

peer reviewed) journal. Attributed to Oscar Wilde, I eagerly rushed to consult my 'complete works'. Unsuccessful in my attempts to locate this gem, I pursued the author, a GP tutor, and was disappointed to discover that even this quotation lacked an evidence base after he announced, 'I'm afraid I made it up!' Is this the real problem with EBM?

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Sir,

The discussion paper by Jacobson *et al* (*July Journal*) raises some interesting issues about the application of evidence-based medicine in general practice. While I entirely agree that the evidence from randomized controlled trials is not in itself sufficient to determine the management of individual patients in practice, it seems to me unwise not to keep up to date with the best evidence available so that this can be taken into account in making clinical decisions.

One of the purposes of publications like the *Journal of Evidence Based Medicine* is to pick out trials that are less open to bias and present them with a commentary from an expert. Time is too short to read everything that is currently published and I find this format very useful. Moreover, it is now available on CD-ROM (*Best Evidence*), which has the great advantage of allowing speedy searches to be carried out when seeking to answer questions raised in daily practice. Used in conjunction with the growing number of systematic reviews on the Cochrane Library (and the 130 000 randomized controlled trials listed with abstracts on the CD-ROM version of the Library), it is now possible to obtain more reliable answers to clinical

questions than ever before.

The essence of an evidenced-based approach to general practice is to ask questions generated by uncertainties in daily practice (of which there are many) and to search for answers to the questions using the most reliable evidence available. I have found this a good way to regenerate enthusiasm for day-to-day work, and much more rewarding than attending lectures.

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### Hospital admissions and quality of chronic illness care

Sir,

The increasing availability of routinely collected data provides tempting material for prospective researchers, but the quality and relevance of the data must be assured to make analysis useful. Paul Aveyard's paper (*July Journal*) demonstrates this point.<sup>1</sup> His hypothesis that there is a link between hospital admissions for asthma and the quality of general practice care as measured through routinely collected data is dependent on a number of unlikely assumptions.

While it might seem reasonable to postulate a link between the number of asthma admissions and the quality of general practice care, such a link has not been demonstrated. Of the 120 patients with asthma on an average GP's list, two to four are likely to be admitted with asthma each year. Is it likely that the overall care of the GP's 120+ asthmatics will be accurately reflected in the care of the two to four patients admitted? Aveyard focuses on three categories of routinely collected data to describe the performance of general practice. The validity and reliability of the first of these (chronic disease management annual reports) has not been examined. The new contract for GPs, introduced in 1990, required GPs to collect information on chronic illness care. GPs have not had the resources to ensure the accuracy of these reports, and health authorities have been unable to check them. It seems unwise, therefore, to assume that chronic illness reports give a good reflection of the quality of GP care without further examination.

Prescribing analysis and cost data (PACT) is the second category of routinely collected information to which Aveyard

refers in this paper. A high asthma preventer/reliever ratio in PACT has already been shown to be associated with lower rates of admission for asthma.<sup>2</sup> A low asthma preventer/reliever ratio in PACT is associated with lower socioeconomic status and may be an indicator of need.<sup>3</sup> It is not necessarily an indicator of lower quality care. High levels of reliever use and low levels of steroid use may be the result of low compliance with steroids, lower uptake of structured care, or lower uptake of return appointments. All of these are associated with lower socioeconomic status.

The third measure used by Aveyard — the Townsend score — is itself a measure of socioeconomic status. As has been shown before, hospital admissions for asthma are related to the socioeconomic status of the patient, which Aveyard's paper confirms.

The relationships identified by Aveyard deserve more examination, but it is unlikely that routine data of the sort he has used will throw any light directly on the quality of GP care. At best they may act as proxy measures after they have been compared with more direct assessments of GP quality.

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### Summative assessment

Sir,

Willis and Robinson (*July Journal*) raise issues concerning summative assessment in general, and methodological issues about our paper in the *May Journal* in particular.<sup>1</sup>

As a result of summative assessment there has been a 25-fold increase in GP registrars not reaching minimal compe-

tence. Despite the VTR1, trainers (understandably) never addressed the problems of failing a non-competent registrar, just as most people would be uncomfortable with the British School of Motoring both teaching *and* assessing future drivers on the road. The West of Scotland experience has been mirrored nationally with a failure rate of 5%. This year, two of our trainers have left the final decision to summative assessment as they felt unwilling to fail the registrar themselves.

Criterion referencing using a defined passmark is now a recognized benchmark for assessment methodology. What made the assessors 'expert' was their extra training that led to better reliability in marking. As we mentioned in our paper, two attempts to run training courses for audit, much of which would have been based on using the assessment criteria to produce a more rigorous approach to audit, had to be cancelled owing to lack of interest.

We have never stated that our criteria are absolute, but the overriding advantage of defined criteria is the transparency with which trainers and registrars alike understand the key issues in which they are being assessed, and the fairness of such a system, which (in theory), allows a 100% pass rate. The five projects were chosen to maximize assessor agreement and not to highlight the maximum inadequacy of the projects. The method for developing the marking instrument in consultation with all trainers in the region is described elsewhere.<sup>2</sup>

It is against this backdrop that, in the West of Scotland at least, we now clearly understand some of the difficulties in implementing audit within training practices and are attempting to raise the profile of assessing quality of care in a rigorous and mature way for a future generation of general practitioners. Willis' personalized attack in the last paragraph of his letter adds to the undermining of this process and bodes ill for the new-look *BJGP*.

Also, in response to Patrick Trust's letter on the same subject (October *Journal*), we would like to remind him that training is an academic appointment and that spending 'very little time looking through for criteria for marking' is more a reflection

on his attitude to rigour than a justification for condemning our 'artificial' study.

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### Aspirin therapy for cardiovascular disease

Sir,  
McCallum *et al* (July *Journal*) report that a small proportion of men in the British Regional Heart Study cohort are receiving aspirin after myocardial infarction (44% taking daily aspirin, 58% taking less than daily aspirin) or after coronary artery bypass graft (52% taking daily aspirin, 69% taking less than daily aspirin). We believe that these results are an under-estimate of current clinical practice. Since their survey was undertaken (November 1992), the major systematic review concerning the effectiveness of antiplatelet therapy has been published,<sup>1,2</sup> and an evidence-based summary of this review has been distributed to all GPs in the United Kingdom.<sup>3,4</sup>

A prospective audit carried out by Avon Primary Care Audit Group (PCAG) in 21 general practices covering 148 000 patients revealed that more people with these conditions are now receiving aspirin and that this proportion is increasing over time (Table 1).

Some of the observed differences between our study and that of McCallum may be due to the fact that we asked practices about prescribed medication or known over-the-counter medication, while they surveyed patients directly.

Nevertheless, it does appear that the prescription and uptake of aspirin has increased since 1992.

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### Screening for diabetes

Sir,  
Bullimore and Keyworth (June *Journal*)<sup>1</sup> have written of their experiences of screening for diabetes by the self-testing for glycosuria by individuals in their practice. They record, inaccurately, the report of the Birmingham Diabetes Survey Working Party of the College of General Practitioners,<sup>2</sup> in which we participated. This survey, now 36 years old, succeeded in obtaining a self test of a post-prandial sample of urine in 18 532 patients (95%) of the practice populations of 19 412 individuals on the lists of 10 Birmingham general practices, excluding known diabetics. The tests were performed at home, using a clinistix<sup>3,4</sup> in a sealed tube to which were attached the instructions for use; space was allowed to record the result of the test. The tested strip was returned in the container to the practice concerned. The 493 individuals with positive tests were invited to undergo a glucose tolerance test using 50 g glucose; 465 (95.5%) individuals accepted. This cohort was followed up by re-testing at five yearly intervals for 10 years, together with 343 individuals who had tested negative to clinistix.<sup>5,6</sup>

The pilot studies used test tape in rolls, as produced initially by Ames and Company at that time. As a result of these and other pilot studies, test tape was pro-

**Table 1.** Aspirin use (75 mg to 300 mg daily on prescription or taken as over-the-counter medication) in individuals aged 16 to 64 with a history of either myocardial infarction or coronary artery bypass graft: number (per cent, 95% confidence interval).

Diagnosis	September 1995	May 1996	Difference	P value
Myocardial infarction	390 (67, 63-71)	469 (73, 70-77)	7 (2-12)	0.014
Coronary artery bypass graft	134 (80, 74-86)	144 (83, 78-89)	3 (-5-11)	0.57