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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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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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-

care arrangements, would appear to have backfired and to have enabled an unplanned disengagement from provision of care to this important clinical group.

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Prescribing antidepressants

Sir,
I write concerning Kerr's paper, comparing antidepressant prescribing between general practitioners and psychiatrists (June *Journal*, p275). The author comments on the significant differences in reported prescribing between the two groups considered but does not discuss whether the patients seen by the two groups were comparable in demography or severity of depression. The finding that the psychiatrists generally used higher doses does not imply that general practitioners were using doses which were too low. Their compliance or otherwise with guidelines is a separate issue.

The author fails to comment on the fact that several general practitioners reported sometimes prescribing doses well beyond those recommended in the guidelines,[1] preferring to concentrate on those (admittedly a larger group of doctors) prescribing low doses. Although the table presents separate results for elderly patients the paper does not point out that recommended doses for elderly people are much lower than the 125–150 mg equivalent of amitriptyline quoted.

General practitioners reading this paper may be left with the impression that they need to increase their prescribing of antidepressants when the data do not support such a conclusion.

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Assessing inhaler fullness

Sir,
Rickenbach and Julious claim that previous papers on the floatation of inhaler canisters in water have been limited to the principle that a full canister will sink and an empty canister will float (July *Journal*, p.317).

In fact, in a discussion of the techniques which may be of use when assessing patient compliance with a beclomethasone dipropionate aerosol, five floatation positions have been described.[1] The positions are: fully immersed indicating a full canister; vertical but fully submerged indicating three quarters full; vertical but with the base exposed to the air indicating half full; on the side with the valve immersed indicating one quarter full; and on the side with the corner of the canister valve exposed to the air indicating empty. However, this description does not include any measurement of the canister contents.

Further reference to the technique of floating canisters in water is to be found in the 1993 National Pharmaceutical Association booklet *Asthma and the pharmacist.*[3] The diagram in this publication again suggests five floatation positions are possible, but unfortunately only three of them are identical to those in the paper by Fischer and Kuhn.[1]

It is well documented that many health workers involved in asthma care lack rudimentary skills in the actual use of inhalers[3,4] and one wonders whether they will be able to describe accurately the floatation assessment method.

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Part-time training in general practice

Sir,
I would like to draw readers' attention to article 34 of the council directive 93/16/EEC which refers to specific training for general medical practice.[1]

The European Union will require, with effect from 1 January 1995, that 'the weekly duration of part-time training may not be less than 60% of weekly full-time training', and that 'part-time training must include a certain number of full-time training periods, both for the training conducted at a hospital or clinic and for the training given in an approved medical practice or in an approved centre where doctors provide primary care. These full-time training periods shall be of sufficient number and duration as to provide adequate preparation for the effective exercise of general medical practice.'

The provisions about 60% and undertaking some full-time training are appreciably different from the requirements of the vocational training regulations and it is important that all readers who may be planning part-time training for general practice after 1 January 1995 are aware of these new requirements.

The Joint Committee on Postgraduate Training for General Practice will be considering how to implement these new requirements in the most sensitive and practical way possible.

All those interested in or considering planning part-time training for general practice are advised to seek advice from the regional advisers in general practice who have been appointed in every region in the United Kingdom.

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Reference

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