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Rubella antibody screening

Sir,

Redhead and colleagues adopted the pragmatic approach suggested by the Immunization Practices Advisory Committee in the United States of America with respect to screening for rubella immunity.[1] The committee endorses the view that a documented history of rubella vaccination can be considered presumptive evidence of immunity.[2]

A retrospective survey of women aged between 16 and 39 years found to be rubella susceptible (that is, not immune) on opportunistic screening was carried out. The setting was a rural practice with a list size of 4600 patients. A list of women who were found to be susceptible to rubella was generated using a search of computerized patient records. The results of the computer search were checked against the written notes. Data were available from April 1988 until April 1994. During this period 559 women had been screened and 12 had been found to be susceptible to rubella. The notes of these 12 women were then reviewed and it was found that eight of them had a record in their notes of previous rubella vaccination.

It would therefore appear unwise to assume that a documented history of vaccination against rubella implies immunity in all women; repeated screening of rubella status is still required.

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Reducing benzodiazepine consumption

Sir,

Cormack and colleagues claim to have evaluated 'an easy, cost-effective strategy for cutting benzodiazepine use in general practice' (January *Journal,* p.5). The study evaluated the relative effectiveness of two strategies to reduce benzodiazepine usage versus control. The authors have shown that both strategies were effective. However, careful reading of the paper fails to reveal any economic evaluation of the costs of the strategies. To evaluate the cost-effectiveness of the strategies, the authors would have to measure all resultant costs arising from the strategies. First, costs associated with identification of the target population, including administrative and general practitioner time, would have to be measured; secondly, the stationery, administrative and postal costs associated with the strategies; and thirdly, other cost consequences of the strategies if they led to an increase in consultations or the use of other medication. These represent opportunity costs for a general practice. Set against these possible costs are savings in drug costs and patient time costs from not having to attend for repeat prescriptions. Clearly these savings could outweigh the costs of the intervention; however, it is not possible to know from this study. An equivalent error would be the claim that the strategies were significantly better than control without formal statistical testing.

Economic evaluation is an increasingly important component of general practice research. The loose and incorrect use of health economic terms devalues the discipline of health economics and is likely to delay general practitioners' understanding of its principles and practice. It is disappointing that the incorrect use of health economic terms should appear in the *Journal* and we hope this will not be repeated in future.

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Assessing clinical competence

Sir,

The introduction of the assessment of consultation skills as part of the examination for membership of the Royal College of General Practitioners, as described by Professor Southgate, needs debate (James Mackenzie lecture 1993, February *Journal,* p.87). Since the assessment may form a model for reaccreditation, it is of importance to all general practitioners.

The use of videotapes of real consultations poses ethical and technical problems. There is evidence that patients do not want their consultations videotaped[1] and the assessments may be unfair if candidates are presented with differing clinical material.[2] These problems can be overcome by using simulated patients who can be standardized, thus ensuring a more objective test. Furthermore, the suggested test of validity that experienced doctors should perform better than those who are less experienced is questionable. If course organizers and trainers are doing their job, it could be expected that recently trained candidates should do better than their older colleagues.[3]

Professor Southgate goes on to emphasize the determination of the RCGP examiners to assess those areas of the consultation that affect patient outcomes. This desire, however, poses further difficulties since there is a relative absence of data relating consultation process to outcomes.[4] In particular, there is no evidence for the specific standards, described by Professor Southgate, that have been chosen for the evaluation.

Moves towards measuring clinical competence and performance for future general practitioners are laudable. There are other aspects of doctor–patient communication which could be considered, some of which, for example patient-centredeness, can be easily and reliably measured and have been shown to affect outcomes.[5] Surely it would be helpful if the RCGP examiners provided a full explanation of the rationale behind their decisions and then sought voluntary participation from members as part of the validation process.

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