New 'transparent' assessment methods make explicit to both student and assessor not only the content of the assessment, but also the criteria by which success or lack of success will be measured.[1] They are based on criterion rather than norm referencing, and are tackling some of the problems associated with more traditional forms of examination. The four parts to the proposed endpoint assessment of trainees, based on tests of factual knowledge and problem solving, practical work, evaluation of clinical and consulting skills, and the trainer's overall assessment,[2] will, hopefully, follow this pattern.

It is self evident that there is a need to ensure the safety of trainees about to leave the training arena to become fully fledged, independent practitioners. But why let the assessment process stop there? In the light of the decision of the Joint Committee on Postgraduate Training for General Practice to introduce assessment for trainees,[2] general practice has the opportunity to create an assessment system that can be both formative and summative in function. It can be based not on merely local, or even regional perceptions of a competent new general practitioner as suggested by Pereira Gray, but could be agreed nationally. With a national agreement on the standards embodied in such an assessment, the profession could establish an agreed definition of 'competence' in general practice, in line with reviews of training being carried out by other professions.[3] Current discussions relating to reaccreditation of general practitioners indicate that the issue is already one which is occupying the minds of many.[4] Such a framework of defined competence would allow students, trainees and practising general practitioners to work in a structured and self directed way towards achieving those standards. The endpoint assessment of trainees may then become a point on a continuum of training and development that begins with undergraduate training and ends at retirement.

Agreeing what such a continuum could look like would be arduous, but its existence would create a validity for the professional status of general practitioners, that could only be beneficial for both doctors and their patients. As change is on the way, it would be a shame to stop half way and miss this opportunity to create a national framework for assessment for all general practitioners.

MAGGIE CHALLIS

Department of General Practice
Sheffield University Medical School
Beech Hill Road
Sheffield S10 2RX

References

1. National Council for Vocational Qualifications. *Guide to national vocational qualifications.* NCVQ, 1992.
2. Joint Committe on Postgraduate Training for General Practice. *Report of the summative assessment working party.* London: JCPTGP, 1993.
3. Eraut M, Cole G. *Assessing competence in the professions.* Sheffield: Employment Department, University of Sheffield, 1993.
4. Hilton S.Reaccreditation for general practice [editorial]. *Br J Gen Pract* 1993; **43:** 315-317.

Sir,

I wish I could share Pereira Gray's upbeat view of compulsory summative assessment of vocational training (October *Journal*, p.402). He particularly welcomes the idea of an objective examination at the end of training. In contrast, I believe that the words of another strong RCGP protagonist, the late John Stevens, are as valid now as they were in 1973: 'Subjective and peer evaluation is of infinitely greater value than any so-called objective assessment. I believe it to be wholly wrong ever to prepare a trainee for an examination... To do so is an admission of educational failure'.[1] It was Marinker, a distinguished former RCGP examiner, who pointed out the dangers of examinations in controlling the curriculum of training.[2] I shudder at the thought, for example, of trainees practising videorecording their consultations with the idea of 'passing' in mind, rather than as part of a professional ethos of self criticism that does not stop the day training finishes.

From all over the country we hear of applicants to general practitioner training schemes being as scarce as oases in a desert. Is the prospect of another major compulsory examination likely to improve recruitment? Of course the public needs to be protected from incompetent doctors but, even if the proposed objective assessment were to work, it could well weed out the odd bad doctor at the price of a huge shortage of general practitioners. And is there really pressure from the public for such a 'bizarre *rite de passage*'?[1]

Pereira Gray admits that the details still need to be worked out. I share his admiration for many aspects of the MRCGP examination, but translating that examination to a compulsory endpoint assessment of training is more than a detail. Presumably the examination would have to be criterion referenced. This alone would alter its whole concept as it would be necessary to define precisely what standard is required to achieve a pass. I imagine there would be an outcry if the pass rate remained of the order of only 75%. If the standard is to be lowered, how is this to be done? How would the examiners feel about running an examination of a very different character and which might no longer be linked with RCGP membership? I, for one, will not be applying to become such an examiner.

'I am horrified when I think of the rigidifying influence and sheet waste of resources in erecting an examination industry to process well over 1000 candidates each year'.[1] 1994 would be a landmark year for me if instead we used those resources to try and restore the morale of our profession. Only then can we adequately serve the public.

PAUL SACKIN

Flat 12, Stukeley Park
Chestnut Grove
Great Stukeley
Huntingdon
Cambridgeshire PE17 5AD

References

1. Stevens J. Brief encounter. James Mackenzie lecture 1973. *J R Coll Gen Pract* 1974; **24:** 5-22.
2. Marinker M. The MRCGP revisited [editorial]. *J R Coll Gen Pract* 1984; **34:** 529-534.

Videotaping consultations for assessment

Sir,

The efforts of those seeking to formalize the assessment of general practice trainees are to be applauded. However, the long-awaited discussion paper arising from the west of Scotland pilot project must be viewed with disappointment (October *Journal*, p.430). It fails adequately to justify the videotaping of live consultations, a technique which represents an unacceptable intrusion into the unique and intimate environment of the consultation.

To have cited the results of Martin and Martin does nothing to dissipate the ethical objections of many within and outwith the medical profession.[1] This study is often quoted by proponents of videorecording of consultations, but it is inherently biased, as patients would potentially be influenced by an impression that their doctors' participation rendered this to be an acceptable or desirable technique. Also of interest is the finding that 11% of those who consented disapproved of recording.

A recent survey of patients' attitudes to videotaping of consultations has found that approximately half would feel under pressure to participate in a videotaped consultation.[2] A significant majority anticipated feeling uncomfortable during such a consultation, said that they would find it either difficult to extremely difficult to forget that it was being recorded, and would not be able to discuss their problem(s) fully with the trainee.

The use of simulated patients, as discussed by Kinnersley and Pill, would avoid such problems.[3] If only one patient is sufficiently inhibited to omit an embarrassing or intimate symptom because of the presence of the videorecorder, and this results in a delayed diagnosis, the medico-legal implications are considerable. It is to be hoped that good sense will prevail, and that the doctor–patient relationship will cease to be abused in the name of assessment.

NEIL S D MACKAY

The Surgery
75 Bank Street
Alexandria
Dumbartonshire G83 0NB

References

1. Martin E, Martin PML. The reactions of patients to a video camera in the consulting room. *J R Coll Gen Pract* 1984; **34:** 607-610.
2. Bain JE, Mackay NSD. Videotaping general practice consultations. *BMJ* 1993; **307:** 504-505.
3. Kinnersley P, Pill R. Potential of using simulated patients to study the performance of general practitioners. *Br J Gen Pract* 1993; **43:** 297-300.

Voluntary Service Overseas

Sir,
It is sad that Lonsdale takes issue with a Voluntary Service Overseas/Royal College of General Practitioners leaflet for not making it clear that VSO doctors do not earn large amounts of money (letter, October *Journal*, p.437). However, he fails to understand that the overwhelming majority of VSO volunteers are not attracted by financial rewards but by the general philosophy of VSO which is one of partnership with the people of developing countries and a sharing of skills with them. It may be difficult for a few volunteers like Lonsdale to keep up with the lifestyles of some highly paid expatriates, but as noted in Green's reply, for most volunteers the allowance provides for a reasonably modest lifestyle without any need to use their own private money (letter, October *Journal*, p.438).

I worked as a VSO district health officer in Malawi from 1986 to 1989. Although I had initially intended to stay for two years, I stayed an extra year and received much encouragement and support from VSO. I then returned to the United Kingdom and now work in general practice.

Although VSO encourages most volunteers to extend their service for a third year, some doctors may prefer to continue working overseas with a different organization, such as the Overseas Development Agency. Others choose to do further studies before returning to work overseas, doing courses in tropical medicine or public health, where their experience of having actually worked in a developing country is a great advantage. Some doctors work abroad for two or three years and then return to work in the UK, usually in general practice or public health. Their experience in administration, and financial and manpower planning is much more than would have been gained in the UK and is of great benefit in dealing with the increasing administrative burden of the National Health Service.

Whatever their length of service and whatever their future plans, VSO encourages all returned volunteers to attend a debriefing weekend to discuss their experience overseas with other returned volunteers and VSO staff. This provides a good opportunity to review all aspects of working overseas and encourages each returned volunteer to consider how best to use the experience in future work, either overseas or working in the UK.

Lonsdale is certainly right when he says 'working in a developing country is a worthwhile experience'. The work done by the volunteer helps the people of the host country, and the volunteer learns about another culture and other ways of working to promote development. The RCGP has recognized the value of such work and the recent links with VSO are to be applauded and encouraged.

DAMIAN KENNY

18 High Furlong
Cam
Dursley
Gloucestershire GL11 5UZ

Aid for Bosnia-Herzegovina and Croatia

Sir,
The agony of Bosnia continues and we have all been appalled by what is happening. Edinburgh Direct Aid is a registered charity run entirely by volunteers. Each month it sends a convoy to areas of specific need in Bosnia and Croatia. People who have been through expulsions, shelling, blockade and economic collapse and who are now experiencing another cold and hungry winter must get food and medicines.

Any drugs which have recently become out of date or are not needed could be sent to alleviate suffering. If you have any antibiotics, analgesics, diuretics, drugs for epilepsy, depression or stomach ulcers, digoxin or vitamin tablets, please do not destroy them. We need full blister packs and not half-used personal returns. Any medical/dental equipment or surgical supplies that can be spared would also be very welcome.

Please send anything you think will be useful to Jeanne Bell, consultant neuropathologist at the Western General Hospital in Edinburgh, or contact her by telephone on 031-551 2639.

DIANA KINNEAR

Edinburgh Direct Aid
4 Carlekemp
North Berwick
East Lothian EH39 5DA

Research in diabetes mellitus

Sir,
We are trying to compile a comprehensive database of all clinical trials (completed, in progress or planned) which are concerned with shared care (that is, any form of combined approach involving both primary and secondary care) in the management of patients with diabetes mellitus. We would be interested to hear from any workers who have undertaken research in this field, either in the United Kingdom or abroad.

P M GREENHALGH
A P HAINES
J S YUDKIN

Department of Primary Health Care
University College London Medical School
Whittington Hospital
Archway Site, Highgate Hill
London N19 5NF

Gilles de la Tourette syndrome

Sir,
The parents of a 13 year old sufferer of Gilles de la Tourette syndrome have noticed that his symptoms of twitching and utterances are much better after exertion. The boy's parents are keen to avoid drug therapy and would be interested to hear anyone's experiences of the non-pharmacological management of this syndrome.

P G WEAVING

The Surgery
4 Market Place
Brampton
Cumbria CA8 1NL