Note to authors of letters: Please note that all letters submitted for publication should be typed with *double spacing*. Failure to comply with this may lead to delay in publication.

Assessing trainee audit projects

Sir,

Benett and Hayden's discussion paper (January *Journal*, p.47) considered the need for an objective and reliable method of marking general practitioner trainee audit projects as part of the summative assessment of vocational training in the future. We should like to offer the following marking schedule that has been devised and piloted in the West Midlands.

Up to 16 points can be awarded for the choice of topic, points being awarded for relevance and importance of the topic, involvement of staff in choosing the topic, the presence of clear objectives and a review of the key literature.

Up to 16 points can be awarded for the setting of target standards. Points are awarded according to the appropriateness of the criteria/standards, according to how they were set (whether ideal standards or practice standards) and according to how achievable and realistic the standards are.

Up to 16 points can be awarded for observed practice — method of data collection and analysis, and validity and reliability.

Up to 16 points can be awarded for the comparison of performance with targets — presentation of results, and discussion in the practice about outcomes.

Up to 16 points can be awarded for proposed implementation of changes — with whom proposals have been discussed, how realistic the changes are, and what extra resources (time, skills and money) would be needed.

Points can be awarded for re-audit where previous changes are re-evaluated. Up to 20 bonus points can be awarded where a re-audit identifies any changes or whether other good audit performance features are identified.

Audits are marked excellent, good, acceptable, deficient or unacceptable for each section. For the audit to be passed as proficient it is necessary for the first five sections (choice of topic) setting of target standards, observed practice, comparison of performance with targets and implementation of change) to be graded as acceptable.

The schedule appears to meet the criteria set out in Benett and Hayden's paper and could form a basis for pilot schemes in other regions. It was originally constructed on the principles expressed by Bhopal and Thomson[1] and the Oxford Medical Audit Advisory Group,[2] and then modified for local use. Consensus about the relative importance of the different sections of the audit cycle and their proportionate marks was agreed by members of Staffordshire Medical Audit Advisory Group.

No marks were allotted to the re-audit stage specifically, because time constraints in a general practitioner trainee's six- or 12-month post usually mean that re-audit is impracticable.

Up to 10 bonus points can be awarded for re-evaluation or re-audit of previous changes (outcomes and effects). Ten other bonus marks are awarded for excellence in one or more sections, such as wholehearted involvement of the whole practice team in the audit.

The marking schedule has recently been tried out on all nine general practitioner trainee audit projects submitted for the West Midlands regional trainee audit prize. Two of the authors, both medical audit advisory group chairpersons, examined all nine project reports and assessed them independently using the assessment sheet. The results of their rankings are shown in Table 1.

There was a high correlation between the two sets of marks (Spearman's rank correlation coefficient = 0.7417, $P<0.05$). On retrospective analysis the second examiner felt that trainee H had been marked too harshly for failure to close the audit loop in this instance.

We commend the marking schedule from our preliminary experience and invite others to try it out and feed back constructive criticism so that it can be refined further and possibly adopted in other regions or at a national level.

We should like to point out that expertise in assessing audit projects need not be confined to trainers, course organizers and the vocational training scheme establishment, as Benett and Hayden suggest. Medical audit advisory groups should prove helpful in assisting in this part of summative assessment, and would be regarded by trainees as an independent body of examiners.

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Table 1. Ranking of trainee audit project marks following assessment by two assessors.

Trainee	Examiner 1 score (rank)	Examiner 2 score (rank)	Total score	Overall rank	Rank difference
A	84 (1)	75 (1)	159	1	0
B	74 (2)	74 (2)	148	2	0
C	64 (4)	67 (3)	131	3	1
D	60 (6)	56 (4)	116	4	2
E	62 (5)	51 (5)	113	5	0
F	41 (7)	50 (6)	91	7	1
G	41 (7)	45 (7)	86	8	0
H	72 (3)	40 (8)	112	6	5
I	24 (9)	37 (9)	61	9	0

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Asthma clinic questionnaires

Sir,

Pre-interview questionnaires have been recommended as a way of maximizing the information gained from interviews, reducing interview time, and making the interview more client focused and individual.[1-4] Whether quality of life questionnaires could aid the interview process in nurse run asthma clinics was tested. In 1994, 27 practice nurses selected from throughout the United Kingdom who ran asthma clinics evaluated the asthma bother profile[5] and the St George's respiratory questionnaire[6] with a total of 133 patients randomly recruited from the clinics. Each patient completed the two questionnaires on sequential visits in random order. Using evaluation questionnaires the patients evaluated the questionnaire after the interview, and the nurses evaluated the interview and questionnaire. In addition, free-format comments were solicited from the nurses about the way they used the questionnaires.

The results of the evaluation questionnaires are shown in Table 2. The majority of patients and nurses found both questionnaires to be helpful. For both nurses and patients there was a significantly higher level of satisfaction with the asthma bother profile compared with the St George's respiratory questionnaire (Wilcoxon test, both $P<0.01$), though high levels of satisfaction were obtained with both questionnaires. In addition, the nurses rated interviews where the asthma bother profile had been completed by patients as having a significantly better outcome compared with the respiratory questionnaire (Wilcoxon test, $P<0.01$). The free-format responses of the nurses indicated that the questionnaires were used in different ways depending on the type of patients and on which questionnaire was completed. However, a major function of the questionnaires, particularly the asthma bother profile, was that they highlighted worries and fears which had not been discussed on previous visits. Some nurses reported that their interview technique had changed after the use of these questionnaires so that they focused more on the emotional concerns of the patient.

It can be concluded that pre-interview quality of life questionnaires are a useful tool in asthma clinics.

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4. Herbert M. *Working with children and their families: psychology in action.* London: Routledge, 1988.
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Table 2. Responses given by nurses and patients after interview.

	% of respondents				
	Poor	Poor/ Moderate	Moderate	Moderate/ Good	Good
Patient's perception of how helpful questionnaire was in describing experiences					
ABP (n = 129)[a]	*3.1*	*5.4*	*19.4*	*34.0*	*38.0*
SGRQ (n = 127)[b]	*7.9*	*10.2*	*23.6*	*27.6*	*30.7*
Nurse's satisfaction with consultation					
ABP (n = 131)[c]	*0.8*	*3.8*	*9.9*	*47.3*	*38.2*
SGRQ (n = 130)[d]	*3.1*	*4.6*	*16.9*	*43.1*	*32.3*
Nurse's perception of usefulness of questionnaire					
ABP (n = 121)[e]	*1.7*	*7.4*	*22.3*	*44.6*	*24.0*
SGRQ (n = 128)[f]	*10.2*	*21.1*	*23.4*	*34.4*	*10.9*

n = number of repsonses. ABP = asthma bother profile. SGRQ = St George's respiratory questionnaire. Data missing in: [a]4 cases, [b]6 cases, [c]2 cases, [d]3 cases, [e]12 cases, [f]5 cases.

Corticosteroids and peptic ulceration prophylaxis in patients with advanced cancer

Sir,

Polypharmacy in patients with advanced cancer may undermine compliance in this patient group. One area of prescribing controversy is the concurrent prescribing of corticosteroids and prophylaxis regarding peptic ulceration. A review of corticosteroids and peptic ulceration suggests that prophylaxis is indicated for patients who have two or more of the following risk factors:[1] total dose of corticosteroid over 140 mg dexamethasone,[2] previous history of peptic ulcer,[2] and concomitant use of a non-steroidal anti-inflammatory and corticosteroid.[3]

A retrospective study was carried out of 200 consecutive patients with incurable cancer admitted to St Christopher's Hospice, London in 1992; data were gathered on risk factors for peptic ulceration.

A total of 71 patients (36%) were receiving corticosteroids on admission to the hospice (mean age 67 years). Of these, 34 patients (48%) had a total equivalent dose of over 140 mg of dexamethasone, 10 patients (14%) had a history of peptic ulceration, and 22 patients (31%) were taking a non-steroidal anti-inflammatory drug and corticosteroid. Overall, 15 patients (21%) had two risk factors, and one patient had three risk factors.

Twenty three patients (32%) were receiving medication as prophylaxis against peptic ulcer. However, the patient with three risk factors and five of the 15 patients with two risk factors (33%) were not receiving prophylaxis. Further analysis revealed that nine patients with one risk factor (27%) and four with no risk factors (18%) were receiving prophylaxis.

In order to prevent corticosteroid-induced peptic ulceration but avoid unnecessary polypharmacy it is important to prescribe prophylactic medication to patients at high risk. This study shows that 38% of patients on admission to the hospice who were at high risk of developing corticosteroid-induced peptic ulceration were not receiving prophylaxis. A further 24% of patients taking corticosteroids and prophylactic medication were not in the high risk group. Prophylaxis may not be appropriate for those patients who are in the terminal phase of their illness. However, we suggest it should be considered for patients with advanced cancer who have two or more of the risk factors outlined.

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