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Formative and summative assessment

Sir,

We would like to comment on the editorial by Tombleson (May *Journal*, p.183). He points out that formative assessment is attractive to teachers because it measures improvement. Although true, there is a theoretical danger that trainees who are good at the commencement of training may be penalized because they show less improvement than colleagues who are poorer initially but then attain a similar standard of achievement. Furthermore, the trainer's eagerness to show improvement in a trainee's performance may bias his or her judgement.

The problem of assessor bias is a potential disadvantage of 'in house' assessment by trainers since poor trainee progress can pose a potential threat to the trainer who may feel that it reflects on his or her competence as a teacher. A potential solution to this problem is to separate the role of assessor from that of the trainer or mentor.

Formative assessment can be valuable but can prove threatening to a trainee if it is regarded as a series of mini-examinations to be negotiated during vocational training. Since its purpose is primarily educational, would it not be better to call it formative education rather than formative assessment? The same tool could be used for the purpose of summative assessment, provided the change in purpose was recognized.

General practitioners who are involved in training at any level must accept responsibility for making assessment decisions. They should be aware that these decisions could profoundly affect the careers of those whom they assess and so must feel confident that the assessment tools they use are valid, reliable and in the public interest. However, even an imperfect assessment procedure can be used to introduce a sense of value. This must surely be better than an almost casual transition from traineeship to principalship?

In summary, summative assessment of competence for entry to general practice is necessary and is best conducted by a doctor who is not the trainee's mentor. Assessment of competence in order to identify learning needs should be formative. The assessment tools may be identical, but the different purposes must be clear to both the assessor and the person being assessed.

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24-hour cover

Sir,

As a former general practitioner, I am well acquainted with the burden which 24-hour cover places on doctors. However, I was surprised to read that relatively little progress has been made in providing alternative or supportive services (apart from the deputizing services) in the period since I left practice in 1984 (editorial, June *Journal*, p.226).

Most practices, I understand, are now group practices and operate from health centre-type premises. In addition, the support services provided therein have also been widened and increased. Practice nurses have, at last, made their presence felt and are now accepted as valuable members of the team. However, the practice nurse is only the first step on the way to a better and more efficient use of paramedical staff at the point of first contact with the general public. The suitably trained nurse practitioner and the general practitioner could work in tandem on a shift basis to provide 24-hour cover.[1] This would ensure that, out of hours, all patients were treated by staff from the group practice.

It was stated in the editorial that 'whatever arrangements are made, it is important that primary medical care be provided by trained general practitioners at all times', but is this necessarily the case, and is it in fact necessary?[2]

In 1978, I asked 'is the general practitioner really necessary?'[3] and in a series of articles, I pointed out that suitably trained paramedical staff could provide a general practitioner type service, with the general practitioner acting in the role of specialist generalist.[4]

Reading the editorial by Maxwell and Toby, it does not appear as if there has been much movement in this direction. With the proper use of paramedical staff working with general practitioners, 24-hour cover could be provided, care remaining within the practice which would be to the mutual benefit of all concerned.

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Voluntary Service Overseas

Sir,

Enclosed with the December 1992 copy of the *Journal* was a leaflet issued by Voluntary Service Overseas and the Royal College of General Practitioners encouraging doctors to enquire about medical posts abroad. I am a medical volunteer and have been working in Malawi for the last two years and I am concerned that some of the information in the leaflet is not strictly accurate.

Under VSO terms and conditions volunteer doctors are not paid a national wage in Malawi; they receive an allowance which is considerably less than that paid to a Malawian doctor in a similar position. It is supposed to cover basic living costs and is the same amount for every volunteer in Malawi, whatever their profession or level of responsibility. To maintain a reasonable standard of living the medical volunteer will have to be prepared to spend his or her own money.

Most VSO doctors are posted as district medical offices and spend much of their time with administration. At the end of two years they usually have reached some

degree of efficiency in their post. However, VSO do not appear interested in retaining them in their jobs for longer periods to use this expertise. The financial incentives to extend are minimal and VSO are opposed to exploring the possibility of an Overseas Development Agency top-up. As a result some district medical officers who would like to continue do not do so because of financial restraints. It would appear that VSO London, at present, are less interested in development and more in the promotion of the two year contract.

Working in a developing country is a worthwhile experience. However, the VSO two year posting is not really development work. It is a useful stepping stone to joining other development agencies and it is a pity that it is not promoted as such.

I am an ex-general practitioner trainer and doubt whether a two year contract has much relevance to vocational training for general practice in the United Kingdom. However, shorter attachments should be considered by trainees.

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Sir,

I am writing to respond to some of the comments made in Dr Lonsdale's letter. In doing so, I am reiterating much of what has already been said or written to Dr Lonsdale on a number of occasions.

Voluntary Service Overseas' commitment to the concept of volunteering and, as part of that, the volunteer allowance has recently been reaffirmed in the organization's 'Strategic plan: investing in people'. The volunteer allowance is a monthly payment intended to cover volunteers' daily needs. It is not linked to the type of work a volunteer does — nor do we believe it should be. Volunteers are all motivated to offer their service, and the contribution they make is greatly appreciated by VSO and its partners overseas, whatever the volunteers' individual experience or the specific responsibilities of their placements.

The allowance is set in agreement with host governments and usually approximates to a civil service grade. Should the allowance fall below what we believe to be an acceptable level, that is, where it is insufficient for volunteers to live as healthily as we would wish, VSO supplements the allowance. It is certainly not our wish that volunteers should need to spend their savings to subsidize the day to day costs of a modest lifestyle, and I do not believe this to be the case in Malawi. We recognize that it is sometimes difficult for volunteers such as Dr Lonsdale living in a city and working alongside highly paid expatriates to remember that they are working as volunteers. However, Dr Lonsdale is in a small minority of volunteers, the vast majority of whom share VSO's belief that the principle of giving service is central to volunteering.

VSO welcomes volunteers' decisions to extend their service and indeed we encourage them to start thinking about this some time before they complete two years in post. We offer a return flight home for extensions of more than six months and an enhanced end-of-contract payment. However, this would not be a sufficient financial incentive to keep volunteers on: they have to believe that there is still more for them to achieve and to learn. Some volunteers may prefer to leave VSO and work with a non-volunteer organization such as the Overseas Development Agency, where financial incentives will be much greater. Those who do decide to extend with VSO continue to work as volunteers and, as such, accept that the principle of volunteering remains the same, however long their period of service. Fortunately, many volunteers do wish to extend beyond their original two year term — over the last two years on average 30% of volunteers have extended their service.

The two year commitment required by VSO is often a constraint to volunteers and perhaps this is particularly true of the medical profession. To try and be more flexible and to meet the needs of both volunteers and employers we are developing new services, one of which will be short-term placements for discrete and specific posts. This initiative has met with considerable interest from the different health professions and I hope we will be able to send more, much needed health volunteers in future, by offering both two year and shorter term placements.

Finally, I believe the Royal College of General Practitioners is better able to comment on the relevance of working overseas to the role of general practitioners in the United Kingdom. However, it is important to point out that volunteers serving as doctors, such as those in Malawi, have responsibility for administration, including financial planning and management, personnel matters, including staff management and development and of course for the general welfare and medical care of their patients in the district hospital and the many clinics and health centres throughout the area. Having spoken to a number of district health officers who have served overseas with VSO, I understand it to be a demanding and stimulating position, offering a wide variety of challenges and rich experiences.

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Vestibular neuronitis

Sir,

I enjoyed Christopher Cooper's excellent summary of the frequently confused subject of vertigo (April *Journal*, p.164).

I have noted non-specific vertigo in many patients taking non-steroidal anti-inflammatory drugs over many years. Most of the commonly used drugs have been implicated at some time. My evidence is entirely anecdotal and I am sure it has been noted by anyone who has frequently prescribed such medication. However, I believe it is sufficiently common to bear in mind when taking a history, especially from older people. The symptoms cease almost immediately on withdrawal of the drug and often do not recur on replacement with an alternative non-steroidal anti-inflammatory drug.

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History of general practice

Sir,

I am pleased to report that two books are currently being prepared on the history of general practice. One, for the period 1858–1948, will be a single author book written by Anne Digby, professor of social history at Oxford Brookes University, Gypsy Lane Campus, Headington, Oxford OX3 0BP; and for the period post-1948 there will be a series of collaborative essays edited by Charles Webster, senior research fellow at All Souls College, Oxford OX1 4AL.

Both these distinguished historians would be grateful to hear from any general practitioner with archival material on their practice or about their predecessors. Casebooks, ledgers, daybooks, diaries, correspondence and photographs would all be of interest, as well as any minute books or guidance to public documentation in private hands.

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