mini-PAT (Peer Assessment Tool): a well kept secret?

I read with interest the article by Dr Abdulla about the use of mini-PAT (*JRSM* 2008;**101**:22–26).[1] The author raises a number of important points about the utility of multi-source feedback (MSF) but fails to recognize that mini-PAT has been published.[2,3] The paper reports an evaluation including 553 trainees and answers many of the questions raised.

Assessor selection does indeed seem important as a source of bias that can undermine validity,[3,4] with less-senior doctors and nurses scoring colleagues more leniently. This informs the online selection process from Healthcare Assessment and Training (HcAT), which is now limited by occupational group. Local training must continue and be targeted correctly, with 60% of assessments currently being assessed by senior trainees, not consultants.

Linking good assessment practices to better patient outcomes will never be a clear outcome measure as the naturalistic world of medical practice is too confounded for such study designs. However, the author quite rightly points out the lack of patient involvement in Foundation assessment, a PMETB assessment principle which does need addressing.

The work on MSF in medicine is in its infancy. Much is yet to be understood and sadly the work is under threat. There appears to be a move towards assessment as simply an 'add on' to online portfolios. Without large, regulated databases, further research to assure validity and reliability will simply support the 'no evidence' view held by critics of recent postgraduate initiatives.[5]

I welcome the opportunity to debate all these issues as I remain concerned about widespread, unsupported implementation of MSF. MSF can be – when well-supported, well-implemented and quality assured – an important educational instrument, but our profession will be quick to dismiss it if it is poorly supported and lacks evidence.

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Competing interests
HcAT (www.hcat.nhs.uk) is a not-for-profit organisation whose aim is to promote excellence in assessment systems and to support these by appropriate training and quality assurance programmes.

References

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Measuring productivity

Bloor *et al*.[1] report that men have significantly higher activity rates than women after accounting for age, specialty and Trust (*JRSM* 2008;**101**:27–33). No account is taken of the varying number of sessions (or programmed activity sessions) undertaken by consultants, other than to note that all are on full-time or maximum part time contracts. This can vary quite considerably for those on these contracts, with full-time ranging from 10 to up to 15 programmed activities in exceptional circumstances. Whilst there are technical difficulties in gaining access to this level of data, without this it is difficult to conclude that men have a higher productivity, as measuring productivity requires a measure of both inputs (often considered to be labour, equipment and capital) and outputs. It may be, for example, that for the same inputs the outputs are the same, if women doctors are in general working fewer programmed activities. This model might also be delivering a safer higher quality service, another key output.

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Competing interests
SG is a Past President of Medical Women's Federation, a charity which aims to advance the personal and professional development of women

Reference

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