

Denmark and required three-monthly assessment over a period of three years. The research reported by Rubenstein and colleagues² was conducted in an American hospital and involved specialist physicians and a multidisciplinary team working in what would be equivalent to a geriatric assessment unit in a British hospital. Both studies undoubtedly produced clear cut results, but cannot be generalized to the primary care situation in the United Kingdom as a justification for routine screening. Tulloch's own controlled trial was conducted in his Oxfordshire practice and did demonstrate less time spent in hospital in the study group.³ However, in discussing these results the authors suggested that 'generalizations drawn from these findings must be made with great care as the practice involved is atypical in a number of respects'.

I have always believed that to improve the preventive and anticipatory care of elderly people it is necessary to find methods which are acceptable and feasible for all practices and not just those with a special interest in the care of elderly people. I also believe that it is important that general practitioners do not underestimate the anticipatory and proactive element of the existing routine care provided by general practice. I would prefer to build on this traditional role and am concerned about what may be lost through the fragmentation of care through a growing range of screening, special disease and health promotion clinics. I remain to be convinced that the new contract requirements will prove efficient and effective.⁴ Moreover, it is disappointing that the mandatory and rigid requirements of the new contract appear to have inhibited and stalled the many exciting research projects of the 1980s exploring cost effective screening methods by removing justification for them.

CHARLES FREER

1 Grange Road
Bearsden
Glasgow G61 3PL

References

- Hendriksen C, Lund E, Stromgard E. Consequences of assessment and intervention among elderly people: a three year randomised controlled trial. *BMJ* 1979; **289**: 1522-1524.
- Rubenstein LZ, Josephson KR, Wieland GD, et al. Effectiveness of a geriatric evaluation unit. A randomised control trial *N Engl J Med* 1984; **310**: 1664-1670.
- Tulloch AJ, Moore V. A randomized controlled trial of geriatric screening and surveillance in general practice. *J R Coll Gen Pract* 1979; **29**: 733-742.
- Freer CB. Screening the elderly. *BMJ* 1990; **300**: 1447-1448.

Sir,
Dr Tulloch's editorial (September *Journal*, p.354) suggests that the Barthel index is the most commonly used instrument for measuring disability in the elderly. I cannot believe that I am alone in never having heard of this index. A straw poll of colleagues and consultant geriatricians, revealed no one who knew what this index was.

It is a pity that the author could not provide a reference for the source of this index, as I suspect that this omission will generate a considerable amount of work for medical librarians up and down the country.

I D WATSON

Millfield Medical Centre
63-68 Hylton Road
Sunderland SR4 7AF

Does nose blowing improve hearing in serous otitis?

Sir,

The paper on the effect of nose blowing on hearing in serous otitis is a fascinating piece of work (September *Journal*, p.377). I would like to suggest another factor which should perhaps be investigated — the venturi effect. This is the suction effect produced by passing a current of air transversely over the top of a tube. In flying, it is the basis of the air speed indicator. When I was a medical student, I was taught that whereas blowing the nose increased the pressure in the nose, pushing mucus back up into the sinuses, closing the eustachian tubes, sniffing by the venturi effect emptied the sinuses, opened the eustachian tubes and drew the mucus down from the back of the nose into the throat, from where it would be disposed of by swallowing. As my teacher pointed out, one inhales steam with menthol and eucalyptus and there is little point in blowing it out.

Since then I have advised adults with sinus problems and catarrhal children to sniff instead of blowing. This suggestion is initially greeted with surprise but later by grateful thanks. As I do not work in an ear, nose and throat department, I have never had a large enough series of patients to analyse, but I feel that this experience and theory could well be incorporated in the further work which Dr Heaf and colleagues are obviously going to carry out.

S L GOODMAN

Ladybarn Group Practice
177 Mauldeth Road
Fallowfield
Manchester M14 6SG

Randomized controlled trials

Sir,

I was surprised to read in the *Journal* the editorial on the price to be paid for randomized controlled trials (September *Journal*, p.355). Dr Charlton, an anatomist, suggested that the gain in objectivity achieved by randomized controlled trials makes management tend towards the routine application of simple algorithms, with depersonalization of the patient. This is often true of hospital practice and undergraduate teaching, but not of modern general practice where emphasis is placed on the individuality of the patient. The motto of the Royal College of General Practitioners is *scientia cum caritas*, which dispels the image of a practitioner of reductionist science. It is far from the truth to suggest that when patients tell the doctor their story it is ignored in favour of the findings of group trials. Exactly the reverse is the case as we endeavour to share the experience of the individual. On the other hand, we are greatly indebted to randomized controlled trials without which we should not place reliance on the *British national formulary* and other texts.

Dr Charlton writes of our oldest and greatest allies — natural remission and the placebo effect. In my view, these are the patient's, not the doctor's allies. Nor would I agree that alternative practices such as acupuncture and homoeopathy tend to use individualist factors far more effectively than does general practice.

We are on the verge of huge advances in medical science and must avoid falling back into medieval empiricism. I should like Dr Charlton to see how we train and relearn the importance of the unique personal charisma.

M KEITH THOMPSON

28 Steep Hill
Stanhope Road
Croydon CR0 5QS

Rating scales for the assessment of vocational trainees

Sir,

The paper by Difford and Hughes is a useful contribution to the debate on trainee assessment (September *Journal*, p.360). However, their conclusion that 'the most useful way to achieve systematic assessment of vocational trainees is by the use of the 23 [Manchester] rating scales' does not appear to be supported by the evidence produced.

As the authors point out the main criteria for judging any assessment pro-

cess are its validity, reliability and feasibility. The Manchester rating scales have serious drawbacks in all three areas. The paper quite rightly points out that the scales do have face validity and discusses the difficulty of determining predictive validity. However, it is striking that at four months into the trainee year 89 out of 134 trainees were rated by their trainers as being better than the average general practitioner. Few of us would accept that this number of trainees could be better at general practice than the average general practitioner. What then was the rating scale actually measuring?

As far as reliability is concerned the authors acknowledge that the trainer is the only person with enough information to carry out the assessment. If reliability means the ability to generate consistent scores on different occasions and with different assessors then it is clear that the Manchester ratings are not reliable in this sense. If the examiners were intensively calibrated, this problem would be diminished but some of the evidence presented to indicate that trainers were using the scales consistently, such as the variation in the number of points used by trainers, might well indicate that some people mark near the centre of any scale while others mark at the extremes, as is commonly observed. A simple way of elucidating this would be to look at trainer marking to see if the range varies with successive trainees.

From the point of view of feasibility it is pointed out that in the second year 38% of trainers carried out the assessment programme. In many regions trainee assessment now figures strongly in the criteria for reselection of training practices. In the light of this a response rate of 38% to a 'voluntary' assessment programme does not seem particularly high. In the west of Scotland region the response rate for our programme of multiple choice papers and objective structured clinical examinations is more than 80%. It must also be borne in mind that, as the authors acknowledge, the Manchester rating scale is an indirect assessment based on other assessment methods. The true measure of the feasibility of the rating scales is the feasibility of the methods used to obtain the necessary information.

An area that was not touched on was the perceived value of the rating scales by the trainers and trainees. In a survey of trainees in the west of Scotland¹ the Manchester rating was the only one of five assessment methods not rated to be useful by those trainees who had used it. An alternative approach to trainee assessment, which has now been established in this region, is the use of a balanced

package of assessment tools which are then looked at as a group rather than combined into a set of rating scales.

L M CAMPBELL
T S MURRAY
G S DYKER

West of Scotland Committee for
Postgraduate Medical Education
University of Glasgow
Glasgow G12 8QQ

Reference

1. Campbell LM, Murray TS. Trainee assessment — a regional survey. *Br J Gen Pract* 1990; 40: 507-509.

Erythrocyte sedimentation rate and plasma viscosity

Sir,

The study by Dinant and colleagues of the discriminating ability of the erythrocyte sedimentation rate (September *Journal*, p.365) concludes that the test still deserves a place in the general practitioner's daily routine. Nevertheless, they acknowledge that problems with the test have led to alternatives being recommended. One of these is the plasma viscosity estimation¹ and since this test is provided by the local pathology laboratory I decided to assess its usefulness.

A plasma viscosity of 1.72 centipoise is generally taken as the upper limit of normality.¹ In the two year period August 1989 to July 1991 I ordered 140 plasma viscosity estimations as part of my normal work, usually as a screen for occult pathology; 42 (30%) were at levels of 1.73 centipoise and above. On follow up for at least three months (and often for at least a year) four patients have been found to have malignant or chronic inflammatory disease (one of these patients had a plasma viscosity less than 1.72 centipoise). However, in none of these four patients was the plasma viscosity helpful in making the diagnosis, and in several patients with elevated results unnecessary follow up and investigation was arranged.

A comparison of the use of plasma viscosity and the results of Dinant and colleagues for the erythrocyte sedimentation rate reveals: sensitivity 75% and 53%, respectively; specificity 71% and 94%; positive predictive value 7% and 48%; negative predictive value 99% and 91%. Thus these two tests are not greatly different in their value to general practitioners. They frequently produce false positives and cannot be relied upon to be positive even in cases of temporal arteritis,² one of the classic conditions they are supposed to identify.

Once again we return to careful history taking, judicious examination and selective investigation as the foundation of accurate diagnosis in our patients. Experienced doctors will also use a 'wait and see' approach to distinguish those patients with a high probability of disease from those with a low probability. A useful general screening test for occult pathology in general practice may remain an illusion.

JOHN HOLDEN

The Health Centre
Station Road
Haydock
St Helens WA11 0JN

References

1. Harkness J. The viscosity of human blood plasma; its measurement in health and disease. *Biorheology* 1971; 8: 171-193.
2. Jundt JW, Mock D. Temporal arteritis with normal erythrocyte sedimentation rates presenting as occipital neuralgia. *Arthritis Rheum* 1991; 34: 217-219.

Asthma care

Sir,

Dr Struthers (letters, September *Journal*, p.387) displayed a lack of understanding of the nature and management of asthma in his criticism of the papers on this subject (June *Journal*, p.224, 227, 232). Instead of criticizing those doctors who have helped pioneer improved community based asthma management as well as research, he should focus on the employers who fail to recognize that asthmatic people can lead a normal life given proper management.

Dr Struthers refers to overdiagnosis and overtreatment of asthma; I know of no evidence to support this statement. In fact there are good reasons for using the diagnostic label 'asthma'. First, it results in appropriate therapy with reduced morbidity for the patient.^{1,2} Secondly, it is now accepted that children do not 'outgrow' their asthma,³⁻⁶ and it is now regarded by many experts as a chronic incurable disease, subject to remissions of variable duration. Finally, by recognizing the chronic nature of asthma, with the responsibility of ensuring long-term follow up and the provision of emergency medication, health professionals may help reduce the unacceptably high mortality and morbidity from this disease.

If doctors do not take asthma seriously, how can patients be expected to act appropriately when symptoms arise? Retrospective studies on asthma deaths have shown that patients, their families as well as their doctors underestimate the symptoms and severity of attacks.^{7,8}

How can Dr Struthers justify his com-