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Summative assessment for GP registrars

Sir,

At a recent meeting of all Tayside trainers, it was concluded, after prolonged debate, that while the need for certification of trainee competence was undeniable, the current proposals for introducing Summative Assessment were both cumbersome and difficult to accept. Subsequently, these views were recorded in this letter which was circulated to all trainers (42) within Tayside. Over 80% of them (34) replied in writing confirming their support for the views expressed.

Several areas of concern are highlighted:

1. There has been insufficient consultation with ordinary trainers who will be expected to carry through much of the Summative Assessment process. Although the proposals may have been around for some time, it is only now that there is some detail that sensible discussion can take place about.
2. The very short timetable for introduction poses many problems, among which is a strong feeling that criteria and standards for the component parts are being hurriedly rushed through. Thus, it is unlikely for these standards to stand challenge when trainee registrars are referred and subsequently appeal.
3. There is serious concern expressed over the understanding that the multiple choice components of the assessment are being purchased from Australia. This would almost certainly mean that important aspects of UK general practice would be excluded by an examination not validated in this country. How can this be defended when the College probably possess this most thoroughly validated bank of MCQ questions on general practice in the world?
4. It is strongly felt that the resource issues have not been fully addressed. Some regions will have great difficulty in identifying sufficient assessors, protecting time to carry out assessments and training, and resourcing the whole process.
5. It seems that the workload of hard-

pressed general practitioners will be increased once again, with extra demands being imposed.

6. It appears likely that Summative Assessment will come to dominate the registrar year to its overall detriment.
7. The medico-political and educational manoeuvres behind the current proposals are quite frankly unacceptable in this day and age.

The need for competence certification is not challenged in any way, but a validated tool already exists in the form of the MRCGP which could be modified into a two-part examination with a little work and goodwill. Indeed, such proposals are already very much to the fore.

It is felt that Part I of the examination could consist of the current MCQ, modified to ensure an appropriate pass rate and augmented by a video assessment to ensure consulting competence. This would provide the basic test necessary to allow the VTR 1 to be signed. (This could also be supported by the trainer's report.) It is pointed out that, if young doctors wish to become members of the College, then they could do so at a later stage in their careers, by passing a new Part II examination.

It is well recognized that these eminently sensible and reasonable proposals are not new and have been around for some time. Considerable anger was expressed that they had been blocked for medico-political and not educational reasons.

It is felt that a golden opportunity to bring some much needed unity into general practice education and training as well as an overall boost to the vast majority of the professions morale is in danger of being lost. We would wish to know whether the views expressed so strongly by the trainers in this region reflect those being expressed elsewhere. If this is the case, we feel that there should be a major re-think of the JCGPT proposals.

In all other medical specialities, the mechanism for certification of competence of a period of higher professional training is through the relevant specialty College examination, thus achieving professional self-regulation. Why should general practice be any different? Unfortunately, a number of institutions and organizations in general practice have

a vested interest in vocational training, including the RCGP, the GMSC, the JCPTGP, the Conference of Regional Advisors and the AUDGP. We would urge these bodies, even at this late stage, to attempt to come to an agreement on a single pathway to certification assessment.

If we fail our colleagues and the general practitioners of the future by settling for a poor and flawed compromise once again, then we deserve all the ridicule of our professional colleagues as well as the bemusement of our increasingly disenfranchised patients.

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Heart failure in primary care

Sir,

The study by Dr Mair and colleagues (February *Journal*, p. 77) further emphasizes the problems faced by researchers when studying patients with heart failure in primary care. Firstly, they included patients diagnosed as having heart failure clinically. There are no uniform diagnostic criteria for congestive heart failure. In practice, however, the diagnosis of heart failure relies on clinical judgement based on a history, physical examination and appropriate investigations.¹ The patients should have the following symptoms: symptoms of heart failure, typically breathlessness or fatigue, either at rest or during exertion; or ankle swelling and objective evidence of major cardiac dysfunction at rest.¹ Breathlessness, ankle swelling and fatigue may be difficult to interpret particularly among elderly patients, the obese and in women.¹ Furthermore, inter-observer agreement on the presence or absence of symptoms may also be low.² At present, the echocardiogram is the single most effective tool for the objective evidence of heart failure.^{1,3}

Secondly, the investigators scrutinized records to determine what investigations had been performed for each of the patients including blood urea and electrolytes to assess for renal function in the preceding 12 months. However, there is no evidence to show that annual assess-

ment of blood urea and electrolytes leads to an improvement in outcome of these patient. A more appropriate investigation to report would have been the number of patients commenced on an ACE inhibitor who had an assessment of renal function and serum potassium prior to commencement of an ACE inhibitor and one week after. This is the suggested practice according to evidence-based guidelines.⁴

Finally, the authors conclude that 67% of patients were not receiving treatment with ACE inhibitors. However, they do not indicate how many patients diagnosed as having heart failure had confirmation of their diagnosis by echocardiography. A community study has shown that only 50% of patients being treated for heart failure have echocardiographic evidence of left ventricular systolic dysfunction.⁵ There is good evidence that all patients with symptomatic heart failure and impaired left ventricular systolic function will benefit from treatment with an ACE inhibitor.^{6,7} Furthermore, the authors failed to report how many patients being treated with an ACE inhibitor had confirmation of left ventricular dysfunction. Therefore, some of these patients could have been prescribed these drugs inappropriately. Clearly, we need to identify uniform criteria for inclusion when studying patients with heart failure in primary care.

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Sir,

Mair and colleagues attribute the almost four-fold increase in prevalence of heart failure in their study (15 per 1000) (February *Journal*, p.77) compared with a previous London study¹ (3.9 per 1000) to the superiority of their computerized record systems. It also probably reflects the non-specificity and insensitivity of the clinical signs and symptoms used to diagnose heart failure.² The importance of echocardiography in confirming the diagnosis has been emphasized,^{3,4} and in both studies, the majority of patients were not investigated in this way. With increasing access to echocardiography, the accuracy of diagnosis is likely to improve.

In our practice of 8131 patients, a computer search was made in February 1995 for all those patients with a recorded diagnosis of cardiac failure, and also for all patients on repeat prescriptions for loop diuretics. Records were examined manually and the following results obtained:

1. Prevalence of cardiac failure: 84 (10.3 per 1000 patients)
2. Number (%) on ACE inhibitors: 33 (39.3) seven others unable to tolerate
3. Number (%) who had had echocardiogram: 43 (51.20)
4. Other patients with heart disease (e.g. previous myocardial infarction, angina or valvular disease) and on regular loop diuretics: 44 (i.e. possible cardiac failure)

In common with the above studies, the results suggests a substantial number of patients in primary care who merit echocardiography and consideration for ACE Inhibitor therapy. Where open-access exists, general practitioners must decide whom to refer for this investigation. Assuming a prevalence of around 1% and that half of these patients may not have had an echocardiogram, an average UK practice of 10000 patients will have at least 50 patients who are potential candidates.

The selection of patients, who are often elderly or relatively asymptomatic (more severe cases will self-select), will involve time, organization, and the acceptance of peoples' right to refuse unsought-after scans, blood tests or medication. However, with the increasing use of computerized disease registers and easy identification of 'high-risk' patients, the challenge for those in primary care is to find

ways to offer effective interventions to those who stand to benefit.

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Medical audit in France

Sir,

Medical audit is a way of ensuring the quality of care in everyday practice. This type of evaluation is still insufficiently developed in France. The National Agency for the Development of Medical Evaluation (ANDEM) is a non-profit organization aimed at the promotion of evaluation methods in hospitals and ambulatory care.

Our audit concerned the practice of influenza and tetanus immunization in patients over 60 years of age by general practitioners. An external pilot committee designed and followed up the study. The initial guidelines were based on literature review and specialist consultation. These were established by a group of 50 practitioners as follows: for tetanus, patients aged over 60 should be immunized every 10 years; for influenza, annual immunization for patients aged over 70, or between 60 and 69 years presenting with one of the conditions considered as special risk if they develop influenza.

The initial data collection began in December 1991. Three hundred physicians from all over France were contacted by letter during the one-month recruitment period. Out of these, 151 accepted and performed the initial data collection. Overall, 102 (67%) out of the 151 physicians completed the entire 2-year audit cycle. Patient data were recorded for the first 30 consecutive patients over the age of 60 seen in the physician's office or at a home visit. In 1991, 2898 patients over the age of 60 were recorded, including 2046 over the age of 70 or with a risk factor for influenza. The initial data showed a