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.[2]

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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References

1. Lough JRM, Murray TS. Training for audit: lessons still to be learned. *Br J Gen Pract* 1997; **47:** 290-292.
2. Lough JRM, McKay J, Murray TS. Audit and summative assessment: a criterion-referenced marking schedule. *Br J Gen Pract* 1995; **45:** 607-609.

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,[1,2] and an evidence-based summary of this review has been distributed to all GPs in the United Kingdom.[3,4]

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.

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

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References

1. Antiplatelet Trialists' Collaboration. Collaborative view of randomised trials of antiplatelet therapy - I: prevention of death, myocardial infarction and stroke by prolonged antiplatelet therapy in various categories of patients. *BMJ* 1994; **308:** 81-106.
2. Antiplatelet Trialists' Collaboration. Collaborative view of randomised trials of antiplatelet therapy - II: Maintenance of vascular graft or arterial patency by antiplatelet therapy. *BMJ* 1994; **308:** 159-168.
3. NHS Centre for Reviews and Dissemination. Aspirin and acute myocardial infarction. *Effectiveness Matters* 1995; **1:** 1-4.
4. Deeks J, Watt I, Freemantle N. Aspirin and acute myocardial infarction: clarifying the message. *Br J Gen Pract* 1995; **45:** 395-396.

Screening for diabetes

Sir,

Bullimore and Keyworth (June *Journal*)[1] 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,[2] 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[3,4] 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.[5,6]

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-