Summative assessment
T Stuart Murray 1267

The feasibility of standardized data collection in primary care
J A Spencer and K P Jones 1267

Primary care counselling and the community mental health team
Terry Cubit 1268

Right from the start
Elizabeth Muir 1269

Summative assessment
Brian D Keighley 1269

Counselling in primary care
B S Cole 1269

Hormone replacement therapy
Helen Winpenny 1270

STD and HIV screening in general practice
Tim Stokes, Rashmi Shukla and Paul Schober 1270

Watchful waiting in glue ear
Gordon Hickish 1271

Counselling
Martin J B Wilkinson 1271

Evidence-based consultation
Tom Marshall 1271

Audit activity
Murray Lough and T S Murray 1272

Shifting the work
D T Price 1272

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Summative assessment

Sir,

I am surprised that Rhodes and Pietroni (January *Journal*), on discovering that the results in their region for summative assessment were at such variance from the published work,[1,2,3] immediately chose to criticize a valid and reliable system rather than carry out an internal audit within their own deanery. The only purpose of summative assessment is to identify the GP registrar who is not competent, and the system is set up to achieve this aim. In the video component, the first level of assessment is all about sensitivity, with the two assessors working individually to make a judgement: either that the GP registrar is competent or that there is some doubt. If there is doubt, the videotape is referred to the second level. The aim of the first level is to ensure that all potential GP registrars who could fail are identified. The published work[1,2,3] has not only shown that 20% of GP registrars will be identified at the first level for further examination, but that, ultimately, around 5% of GP registrars will fail summative assessment. The comparative data for North West Thames is only 1.2% — this finding must surely raise questions as to why such a disparity has arisen.

Fortunately, the United Kingdom (UK) Conference of Regional Advisors have the National Quality Control system, and, for the first year, 20.8% of GP registrars throughout the UK were identified at the first level for referral to the second level in the video analysis, which mirrors the published work. Unfortunately, North West Thames only referred 11.3% from the first to the second level and there clearly is a training/calibration issue within the region, which should be in keeping with their low fail rate. The region also refers fewer candidates to the National Panel than would be expected, and these two factors explain the disparity. Rhodes, although leading summative assessment in his own region, opposes[4] the current content of summative assessment.

We have been able to look at the five multiple choice questions and problem-solving tests that were held from September 1996 to September 1997, with a total of 1871 candidates. This is the only objective test taken by all GP registrars. When comparing all the mean percentage scores by regions, the mean for all candidates was 73.64. The GPs in the North West Thames region scored 74.95 and the range of means for all regions differed by only 1.5 marks. This provides unequivocal evidence that there is no difference in the range of abilities of GP registrars throughout the UK. The information demonstrates that there is a training calibration problem within North West Thames, and, as professional educators, I know that they will respond to this problem in a very positive way.

The cost for summative assessment quoted by North West Thames is £775 per candidate. A study of costs has been carried out by the National Summative Assessment Office and almost all regions have costs per candidate of between £425 and £450. North West Thames must look at why their figures are so much more expensive. Comparative data are uncomfortable for those who are different but surely everyone else cannot be out of step.

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The feasibility of standardized data collection in primary care

Sir,

Data collection in the National Health Service (NHS) has significant costs[1] and consumes much staff time in primary care.[2] Despite considerable activity and enthusiasm in general practice,[2] few data have appeared to aid resource allocation and improve health care. Relevant primary care data can be collected at several tiers of the NHS, but their importance should be judged by their perceived usefulness within primary health care teams. Provided that different data sources can be combined, general practitioners and their teams need only collect information that cannot be gleaned elsewhere.

Sixty-four practices in north-east England, selected by their FHSAs, were invited by post to pilot a minimum dataset over a three-month period. Items requested were data of potential significance for clinical care not collectable elsewhere. Feedback was sent to practices together with evaluation questionnaires. Fifty-three local providers were contacted by letter and followed up by telephone to recover data collected and stored by them.

Twelve practices agreed to take part in the pilot, but only nine, covering 51 650 patients with 30 doctors, submitted a pilot dataset. Practices were unable to capture all of the information requested.