supporting evidence was provided. In another study quoted,[5] the persistence of functional independence was attributed to family involvement in rehabilitation but, again, no evidence was given.

The authors' common sense and humane suggestions of how the carers of stroke patients can be helped deserve to be resourced and tested, and studying the complex relationship between stroke patients, their carers and their problems may lead to more effective ways of improving stroke rehabilitation.

J R F GLADMAN

Department of Health Care of the Elderly
University Hospital
Nottingham

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Rating scales for the assessment of vocational trainees

Sir,

In their letter (December *Journal,* p.520) Drs Campbell and Murray use selective data from both our paper (September *Journal,* p.360) and their own questionnaire survey,[1] to support their established approach of not using rating scales in the assessment of vocational trainees.

They compare our figure of receiving three rating scale assessments at four, eight and 12 months with 'more than 80%' for their programme of multiple choice questionnaires and objective structured clinical examinations. Theirs is a composite figure based on an unstated number of trainees over an unstated period of time. It appears that only one assessment will count for this figure. Our research found 89% of trainees had had at least one rating scale assessment, usually at 12 months. Trainers in our region have clearly done well and more recent figures show over 60% of trainees have had all three rating scale assessments carried out.

Their questionnaire presumably refers to the original 10 criteria Manchester rating scales which have long been considered inadequate for general practice,[2] and most of their respondents would not have been familiar with the 23 scales of our condensed version. From the data presented in their paper it is unclear whether the trainees saw their rating scale assessments, it is therefore difficult to see how they can make their statement on how trainees rated their usefulness. How many respondents clearly understood that the scales are for bringing together the results of other assessments in a systematic way?

To make comparisons between doctors, we used a mean rating of the 23 scales in order to simplify the presentation of changes with time and ranges of scores. When used for assessing minimum standards of competence, a comparison with the average general practitioner is the most valid measure we have. It is at this lower end of the scales where we need to calibrate the scorings of different trainers and promote consistency, and we would not deny that this is a difficult task. Fortunately when the scales are used for formative assessment this is not such a pressing problem, as it is the difference in the trainee's ratings on different scales which is important, not comparison with the average general practitioner.

We support the approach in the west of Scotland of using a package of assessment tools. If the trainer is to remain the principal assessor, then he must have a systematic way of looking at the various methods, and in the south west we do this using rating scales. The one-to-one relationship for a whole year in general practice vocational training obviously makes it most sensible for the trainer to certificate competence and identify strengths and weaknesses.

F DIFFORD
R C W HUGHES

Medical Postgraduate Department
University of Bristol
Canynge Hall
Whiteladies Road
Bristol BS8 2PR

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Preventive care of elderly people

Sir,

I read with interest the letter from Dr Freer (letters, December *Journal,* p.519) commenting on my editorial (September *Journal,* p.354) on training for preventive care of elderly people.

In the course of the editorial I quoted four papers in support of my contention that preventive care of older people leads to reduced institutional care. There are, of course, many other papers on this subject, but owing to lack of space, I mentioned only the best known. Dr Freer gave his criticisms of the four papers referenced. The first was in Norwegian,[1] but I have sent him a summary of the results in English. The second paper, by Hendriksen and colleagues,[2] although acknowledged as having clear-cut results, was criticized as it 'was conducted in Denmark and required three-monthly assessments over a period of three years'. Freer regards the results of the paper by Rubenstein and colleagues[3] as unequivocal but they were seen as irrelevant to general practice in the United Kingdom. He does not say why.

A major point in his argument seems to be that, while he accepts that hospital doctors, using intensive preventive care, can reduce time spent in hospitals and nursing homes, he is not convinced that general practitioners can do the same. However, a study in Bicester by Moore and myself showed that they could[4] and later evidence seems to confirm these findings even with non-professional volunteers.[5] Given appropriate training general practitioners can work as effectively as hospital doctors, and I have the advantage of 12 years' experience of running a clinic for elderly people in my practice.

It is a pity that Charles Freer, a well respected figure in this field, remains unconvinced that the value of more intensive preventive care of elderly people in general practice is well established. I would advise him and any other sceptics to read the chapter by Rubenstein, the foremost expert in this field in *Improving the health of older people: a world view.*[6] The author, reviewing the effectiveness of geriatric assessments, gives eight pages of references.

The Medical Research Council plans to mount an evaluation of different methods of preventive care of elderly people in 100 practices in the UK by means of a randomized controlled trial and the results may finally settle this debate. Charles Freer and I do share common ground in the conviction that the government's new measures for community care of elderly people are unlikely to be particularly fruitful in their present form.

Finally, Dr Watson's criticism of my editorial (letters, December *Journal,* p.519) is valid and a reference for the Barthel index is now provided.[7] It does not surprise me that neither he nor any of his general practice colleagues had heard of this instrument, as this confirms the ex-