LETTERS

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Assessment of practical skills using video-recording

Sir,

The assessment and teaching of practical skills of trainees is frequently neglected. For instance, some trainers assume that they do not need to teach their trainee to take a blood pressure or cervical smear or assess these skills because they will have been learnt at medical school. Trainers who encourage the learning of skills express surprise at the lack of expertise shown by a number of trainees. Confidence checklists[1] may not ensure a good knowledge of skills, as the trainee may self-mark incorrectly. F.R. Abbatt gives a good outline of methods of teaching skills in his book *Teaching for better learning.*[2]

A useful method is for both trainer and trainee to video-record themselves performing the same activity and look at the recordings together. In the subsequent discussion it is helpful to use the rules described by Pendleton and colleagues[3] when commenting on a colleague's performance. It is also helpful to have an agreed marking form. Together the trainer and trainee can compare one another's performance and observe points needing change. Problems in the consulting room can be corrected later without embarrassing the trainee in front of the patient. The trainee can then practise the skill and re-record the procedure and compare it with the previous recording. The trainee gains in self-confidence when seeing that change has taken place after teaching. The trainer can also learn where teaching needs to be improved and can show the film to colleagues for comment on teaching skills.

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References

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2. Abbatt FR. *Teaching for better learning.* Geneva: World Health Organization, 1980.
3. Pendleton D, Schofield T, Tate P, Havelock P. *The consultation — an approach to learning and teaching* Oxford University Press, 1984.

Glasnost and the medical inspectorate

Sir,

It is a sobering fact that the Cleveland child abuse affair was not uncovered by the medical profession. Only the concern and clamour of parents, a member of parliament, and the media brought the profession and allied services to heel. Certain anxieties, distinct from specific details of the affair, are raised about the National Health Service.

— Has the profession no inbuilt machinery to flush out or even remark upon doubtful practice?

— Had it not been for the media would events at Cleveland have been continuing yet?

— Unless such events are on a large scale do they remain undisclosed and unchallenged?

This case and others (for example, overprescribing of tranquillizers) demonstrate occasional large scale malpractice but small scale malpractice is also worthy of attention. It is essential that doctors confront their own blunders, and those of others, for it presses them into reviewing and improving their *modus operandi.*

Patients are beginning to show a less cowed response to medical errors and the traditional undoubting submission towards their medical advisors is becoming less common. There has been a doubling of the activities of medical defence societies in the last three years. In the USA the consumer and the law are the arbiters of medical quality and the same could happen in the UK before long. However, the more unified structure of the NHS lends itself to internal scrutiny — so avoiding the absurdity of quality control by the legal profession upon the medical profession. So unused to scrutiny are consultants and general practitioners that the notion of a 'medical inspectorate' is unthinkable for many. Doctors are on the payroll of and therefore servants of the taxpayer. Yet they are autonomous. Teachers, dentists, police and pilots statutorily merit scrutiny, but doctors are exempt.

The traditional apothegm 'clinical freedom', means doctors can do what they like, right or wrong. Any suggestion which might change things is deemed an impiety. Yet the Cleveland episode was the result of 'clinical freedom'. Defence societies' actions concern themselves with the results of 'clinical freedom'. A limited amount of *perestroika* is acceptable in the NHS, but *glasnost* and accountability are not, as these are incompatible with 'clinical freedom'.

A medical inspectorate would be similar to any other inspectorate — a small number of doctors (of all specialties) and lay persons perhaps, to check and scrutinize anything they wish; to whom errors may be reported; who may roam around general practice or hospital; who report upon dubious practice to the perpetrator and to others (royal colleges, for example) and who would have the power to stop bad practice. The medical inspectorate, like the regional dental officer or factory inspectorate, must be potent and not a token, its main purpose being to raise standards in the NHS; secondarily it could note inefficiency and waste. The quarry would include misdiagnosis, unnecessarily late diagnosis, overprescribing and iatrogenic disease. Attention to bad practice would have an effect in raising standards. It is also likely that patients would approve of their doctor 'being checked'.

Lawyers tell us that victims of medical mistakes have, almost invariably, one over-