identified in the age group. Of these, 33 were on digoxin for atrial fibrillation. During the one-year study period, 795 patients were screened opportunistically for irregular pulse. Of these, 26 were diagnosed as having atrial fibrillation. Therefore, a total of 59 of the 828 patients screened were identified as having atrial fibrillation a prevalence of approximately 7%.

In order to maximize the benefit to risk ratio, the study protocol required one of three other risk factors to be present in order to initiate warfarin treatment.[2] These were age over 75 years, heart failure, diabetes, and hypertension. Patients not in this higher risk group were offered aspirin treatment. Some patients were excluded at this stage because of other medical conditions, such as dementia (which precluded informed consent and effective monitoring), or social conditions, such as remote location with no transport available.

Of the 59 patients with atrial fibrillation, 18 were invited to be assessed for warfarin treatment. Of these, only three agreed and actually started treatment; six others elected to take aspirin instead, and six patients were already taking aspirin. The number of patients eventually treated with warfarin was surprisingly small and may reflect transport difficulties in this rural practice.

While the study is not yet complete, our data suggest that the numbers of additional patients both requiring and agreeing to treatment and regular monitoring may not be as great as anticipated by Rodgers *et al.*

ELERI RODERICK
JIM COX

The Surgery
Caldbeck
Wigton
Cumbria CA7 8DS

References

1. Rodgers H, Sudlow M, Dobson R, *et al.* Warfarin anticoagulation in primary care: a regional survey of present practice and clinicians' views. *Br J Gen Pract* 1997; **47:** 309-310.
2. Gage BF, Cardinalli AB, Albers GW, Owens DK. Cost effectiveness of warfarin and aspirin for prophylaxis of stroke in patients with nonvalvular atrial fibrillation. *JAMA* 1996; **275:** 909.

Sore throat

Sir,

We read with interest the paper by Howe (May *Journal*) regarding the resolution of sore throat symptoms following antibiotic prescription.[1] Penicillin was not found to be superior to placebo, which supports the evidence of marginal benefit of penicillin in sore throat.[2] The well-described deficiencies of throat swabs might lead one to anticipate the failure of a positive result to predict response to antibiotic treatment rather than the explanation being the efficacy of cephalosporins in patients with a negative swab.[3]

The study raises important questions about the possible benefit of cefixime. However, we would urge caution on three counts. First, what is the clinical value of a reduction in score of 3, in a composite score, on the third day of treatment? Furthermore, significance figures are not given for the differences between the groups on days 2, 4, 5, 6, and 7. It is possible that a significant difference between the groups may have arisen on one day out of six by chance. Secondly, studies on penicillin have raised the possibility of a greater risk of symptom relapse following antibiotic treatment.[4] This study did not address this question, but the possibility of greater long-term morbidity following antibiotic treatment remains. Thirdly, given the expense of cefixime, potential side-effects, and the danger of resistance with a broad spectrum of antibiotics, is it sensible to use such drugs to effect a small reduction in symptoms in what is essentially a self-limiting illness?

MICHAEL MOORE

Three Swans Surgery
South and Western Region Research
General practice
Salisbury

PAUL LITTLE

Aldermoor Health Centre
Aldermoor Close
Southampton

GREG WARNER

Nightingale Surgery
South and Western Region Research
General practice
Romsey

References

1. Howe RW, Millar MR, Coast J, *et al.* A randomized controlled trial of antibiotics on symptom resolution in patients presenting to their general practitioner with a sore throat. *Br J Gen Pract* 1997; **47:** 280-284.
2. Del Mar C. Managing sore throat: a literature review II. Do antibiotics confer benefit? [Review.] *Med J Australia* 1992; **156:** 644-649.
3. Del Mar C. Managing sore throat: a literature review I. Making the diagnosis. [Review.] *Med J Australia* 1992; **156:** 572-575.
4. Little PS, Williamson I. Sore throat management in general practice. *Fam Pract* 1996; **13:** 317-321.

Audit

Sir,

I am increasingly concerned by the description of original papers as 'audit' when, in fact, they are nothing of the sort. An example of this misrepresentation was the paper by Vernon *et al* (May *Journal*) on 'How general practitioners manage children with urinary tract infection: an audit in the former Northern Region'.[1] It is perhaps pertinent that the previous paper in this issue by Lough and Murray, 'Training for audit: lessons still to be learned',[2] clearly demonstrated that trainers are failing to recognize basic audit methodology. Perhaps this also applies to referees and editors? If, as the Government white papers of the last year suggest, clinical audit should be further integrated into the development of quality assurance in primary care, then there are urgent questions to ask regarding the training of all general practitioners and other members of the primary health care team in basic audit methodology. I would suggest that Medical Audit Advisory Groups and Primary Care Audit Groups must take some lead responsibility in addressing these problems.

I K CAMPBELL

The Heacham Group Practice
Snettisham Surgery
Common Road, Snettisham
Norfolk PE31 7PE

References

1. Vernon S, Foo CK, Coulthard MG. How general practitioners manage children with urinary tract infection: an audit in the former Northern Region. *Br J Gen Pract* 1997; **47:** 297-300.
3. Lough JRM, Murray TS. Training for audit: lessons still to be learned. *Br J Gen Pract* 1997; **47:** 290-294.

Sir,

The paper by Lough and Murray[1] (May *Journal*) has made conclusions that are unjustified. In their discussion they mention that approximately 10% of projects were judged to be below the minimum competence level, and thus it must follow that nearly 90% of projects were satisfactory, which would seem to indicate that trainers spent a great deal of time and effort on individual registrars' summative assessment audit. Trainers have had an

enormous burden of paperwork in addition to what has been imposed on general practice over the past five years, particularly as the West of Scotland has been piloting summative assessment.

As I took part in this marking exercise, which was a very artificial one, I know that I spent very little time looking through for criteria when marking these papers. If I thought there was a good outcome from the project, and that this could be implemented relatively easily and then re-audited, I gave a passmark. I certainly did not work 1–2 hours as suggested in the discussion, and the 72% response rate reflects just how well local trainers had been trying to help the Department of Postgraduate Medical Education to get summative assessment in place. We are now more interested in outcomes from audit projects, and the majority of practices in one of the Health Board areas are routinely undertaking audit that have positive outcomes.[2]

This would suggest that considerable help needs to be given to the authors by the trainers to help them overcome false perceptions before a similar exercise is imposed on the profession under the guise of reaccreditation. The philosophy of the discussion paper on reaccreditation by C Salisbury in the same issue of the *BJGP* seems to have a more positive approach.[3]

PATRICK TRUST

Medical Centre
46-62 Bank Street
Alexandria G83 0LS

References

1. Lough JRM, Murray TS. Training for audit: lessons still to be learned. *Br J Gen Pract* 1997; **47:** 290-292.
2. Trust P, Brown C, Johnstone C. General Practice Audit Assistant Scheme in Argyll and Clyde: progress and outcomes. [Occasional paper no 68.] Scotland: Clinical Resource and Audit Group, 1995.
3. Salisbury C. The Australian Assurance and Continuing Education Program as a model for the reaccreditation of general practitioners in the United Kingdom. *Br J Gen Pract* 1997; **47:** 319-322.

Flashcard health education for British Asians with diabetes

Sir,

We are concerned that Hawthorne and Tomlinson (May *Journal*) have used educational methods traditionally used for pre-literate children[1] and promoted them as particularly applicable to British Asians.[2] They have taken the need to be taught by pictures, which is associated with poor education and learning disability, and have extrapolated the results from one ethnic community to the whole group of British Asians; by doing so they reinforce negative racial stereotypes.

There is no doubt that many patients with a chronic illness would benefit from clearer information, especially if given in an empowering and culturally appropriate way. The title emphasizes the pictorial aspect of this education, while the methodology suggests a detailed input by the linkworker, who may have ameliorated the potentially patronizing effect that flashcards can create. Guidelines are available for the use of flashcards in education,[3,4] but we are not aware whether these were followed. A literature search on educational, social science, psychological, and medical/nursing databases confirmed that the use of flashcards is largely limited to problems of literacy, organic brain damage, or learning disability. The authors do not quote the literacy rate in their paper, and some researchers express caution about the use of pictorial aids with non-literate adults.[5,6]

'Education demands a lot from health care providers: specific training, teaching skills, good communication, supportive attitude, readiness to listen and negotiate.'[7] It is possible that the linkworker in this study did all of these things, and that these skills, and not the flashcards, were the reason for the changes described in Hawthorne and Tomlinson's paper. Why do the authors emphasize the flashcards and not the role of the linkworker? We are concerned that the emphasis in this study on pictures and Asians may do more harm than good by seeming to give scientific credibility to a racial stereotype.

SANGEETA PATEL
FRANK SMITH

Division of General Practice and Primary Care
St George's Hospital Medical School
University of London
Hunter Wing, Cranmer Terrace
London SW17 0RE

References

1. Richmond J. In the picture: use of pictorial learning for young children with diabetes. *Prof Nurse* 1994; **9:** 770-772.
2. Hawthorne K, Tomlinson S. One-to-one teaching with pictures - flashcard health education for British Asians with diabetes. *Br J Gen Pract* 1997; **47:** 301-304.
3. Browder DM, Roberts ML. Guidelines for flashcard instruction. *J Behav Ed* 1993; **3:** 235-245.
4. van Houten R, Rolider A. An analysis of several variables influencing the efficacy of flashcard instruction. *J Applied Behav Anal* 1989; **22:** 111-118.
5. McBean G. Rethinking visual literacy: research in progress. *Health Ed Res* 1988; **3:** 393-398.
6. Gustaffson MB. Research among Haitian village women: implications for the nurse's role in health education. Are pictorial messages accurately recognized and self explanatory? *Pub Health Nursing* 1986; **3:** 250-256.
7. Maldonato A, Bloise D, Ceci M, *et al.* Diabetes mellitus: lessons from patient education. *Patient Educ & Counselling* 1995; **26:** 57-66.

The resuscitation of general practice

Sir,

I think that Dr Anita Goraya (Connection, May *Journal*) has hit the nail on the head when she states, 'It appears that established GPs are getting burnt out and the new bright young things are reluctant to burn in.'[1] The latter part of this statement has been addressed in the London Initiative Zone Educational Centre's programme and the London Academic Training Scheme, at least in London.

It is the first part of this statement that I am interested in. It is well-known that there is a high rate of burn-out among established GPs, and I feel that the way to tackle this would be through a similar project to the London Academic Training Scheme, but aimed at the 50+ age bracket of GPs. The aim would be to challenge the image of the monotonous drudgery of general practice in that a GP joining the scheme would be attached to an academic department of general practice, thus combining their work in their present practice with a day or half-day release in the academic department doing research audit, or simply learning. One would hope that such a scheme would be centrally funded.

Such a scheme would, in my opinion, prevent burn-out and would continue to invest in one of our most valuable resources — established general practitioners. It would also elevate the morale of this group of people and (one hopes) prevent early retirement.

L P DOBSON

Health Centre
Bow Street
Guisborough
Cleveland TS14 7AA

Reference

1. Goraya A. Resuscitation of general practice. [Connection.] *Br J Gen Pract* 1997; **47:** VI.