authority. The practice management costs of our model are estimated to be less than a 20th of this amount. The National Health Service Management Executive has begun to recognize the potential advantages of alternative models to fundholding.[4,5]

We agree that an improved information system is essential if the purchaser–provider split is going to be made to work. In collaboration with Nottingham Health Authority, Nottingham Non-fundholders have helped to develop and pilot an electronic outpatient booking system which will give general practitioners up to the minute information on waiting times and enable them to book an appointment in the same way as one would expect to book a holiday through a travel agent. Every appointment, from whatever source, will ultimately be logged through this system, yielding an unprecedented amount of information on which to base future planning and purchasing decisions.

We believe our model has the greatest potential for achieving the foxtrot aspired to by Bowie and Harris — between doctors and patients, purchasers and providers — and will ultimately be recognized as the model of choice.

D G BLACK
A D BIRCHALL
I M G TRIMBLE
S O FRADD

Nottingham Non-fundholders
Sherwood Health Centre
Elmswood Gardens
Nottingham NG5 4AD

References

1. Bradlow J, Coulter A. Effect of fundholding and indicative prescribing schemes on general practitioners' prescribing costs. *BMJ* 1993; **307:** 1186-1189.
2. Keeley D. Prescribing costs: fundholders had a head start [letter]. *BMJ* 1994; **308:** 206-207.
3. Illiffe S, Freudenstein U. Fundholding: from solution to problem [editorial]. *BMJ* 1994; **308:** 3-4.
4. National Health Service Management Executive. *Good practice and innovation in contracting.* Leeds: Department of Health, 1993.
5. National Health Service Management Executive. *Review of contracting — guidance for the 1994-95 contracting cycle.* Leeds: Department of Health, 1993.

Sir,

Bowie and Harris have suggested an interesting and logical way to develop fundholding (January *Journal*, p.38). Some non-fundholders have begun to develop along similar lines, with the setting up of locality purchasing groups. In mid-Devon, for example, 15 practices covering 80 000 patients have combined to form the Mid-Devon Family Doctors Group. For this group, as in the Bowie and Harris model, the district health authority is responsible for commissioning, contracting, financial arrangements and billing. Similarly, the group is able to overcome problems with two tier systems, excessive administrative costs, accountability, fragmentation of purchasing and poor use of general practitioner time. Indeed, the only difference between such a group and the Bowie and Harris model is that we foresee the whole group having a notional fund rather than each individual practice.

Groups can provide common purchasing messages, which are helpful in the planning of local services. With district health authority support, there is no reason to believe that they would find it any more or less difficult to keep within budget than fundholding practices, given the problems that have arisen in setting and policing individual practice budgets. Perhaps in such as system, practices should be able to choose whether to hold individual or group budgets.

With the development of fundholding groups as well, fundholders and non-fundholders seem to be tunnelling towards each other. To be effective, non-fundholding groups will need to be able to attend to detail and also to have a satisfactory information base. Help with administration costs and computer development will be necessary. Such help and support will be required in future from the Department of Health and regional health authorities, who will need to show themselves to be fair and open-minded on the fundholding/non-fundholding issue.

MICHAEL DIXON

College Surgery
College Road
Cullompton
Devon EX15 1TG

Trainee assessment

Sir,

Dr Mackay (letters, January *Journal*, p.44) voices his opposition to our use of videotaped consultations in trainee assessment.[1] He compares the findings of Martin and Martin,[2] which show that most patients find videotaped consultations acceptable, with his own survey which appears to show that this is not the case.

There are facts which are not clear from Dr Mackay's letter which we believe are of importance in weighing up the evidence. The first point is that the Martin and Martin results were published as a peer-referenced paper, whereas Dr Mackay's study has not been published but has been quoted by him in an earlier letter.[3] Readers have therefore not had the opportunity to see the details of the work carried out nor has there been an opportunity for peer review. One of the details is that of the patients surveyed by Dr Mackay none had ever been asked to take part in a videotaped consultation. The patients were in fact responding to hypothetical questions such as 'how do you think you would feel if you were asked to take part in a videotaped consultation?' Provided that patients are given every opportunity to refuse to take part and that consent is freely given we believe that the use of videotaped consultations in summative assessment is an ethical and powerful tool to detect unsatisfactory doctors, something which can only be of benefit to the public.

While agreeing with Dr Allen (letters, February *Journal*, p96.) that if simulated patients could assess clinical competence reliably the need for direct observation by medically trained assessors would be eliminated, the American experience he describes[4] suggests that such reliability would be difficult to attain and would incur its own resource implications. In the American study it required three weeks to administer tests to 70 students with the resultant generalizability coefficient ranging from 0.61 to 0.72 (optimum 0.80). The test also involved written answers after the consultation which would would clearly require medical input to mark. The cost of developing and administering the test to 72 students was calculated at £26 800. The study by Rethans and colleagues and quoted by Dr Allen specifically states that 'the results in this study do not allow us look at individual doctors'.[5]

L M CAMPBELL
T S MURRAY

West of Scotland Committee for Postgraduate Medical Education
The University of Glasgow
Glasgow G12 8QQ

References

1. Campbell LM, Howie JGR, Murray TS. Summative assessment: a pilot project in the west of Scotland. *Br J Gen Pract* 1993; **43:** 430-433.
2. Martin E, Martin PML. The reaction of patients to a video camera in the consulting room. *J R Coll Gen Pract* 1984; **34:** 607-610.
3. Bain JE, Mackay NSD. Videotaping general practice consultations [letter]. *BMJ* 1993; **307:** 504-505.
4. Vu NV, Barrows HS, Mary M, *et al.* Six years of comprehensive clinical performance based assessment using standardised patients. *Acad Med* 1992; **67:** 42-49.
5. Rethans J-J, Sturmans F, Drop R, van der Vleuten C. Assessment of the performance of general practitioners by the use of standardized (simulated) patients. *Br J Gen Pract* 1991; **41:** 97-99.