patient, professions or public purse. It conspicuously fails to make optimal use of the skills of the professions while costing a staggering sum. The benefits which pharmacy can contribute to the prescribing/dispensing sequence are not dependent upon their being provided by a separate contractor.

Lastly, quality assurance and risk management are both hazarded by dispersing an intrinsically unitary process through time, place and unconnected agencies.

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References

1. Clucas K. *Pharmacy: a report to the Nuffield Foundation,* London: Nuffield Foundation, 1986.
2. Brown P. Are pharmacists necessary? *Scrip* 1994; May: 3-4.
3. Audit Commission. *A prescription for improvement.* London: HMSO, 1994.

Leicester assessment package

Sir,

In their paper exploring the face validity of the Leicester assessment package. Fraser, McKinley and Mulholland use an established but misleading ploy in seeking the views of course organizers: they ask the question 'Do you agree with us?', rather than 'What are your views about what should be assessed and how?'.[1]

Who could possibly disagree with the importance of the criteria listed? However, while agreeing that assessment should form an important part of teaching, I am not sure that the Leicester assessment package represents anything other than a refinement of tools we already possess. These tools may be valid, but they often miss the point.

To ascertain, for example, whether the trainee really has considered 'physical, social and psychological factors, as appropriate' one would need to study their thought processes as well as their behaviour as observed on a videorecording. This seems to be what Neighbour is telling us in *The inner apprentice*, but is something that the medical profession as a whole has not yet addressed.[2]

However, other professions have. In his book *Educating the reflective practitioner* Schon explores at length techniques of teaching that involve assessing how and what trainees are thinking, as well as their behaviour and the outcome.[3] The process of supervision as described by Hawkins and Shohet provides a structure in which to explore cognition as well as action and end product.[4]

In these frameworks for teaching, far from being something one does at specified intervals, assessment becomes an integral part of the teaching process, and all the more valuable for that. Perhaps this is something that the profession as a whole, as well as trainers, should consider.

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References

1. Fraser RC, McKinley RK, Mulholland H. Consultation competence in general practice: establishing the face validity of prioritized criteria in the Leicester assessment package. *Br J Gen Pract* 1994; **44:** 109-113.
2. Neighbour R. *The inner apprentice.* London: Kluwer, 1992.
3. Schon DA. *Educating the reflective practitioner.* San Francisco, CA: Jossey-Bass, 1986.
4. Hawkins P, Shohet R. *Supervision in the helping professions.* Milton Keynes: Open University Press, 1989.

Sir,

We read with interest the paper by Fraser and colleagues on the reliability of the Leicester assessment package (July *Journal,* p.293). The statistical analysis was elegant but we believe that the concentration on internal consistency may give a misleading impression of what the study actually demonstrated. The study showed that five out of six assessors were able to rank order five doctors with reasonable consistency. The subjects concerned ranged from principals in general practice to a hospital doctor with no general practice experience at all. We suggest that the reliability of an assessment instrument is best assessed by testing it in the context in which it is intended to be used. We are therefore puzzled as to why the authors chose to use subjects of varying experience, thereby introducing a possible confounding variable, whereas in real life the subjects would have similar experience and the assessment process would be used to identify varying competence.

We are also puzzled by the authors' statement that the system can be recommended for use in summative assessment. The essence of a summative assessment process is that it sets out to identify a minimum standard of competence. The Leicester assessment package produces a score which could certainly be used to rank order candidates but the authors do not offer any suggestions as to what score in the package would equate to minimal acceptable competence. If the system relies on rank ordering which would inevitably result in failing a fixed percentage of candidates it is unlikely to be acceptable to a large body of general practice opinion.

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Treatment of drug misusers

Sir,

Michael Taylor states that our research work on the treatment of drug misusers[1] 'undermined rather than supported traditional patterns of general practitioner behaviour' and that the inception of new community drug teams served to 'undermine general practitioners' confidence at the very time this piece of research was taking place' (letter, April *Journal,* p.186). Far from disagreeing with such critical comments, we regarded this phenomenon as of such importance that we reported on this inadvertent counter-productive effect in our paper. Such damning criticism should not be dismissed, however disappointing the findings may be.

Research can indeed change that which it purports to be studying, usually through the wider impact of the introduction of a new study condition or the new mechanisms required to collect data. However, in our research it seems reasonable to presume that it was the new community drug teams and their regional structure (and not the evaluation by the university research team) that caused any such effect (only one member of the research team was actively involved in the introduction of the new system of drug services). Artefactual reduced activity may certainly occur as a result of the tail-off phenomenon,[2] which could indeed account for any reduced return of data-gathering forms, as Taylor suggests. However, this fails to acknowledge that the reduced level of activity (as reported in our paper) was also evident in face-to-face interviews with general practitioners.

Finally Taylor makes the important observation that the caseload per worker of his local community drug team is little more than his own individual caseload in his single-handed practice. We have previously reported[3,4] on the significantly higher activity levels of community drug teams with inbuilt medical care and we share Taylor's concern that such new teams can often fail to mobilize local provision, such as Taylor's own activity, and may instead recreate a specialist at the local level. When such a development occurs, then a new approach designed to enable general practitioners to take a more active role, for example through shared-