

From theory to reality <i>D Kernick</i>	1433	Drug misuse <i>A J Ashworth and B A Kidd</i>	1435
Simulated surgery <i>T Stuart Murray</i>	1433	Practice nurse triage <i>Richard Gallow</i>	1436
Read codes may prevent UK GPs from using ICD-10 <i>Gina Agarwal</i>	1434	Steroid treatment cards <i>G Zeppetella</i>	1436
Natural history and management of dizziness <i>Michael B Taylor</i>	1434	Cluster randomization <i>Martin Underwood</i>	1436
<i>Mark Rickenbach, Louise Rickenbach</i>	1435	Summative assessment in North Thames (West) <i>Martin Rhodes and Patrick Pietroni</i>	1437
Coming down on drug databases <i>Woody Caan</i>	1435		

Note to authors of letters: Letters submitted for publication should not exceed 400 words. All letters are subject to editing and may be shortened. Letters may be sent either by post (please use *double spacing* and, if possible, include a Word for Windows or plain text version on an IBM PC-formatted disk), or by e-mail (addressed to journal@rcgp.org.uk; please include your postal address). All letters are acknowledged on receipt, but we regret that we cannot notify authors regarding publication.

From theory to reality

Sir,

We must thank Tom Fahey for outlining the problems and barriers to applying evidence obtained from clinical trials into our everyday practice (*April Journal*).¹

Clearly, when dealing with questions such as the treatment of hyperlipaemia, which have significant social implications, rigorous analysis of costs and effectiveness are of utmost importance. But it was his brilliant parody of the evidence-based approach to the problem of a patient presenting with acute sinusitis that provided real benefit to the debate.

By reducing the presentation to a simple question — 'whether the benefit of an antibiotic exceeded their side effects' — Fahey was able to demonstrate, with a plethora of ARIs, F values, S ratios, and PEERs, how the external evidence could be made explicit and be revealed to the patient. It was indeed a master stroke to demonstrate the impracticality of reviewing the evidence and integrating it into an clear system of decision analysis in the time it takes to complete a consultation.

More mundane commentators would have described the real question: 'I think this patient has acute sinusitis. Based on my knowledge that antibiotics are not always effective, my experience of treating this presentation over the past 15 years, the expectation and natural history of this illness in this patient in previous presentations, the fact that my surgery is running 20 minutes late, I have to do a visit after work before picking up my son from hockey practice, I am then due back at the practice for a meeting this evening, I have a slight headache myself, and I mustn't forget to pick up a tin of dog meat, should I prescribe an antibiotic?'

Balancing the demands of the validity of the evidence for the unique needs of the patient, ensuring that resources are equitably distributed between the conflicting demands of patient and society, modulating the often opposing constructs of empowerment and equity is not an easy task.

We are indebted to Fahey for demon-

strating so well that we may have to live with uncertainty and accept a pragmatic system of health delivery; for elucidating so clearly why, while despite all efforts to the contrary, GPs still do not follow guidelines.

D KERNICK

St Thomas Health Centre
Cowick Street
Exeter EX4 1HJ

Reference

1. Fahey T. Applying the results of clinical trials to patients in general practice: perceived problems, strengths and assumptions and challenges for the future. *Br J Gen Pract* 1998; **48**: 1173-1177.

Simulated surgery

Sir,

In the papers by Allen *et al* (*May Journal*),^{1,2} the authors outlined their reasons for using simulated surgeries for summative assessment but unfortunately did not describe any situations in which the reality of general practice cannot be simulated. One of the characteristics of non-competent doctors regularly identified by the video system is the carrying out of an incomplete or inappropriate examination; e.g. listening to the chest through clothing. In a simulated surgery, a GP registrar can only suggest an examination that is inadequate to identify this problem. The cueing produced by providing candidates with answers to questions about examination raises doubts about validity.

Within a consultation, doctors do more than consult. A common problem seen in video recordings of consultations is that doctors spend more time on the computer than listening to the patient. How do you simulate a real conversation, including printing of prescriptions, the need to write notes, and enter and retrieve data during the consultation? A video gives a true picture and, in summative assessment, the candidate submits material that they think

demonstrates their competence. The time of submission and the material submitted are decided by the GP registrar, thus removing the 'artificial exam performance' factor.

Simulated surgeries, by their very nature, will consist of new patients within a certain age range (children and the elderly can not be included) and will be spaced at 10-minute intervals: it is therefore difficult to assess continuity of care. The timing and the case selection may result in a highly artificial general practice situation.

In the method described, the decision regarding passing or failing is made by the simulated patient. In summative assessment, the process decides whether a professional can work in the specialty, and it is difficult to see how this decision can be professionally acceptable if decided by a non-medical person. The authors quote that a simulated surgery is now offered as an alternative in the MRCGP, but they do not state that the College has decided that any judgements can only be carried out by examiners who are GPs.

Introducing patient satisfaction as a criterion for defining competence is an interesting idea; however, it has major problems. While it is clearly helpful to determine if a patient is satisfied with a consultation, there is no straightforward relationship between competence and patient satisfaction. If the authors believe that a certain level of satisfaction is essential for a doctor to practice independently, then a more reliable method would be to use Baker's satisfaction questionnaire³ on several hundred real patients. Since the two scales must both be passed, it will be possible for a doctor to be refused a certificate based on the satisfaction, or otherwise, of eight simulated patients. Even if patient satisfaction is accepted as a valid indicator, it must be pointed out that, since the patients are simulated, their satisfaction or lack of it must also be simulated. This requires considerable psychological gymnastics from the patients, and I am unaware of any evidence to support this use of simulated patients.

I was interested in the comparison with

the current summative assessment video model. The study described showed that, of the 11 registrars assessed, six passed video level one summative assessment and five were referred. The simulated surgery results were that eight out of the 11 passed the simulated surgery. There was clear disagreement between the two methods in two cases. The authors gave weight to whether or not both video assessors referred the candidate — this, in fact, has no significance since one referral triggers the next stage of the process. It is surprising that, when the authors were carrying out this comparative work, they did not go through the full summative assessment process to see what the ultimate comparison would be. There is no point in only comparing parts of processes; particularly parts that have no relationship to each other.

The authors set a minimal competence level for each consultation but then decided that a candidate only needed to pass in six out of eight consultations; i.e. they can have two bad failures and still pass — hardly a valid and reliable test of minimal competence.

The authors do not consider sensitivity and specificity, which are the most important issues as far as summative assessment is concerned: the summative assessment process is set up for one purpose only and that is to determine whether a candidate is competent. Giving feedback is an important component of the simulated surgeries, but this is formative assessment whereas summative assessment is about making a final decision regarding competence. As over 90% of GP registrars will be competent by the end of training, large numbers of candidates would be needed to test the sensitivity of the system; numbers far in excess of those included in the paper. The paper does not address specificity; i.e. how many competent candidates will fail. The referral system used in the UK advisers' video package means that all failing candidates are re-assessed by two national panellists before they actually fail. This makes it very unlikely that poor judgements by assessors will carry weight. Although the new package contains a referral system, it should be noted that the system does not review the evidence but only the conclusions drawn from the evidence. Since the candidate's performance is not recorded or preserved in any way, true review is impossible.

The only way the simulated surgery can be evaluated for use in summative assessment is by a direct comparison, based on outcome, with the method currently used.

T STUART MURRAY

Department of Postgraduate Medical Education
1 Horselehill Road
Glasgow G12 9LX

References

1. Allen J, Evans A, Foulkes J, French A. Simulated surgery in the summative assessment of general practice training: results of a trial in the Trent and Yorkshire regions. *Br J Gen Pract* 1998; **48**: 1219-1223.
2. Allen J, Rashid A. What determines competence within a general practice consultation? Assessment of consultation skills using simulated surgeries. *Br J Gen Pract* 1998; **48**: 1259-1262.
3. Baker R, Whitfield M. Measuring patient satisfaction: a test of construct validity. *Quality in Health Care* 1992; **1**: 104-109.

Read codes may prevent UK GPs from using ICD-10

Sir,

While Maurice-Tison *et al* (May *Journal*)¹ point out that training GPs to use the ICD-10 criteria for depressive illness may improve its diagnosis and recognition in general practice, there are other factors that need consideration. Since 1990, many GPs have installed practice computers, and now the majority of general practices in the UK are computerized. In 1993, 50% of all UK GPs were using computerized medical records in real time in the consultation² — this figure will be much greater now. Most of the common primary care software programs in use (Meditel, EMIS, VAMP) rely on clinician-based input of diagnostic codes at the time of doctor-patient interaction. These codes are the Read codes (of which there are several versions depending upon the age of the software program in use).

Generally, at the time of code input, GPs have just finished or are at the end of a consultation. When prompted to type in a diagnosis, typing in the term 'depressed' will bring up an array of many Read codes — the best of which has to be fitted to the consultation. Unfortunately, none of the Read codes correspond to ICD-10.

I am currently attempting to construct a register of psychiatric disease within the practice in which I work. This has been a difficult task, as not only does it entail all GPs to be coherent in their diagnoses clinically, but also of the coding they input into the practice software. In trying to standardize the coding that we use by matching with ICD-10 diagnoses, I found that the Read codes were totally incompatible. GPs may find they are confused when switching between ICD-10 and Read codes on their practice software.

While anything that helps GPs improve

their recognition of depression is to be praised, use of ICD-10 in practice may actually prove a hindrance to the computer records that GPs all keep now.

GINA AGARWAL

Department of General Practice and Primary Health Care
Imperial College School of Medicine at the Chelsea & Westminster
369 Fulham Road
London SW10 9NH

References

1. Maurice-Tison *et al*. How to improve recognition and diagnosis of depressive syndromes using international diagnostic criteria. *Br J Gen Pract* 1998; **48**: 1245-1246.
2. Haves GM. Computer in the consultation. The UK experience. *Proc Annu Symp Comput Appl Med Care* 1993; 103-106.

Natural history and management of dizziness

Sir,

The papers by Yardley *et al*^{1,2} and the accompanying editorial (April *Journal*)³ are a welcome attempt to support GPs in the improvement of care for patients presenting with 'dizziness'. I am, however, left with a feeling that all papers suffer from an excess of enthusiasm, some of which is excusable and some of which is not.

Many a revered and trusted specialist colleague who is enthusiastic about their subject will overestimate its prevalence and importance. Maybe Yardley *et al* are similarly afflicted. The prevalence of dizziness will depend upon the criteria for its diagnosis and, without sight of the questionnaire mentioned in the prevalence paper, we have no way to compare and judge with other estimates or even the feeling for our own practice.

Similarly, without greater knowledge of the Vertigo Handicap Questionnaire, it is impossible to judge the degree of handicap that patients suffer. Nonetheless, there is much to reward the careful reader, not least the possibility that 'vestibular rehabilitation' (VR) may afford improvement for patients with symptoms and/or signs of instability.

The enthusiasm of the accompanying editorial is less excusable. I would have liked Professor Bain to have preached a little caution. He could have shown that the two papers described quite different populations of patients, that dizziness and anxiety are shown to be associated and not causally related (for neither are necessary

or sufficient for the other), and that there are admitted flaws in the methodology of the VR paper. He could have pointed out that writing to populations asking for symptoms is effectively screening and, therefore, subject to the Wilson and Junger criteria.⁴ One such criterion is to understand the natural history of the disease and, despite the title of the editorial indicating knowledge about the natural history, reading the papers shows that this is entirely speculative.

Despite these misgivings, Professor Bain is convinced of the importance of the introduction of VR into primary care. He offers his opinion that it can best be accomplished by specialization and labels those who might demur as 'traditionalists'.

Certainly we can permit our academic colleagues their hobby-horses, but these should be a little more schooled before inviting, even admonishing, coal-face colleagues to mount up and ride along with them.

MICHAEL B TAYLOR

Heywood Association of Small Practices
York House Surgery
19 York Street
Heywood
Lancashire OL10 4NN

References

1. Yardley L, Owen N, Nazareth I, Luxon L. Prevalence and presentation of dizziness in a general practice community of working age people. *Br J Gen Pract* 1998; **48**: 1131-1135.
2. Yardley L, Beech S, Zander L, *et al.* A randomized controlled trial of exercise therapy for dizziness and vertigo in primary care. *Br J Gen Pract* 1998; **48**: 1136-1140.
4. Bain J. Natural history and management of dizziness: putting evidence into practice. *Br J Gen Pract* 1998; **48**: 1128-1129.
5. Wilson JMG, Junger G. *Principles and practice of screening for disease*. Geneva: WHO, 1968.

Sir,

Yardley *et al* show that dizziness is a common problem that can benefit from vestibular rehabilitation (*April Journal*).¹ Which person will provide the package in primary care is the question asked in the accompanying editorial.² The discussion centred around the GP and practice nurse only.

In our health authority, we refer patients to the physiotherapist based at either our (non-fundholding) surgery or at the local outpatient clinic. The physiotherapist teaches Cooksey Cawthorn exercises,³ which are similar to vestibular rehabilitation movements. Physiotherapists work

with 20-minute appointments for each patient, and they appear to be a most appropriate primary team member to carry out vestibular rehabilitation.

MARK RICKENBACH

Park Surgery
Chandlers Ford
Hampshire SO53 2ZH

LOUISE RICKENBACH

Physiotherapy Department
Mount Hospital
Eastleigh
Hampshire SO50 6ZB

References

1. Yardley L, Beech S, Zander L, *et al.* A randomized controlled trial of exercise therapy for dizziness and vertigo in primary care. *Br J Gen Pract* 1998; **48**: 1136-1140.
2. Bain J. Natural history and management of dizziness: putting evidence into practice. *Br J Gen Pract* 1998; **48**: 1128-1129.
3. Cooksey FS. Rehabilitation in vestibular injuries. *Proc Roy Soc Med* 1945; **39**: 273-278.

Coming down on drug databases

Sir,

It was encouraging to read about the efforts of King *et al* (*April Journal*)¹ to educate GPs in the North Thames region about better management of their drug-using patients. However, their paper also demonstrated the pathetic failure of the North Thames Regional Drug Misuse Database (and the equally unlamented Home Office notifications) to describe the rising drug use in our community, with notifications from practice declining, although drug-related problems are clearly on the increase.² Compiling such unreliable input from all the regional databases, the new *Statistical Bulletin 1998/05* reported such shaky foundations for planning as a supposed immediate decline in drug users' most recent contacts with private general practice from 200 to 7 (six-monthly data).

The North Thames dataset is attributable to individual patients, but South Thames (West) developed a viable Substance Use Database that was non-attributable, focusing instead on the problems presenting to practice.³ What we really have to know about is the pattern of patients' needs across our community casemix if we plan to address those needs using Health Benefit Groups.⁴ As the Government introduces its new performance indicators for drug treatment,² this

need for problem-focused data will grow more urgent.

WOODY CAAN

Research and Development
Lifespan Healthcare Trust
Ida Darwin
Fulbourn
Cambridge CB1 5EE

References

1. King M, Hindler C, Nazareth I, *et al.* A controlled evaluation of small-group education of general practitioners in the management of drug users. *Br J Gen Pract* 1998; **48**: 1159-1160.
2. Hellowell K. Report of the UK anti-drugs coordinator. In: *Tackling drugs to build a better Britain*. London: Stationery Office, 1998.
3. Caan W. Right to privacy. *Druglink* 1994; **9**: 18.
4. Caan W. Creating a new language for planning services: Health Benefit Groups. *Journal of Mental Health* 1997; **6**: 327-330.

Drug misuse

Sir,

General practitioners are a key resource in the management of drug users. They are available at the point of need in time and place; they also have a wider view, which allows them to see patients in their social and medical context.

In our shared care scheme we have addressed the concerns of GPs who previously erred on the side of safety by avoiding involvement in the management of drug misusers. GPs acknowledged that low threshold methadone prescription may have a public health benefit, but their concerns of overdose, leakage to the street, and misbehaviour of drug-misusing patients tended to exclude them from offering treatment.

Our advice to GPs is that they should avoid substitute prescribing until full assessment is completed (we normally initiate the prescription and share back to the GP only when the patient is stabilized). By offering a rapid response assessment service, including urine screen and physical examination as recommended by the Department of health,^{1,2} we have been able to develop good clinical relationships with local GPs. With this joint specialist/GP strategy, we are encouraged that the prescribing protocol of a specialist drug service has been adopted as the policy of our LMC's GP subcommittee.

While specialist drug services have previously tended to focus on the public health benefits of treatment of drug mis-

users, we have been able to shift our emphasis towards the treatment of individuals, which is the basis of general practice.

Prescription of methadone at first consultation, an outcome measure in King *et al*'s evaluations of GP education (April *Journal*),³ may have benefits for the community but it has risks for the patient and others.⁴ By emphasizing measures of safety and compliance (daily dispensing of methadone, careful urine testing, and physical examination for injection sites), we have been able to develop a shared care model involving most of the local GPs.

We believe that quality outcomes based on safety of dispensing and compliance with treatment are better measures of training than volume measures based on availability.

A J ASHWORTH
B A KIDD

Community Addiction Service
Bungalow 3
RSNH
Old Denny Road
Larbert FK5 4SD

References

1. Department of Health. *Drug misuse and dependence: guidelines on clinical management*. (DoH, Scottish Office Home and Health Department, Welsh Office.) London: HMSO, 1991.
2. Scottish Office Department of Health. *Good practice in substitute prescribing*. Edinburgh: Scottish Office DoH, 1996.
3. King M, Hindler C, Nazareth I, *et al*. A controlled evaluation of small-group education of general practitioners in the management of drug users. *Br J Gen Pract* 1998; **48**: 1159-1160.
4. Greenwood J, Zealley H, Gorman D, *et al*. Deaths related to methadone have doubled in Lothian. *BMJ* 1997; **314**: 1763.

Practice nurse triage

Sir,

Any move to reduce the workload of GPs is to be welcomed, especially with regard to trivial illnesses or unnecessarily sought-after reassurance. One 'barrier' to this is usually provided by the patients having some deference to the GP's burgeoning workload and by their taking some responsibility for their own health.

It is therefore with some trepidation that I accept the findings of Gallagher *et al* (April *Journal*),¹ whereby the practice nurse triages acute illness in his practice. If the consultations plummeted after just three months, were the GPs just seeing too many patients unnecessarily in the first

place (my own practice consultation rate is 2.9 patients per annum)?

I am also concerned that conclusions are being made too early from these results. Once word gets around his patients that you just have to phone up the surgery for professional advice, these telephone contacts could escalate as patients realise that they can more readily transfer their health responsibility.

There has recently been a push for nurse practitioners to become involved in triage and in treating minor conditions. It is therefore vital that we are certain that this is an appropriate task for such a valuable resource by ensuring that audits in this subject demonstrate a definite short- and long-term benefit for all practices. They must also ensure that it is a better system than educating patients about treating their own minor illnesses or seeking out the local pharmacist's advice.

RICHARD GALLOW

The Surgery
Parkwood Drive
Hemel Hempstead
Hertfordshire HP1 2LD

Reference

1. Gallagher M, Huddart T, Henderson B. Telephone triage of acute illness by a practice nurse in general practice: outcomes of care. *Br J Gen Pract* 1998; **48**: 1141-1145.

Steroid treatment cards

Sir,

A recent communication from the Chief Medical Officer discussed changes to the steroid treatment card.¹ The communication also highlighted that patients prescribed systemic steroids for more than three weeks should receive a steroid treatment card at the outset of treatment. Steroids are commonly used in palliative care;² their indications are both specific (e.g. superior vena cava obstruction, spinal cord compression, raised intracranial pressure) or non-specific (e.g. mood, fatigue, anorexia). A survey was undertaken to determine the use of steroid treatment cards in terminally ill patients referred to a community palliative care team.

One hundred and eleven consecutive referrals were surveyed and 106 were prescribed medication. A total of 597 drugs were prescribed: 39 patients were prescribed oral or inhaled corticosteroids. Thirty patients took the oral preparations dexamethasone and prednisolone; their mean daily dose was 6.5 mg (range 2-12

mg) and 17.3 mg (range 5-30 mg) respectively. All patients had been taking therapy for more than three weeks. Thirteen patients taking oral steroids (43%) did not have a steroid treatment card.

Prolonged steroid therapy leads to suppression of the hypothalamic-pituitary-adrenal axis, and abrupt withdrawal can lead to adrenal insufficiency, hypotension, or death. Furthermore, patients with severe intercurrent illness, trauma, or surgical procedure require a temporary increase in their steroid dose. Steroid treatment cards detailing dosage and possible complications were introduced to avoid these complications. Terminally ill patients may have several prescribers involved in their care (through attending outpatient departments) in addition to their GP. These patients usually take multiple drugs, thus increasing the risk of drug interactions and adverse effects. Ensuring all patients prescribed steroids are given treatment cards would help minimize such risks and provide continuity of care.

Almost 50% of patients prescribed steroids in this survey did not have a treatment card. A survey of admission to this hospice almost 10 years ago showed similar findings.³ The introduction of the new steroid treatment card is an opportunity to address this issue.

G ZEPPELETTA

St Joseph's Hospice
Mare Street
Hackney
London E8 4SA

References

1. Department of Health. *CMO's update 18*. London: DoH, 1998.
2. Hanks GW, Trueman T, Twycross RG. Corticosteroids in terminal cancer - a prospective analysis of current practice. *Postgrad Med J* 1983; **59**: 702-706.
3. Needham PR, Daley AG, Lennard RF. Steroids in advanced cancer: survey of current practice. *BMJ* 1992; **305**: 999.

Cluster randomization

Sir,

We are grateful to Kerry and Bland (June *Journal*)¹ for identifying the error in our paper (March *Journal*)² and for their series of recent papers on the same topic.

The correct value for intra-cluster correlation coefficient (ICC) is, as they suggest, 0.118 and not 0.018 as stated in our paper. The correct inflation factor is 24.5, as stated. This high ICC value for HbA_{1c} was obtained in another study of diabetes

in primary care. This is likely to be a better indicator of the true inflation factor than relying on the assumption that the value of the ICC is between 0.01 and 0.05. If previous data had not been available and the ICC was assumed to be between 0.01 and 0.05, an allowance for an inflation factor in the range 1.99 to 10.95 would be required. If values for the ICC that have been calculated were routinely included in published data analyses, researchers would be better able to avoid the problems of cluster randomization. Relying on the value of ICC being between 0.01 and 0.05 may not adequately inform researchers of the depth of the trap for the unwary.

MARTIN UNDERWOOD

MRC Epidemiology and Medical Care Unit
Wolfson Institute of Preventive Medicine
Charterhouse Square
London EC1M 6BQ
and
Department of General Practice and Primary Care
Queen Mary and Westfield College
Mile End
London E1 4NS

References

1. Kerry S, Bland M. Cluster randomization. [Letter.] *Br J Gen Pract* 1998; **48**: 1342.
2. Underwood M, Barnett A, Hajioff S. Cluster randomization: a trap for the unwary. *Br J Gen Pract* 1998; **48**: 1089-1090.

Summative assessment in North Thames (West)

Sir,

T Stuart Murray's letter (May *Journal*)¹ implies that the low referral rate of video assessment in North Thames West (January *Journal*)² is due to poor assessor training. He also claims that similar mean multiple choice questionnaire (MCQ) scores across regions demonstrates the quote that 'there is no difference in the range of abilities of GP registrars'. In doing so he raises important questions that require debate, and we are grateful for the opportunity to do so.

By the end of 1997, 13 out of 107 (12.1%) registrars had been referred at the first level of video assessment by our assessors. These registrars were assessed at a second level by assessors at our sister region, North Thames (East). Of these, only three were referred to the national panel, of which, one was failed (it is of

interest to note that this candidate sent the same videotape for MRCGP and was passed).

T Stuart Murray rightly draws attention to the fact that our referral rate, at 12%, is below the national average of 20%. Our response to this difference is that:

- We hold a three-day residential course on consulting skills for registrars, attended by 90% of our registrars. Built on experiential, peer group adult learning techniques, it is well received. The value of such a course has recently been shown.³ Seven of the 13 registrars referred at the first level had not attended our course.
- We have a regional formative assessment system, based on a workbook, that aims to find problems with registrars long before they come for summative assessment.
- All first level videotapes sent for external quality control were judged to be accurately assessed by the national panel.

Professor Murray also checked our results on the MCQ and found the mean for candidates in North Thames (West) to be 74.95 compared with a national mean of 73.64. In addition, only one candidate in our region has actually failed the MCQ (by 0.1%) out of 133, giving an accumulated pass rate of 99.25%; well above the national average.

T Stuart Murray asserts that, on the basis of the MCQ results, there is no difference between regions in the range of abilities of registrars. This is not supported by the evidence. Moreover, the MCQ test cannot be used to determine 'range of abilities', it can only be used to measure the constructs that MCQs measure — this has never included consultation skills.

In his letter, T Stuart Murray challenges us to justify our apparent higher costs in running summative assessment. Our own research has suggested that other regions have calculated the added-on costs of summative assessment as opposed to the actual costs. Our costs include rent, dean time, and our own evaluation of the process of part of summative assessment (in press) — something Professor Murray suggested we should be doing. When these costs are taken out of the equation, then our expenses are comparable to others.

The point we make is that the cost of summative assessment is too great. This is in line with others' experiences of minimum competence testing of the profession.⁴ One of our authors has previously criticized summative assessment because

of its lack of grounding in assessment theory, including its likely education effect.⁵

MARTIN RHODES
PATRICK PIETRONI

Department of Postgraduate General Practice North Thames (West)
Imperial College School of Medicine
Hammersmith Campus
Hammersmith Hospital
Ducane Road
London W12 0NN

References

1. Stuart Murray T. Summative assessment. [Letter.] *Br J Gen Pract* 1998; **48**: 1267.
2. Rhodes M, Pietroni PC. Summative assessment. [Letter.] *Br J Gen Pract* 1998; **48**: 922.
3. Neal R, Robinson P, Anderson W. Teaching the process of the consultation to GP registrars in a residential setting. *Educ Gen Pract* 1998; **9**: 188-189.
4. Shepard L, Kreitzner A. The Texas teacher test. *Education Researcher* 1987; Aug/Sept: 22-31.
5. Rhodes M, Wolf A. The summative assessment package: a closer look. *Educ Gen Pract* 1997; **8**: 1-7.

Apology

We would like to apologise to Dr James Dunbar, Dr Anne Dunbar, and Dr Sue Vincent, who were not included in the list of authors for the letter entitled, A pilot study of the role of echocardiography in primary care (April *Journal*; p1182). We would also like to acknowledge their valuable contribution to the pilot study outlined in the letter.