trainees. However, the paper itself is almost entirely preoccupied with arguments about the reliability of the examiners' observations, about the relative independence of the 11 areas, and about the discriminating power of one or other question. These are, of course, matters of great moment when one comes to ask about the fairness and economy of educational assessment. They are, however, secondary to the much more important matter of the examination's validity.

I would therefore urge the writers to publish a further paper in which they describe their thinking. We need to know about the experiences and the debates which resulted in the construction of this assessment tool. In particular we need to know about the value judgements which underpin their work. Such a paper from the examiners, although it would lack the accustomed cosmetics of a research report (tables and correlations) will nonetheless enrich the literature of general practice, and throw light on the current development of our subject.

Although the intention seems to have been to create a tool of formative assessment, we are offered the prospect that this may become mandatory, a Part I of a subsequent pass/fail diploma. The nature of the assessment would then change fundamentally. It would no longer be purely formative, but would become summative, regulatory and so, yet again, distort the educational process.

There is another aspect of the future use of this instrument, which deserves consideration. It was applied to vocational trainees who on average had had some four to five months experience of general practice. In other words, *de facto,* these young doctors were in that phase of their medical education which Todd describes as 'general professional training'. In the future, therefore, our College may wish to join with sister colleges in the further development of some such instrument as a means of enhancing the early years of training for all future clinicians.

If the examiners will reflect on the difference between what it is that they are assessing in their projected Part I examination, and the MRCGP examination which would follow it, they may be able to describe the true content of vocational training. When they come to look at this true content, I suspect that they may find that it can best be validly assessed in terms of performance review.

The introduction of sound formative assessment during vocational training would allow us to create a socially responsible certificate of satisfactory completion of training. This would remove one of the last defences of the MRCGP, that it acts as a guarantor of good training. To argue for the MRCGP examination simply as a stimulus to further learning, as the writers do in their concluding paragraph, is to create a self-fulfilling prophesy. Every examination provides would-be candidates with a stimulus to prepare for it: this says nothing, however, about the relevance of this preparation to the quality of subsequent professional performance.

Let me add a footnote. The debate about the MRCGP examination and its relationship to membership of the College is an important one and is being conducted by serious and honourable people. It adds nothing to the power of the arguments to impugn bad faith, or to attack the character of colleagues, or to misinterpret their views and then deride these as childish and naïve, or to blow trumpets of self-congratulation as a means of sustaining a point of view. The tone of this debate, no less than its outcome, may have much to say about what sort of College we are to become.

MARSHALL MARINKER
Director, The MSD Foundation

Tavistock House
Tavistock Square
London WC1H 9LG

The MRCGP revisited

Sir,

I have been here before; I know all about it. May I therefore, pour my teaspoonful of oil on the troubled inferno of the debate. I have been here for the past 20 years, an Associate, and will remain so while the College remains unaltered. No urgent ambitions have driven me to vault the membership fence, but from my comfortable position on the edge of the enclosure; a mass of 'mediocrity' (R.D. Walker, January Letters, p.37) behind me; a glittering but smaller display of talent in front, I can see much that disturbs; mainly that the crowd have not come to the games, or if they have are throwing bottles at the officials. I also notice that some of the flashier performers of a few years ago have disappeared from the scene and are now smoking in the toilets! Perhaps a regular mass jog away from the stadium in which crowd, athletes and officials voluntarily join in might do more to raise the general level of fitness than the eliminating time trials we have used up to now; although I suppose those that needed to show off might be allowed to do so occasionally.

NIGEL EARLY

The New Surgery
Ashover
Derbyshire

Careers in general practice

Sir,

I should like to make the following comments on Dr McKinlay's otherwise excellent leading article 'A career in general practice' (January *Journal* p.3). First in regard to female principals he cannot surely assume that because North[1] found that 94 per cent of females in his survey were working part time within two years of completing their vocational training this state of affairs would continue. Many females have a period of part time

employment extending for five to six years during the first 10 years after qualification, depending on family circumstances. In the long term, however, this simply means that the 25-year-old male graduate has a potential career of 40 years, while the 25-year-old female graduate has a potential career of 35 years. We would be unwise either to disregard the investment we have made in these young women or to underestimate their skill and determination in ultimately following their career full time. I am afraid that Dr McKinlay's aspirations for the employment of young female doctors in any scheme arising out of the General Medical Service Committee (GMSC) Report for 1984,[2] are totally misleading. The report seeks to address itself to the specific problem of lack of time off for professional and personal refreshment among obligatorily single handed isolated practitioners. The report makes it clear that such doctors practice in considerable personal and professional isolation. As chairman of the Scottish GMSC's Rural Practice Subcommittee I have been involved in identifying such practices and quantifying their needs. The solution of their problems is not yet clear but various proposals exist, including the provision of locum services. Such locums however would be few in number, would be required to work in the same isolated conditions and cope with the same rigours of terrain and climate as the full-time principals and at all times of the year. This is not an exercise in 'jobs for the boys' far less in 'jobs for the part-time girls'.

E.M. ARMSTRONG

The Surgery
Connel
Argyll

References

1. North MA. Evaluation of the experiences of trainees seeking employment after completion of their vocational training. *J R Coll Gen Pract* 1985; **35**: 29-33.
2. General Medical Services Committee. *Single handed practice — a GMSC discussion document. Appendix III. GMSC Annual Report.* London: British Medical Association, 1984.

Video cameras in the consulting room

Sir,

The paper entitled 'The reactions of patients to a video camera in the consulting room' by E. Martin and P.M.L. Martin (November *Journal,* p.607) described a survey of 637 consultations. The authors expressed concern about the higher than previously reported refusal rate (13 per cent) by patients, and that 16 per cent of patients disapproved of the use of videos. They also show that patients are more likely to refuse (20 per cent) when given a consent form to complete before the consultation, than when asked by the doctor himself (four per cent) on entering his surgery.

As 21 per cent of patients felt the video made the consultation less confidential, and 11 per cent said they were made nervous by its presence, these results are highly likely to underestimate the patients' true feelings. It is therefore surprising that the authors failed to make any recommendations based on their results. From their results I think it would be quite reasonable to recommend that before the use of a video camera in the consultation, patients should be given adequate warning (perhaps a minimum of 24 hours) and time to complete a consent form. This would be given to the receptionist who would then inform the doctor of the patient's decision.

A doctor's first responsibility must be to the patient and teaching commitments must come second.

PETER D. PERKINS

The Surgery
102 Southbourne Road
Bournemouth BH6 5JB

Computers in general practice

Sir,

I was interested in the review of the use of computers in general practice from the Sheffield team (December *Journal,* p.649). There is little doubt that the Sheffield experiment has provided the first properly analysed and documented implementation of general practice computerization.

They comment on the variation in usage of the computer during the consultation. In my experience doctors will only use a computer for record keeping if it is easy to enter and inspect the information. In many computer systems the designers have paid too little attention to this aspect and the screen bears no relationship to the needs of the doctor. Massively structured screens and multiple menus do not fit into most doctors' way of working.

They comment that non-directive doctors found the computer terminal intruded into the consultation. As one who regards himself as non-directive I found that the terminal did not intrude as long as a great deal of thought was given to its position. If the terminal is placed on the doctor's desk it tends to dominate the whole consulting room. If, as many do, the terminal is placed on the side of the desk away from the patient the doctors attention is continually distracted from the patient. I found that, with the patient sitting at the side of the desk, the best place for the terminal was on a low table on the other side of the patient. Thus the patient sits between the desk and the terminal. In this position the terminal is low enough not to intrude and the doctor is always looking in the same direction. The computer then becomes part of the consultation with the patient involved in his records to the extent decided by the doctor.

G.M. HAYES

3 Beech Avenue North
Worcester WR3 8PX

Sir,

Reading the article on the use of computers during the consultation by Herzmark and colleagues (December *Journal,* p.649) two thoughts struck me. First, though the type of visual display units (VDUs) used in the study was not specified, I presume they were of the standard type, that is, resembling a large television. The sight of such a monstrosity on the desk must adversely affect the doctor–patient relationship (though this has not been revealed by the studies to date exploring patient reactions to computers in the consulting room). I wonder if a VDU built into the desk in the manner of the video games one sees, for example, in public houses would be an improvement. I feel that a recessed keyboard, which bears a closer resemblance to the present pen and notepad, might be found to be less intrusive by doctor and patient.

The second thought that struck me is on the more general question of increasing the acceptability of computers to doctors. Given that methods of communicating with computers other than a keyboard are unlikely to be developed in the foreseeable future,[1] would it be worth considering teaching our medical students, or trainees keyboarding skills?

COLIN P. BRADLEY

19 Whiteoaks
Wilton
Cork

Reference

1. Royal College of General Practitioners. *Computers in primary care: the report of the computer working party. Occasional Paper 13.* London: RCGP, 1980.