computer records.

In 1992, we carried out an audit of preventive activities in 16 practices in inner London using a validated measure of patient population, the 'active patient' denominator (September *Journal*, p.463). We found that last recordings of blood pressure and smoking in the medical notes were only recorded in the computer records of 53 and 54% of 1346 patients, respectively. Recording on computer was greater for practices with longer established computer systems, and levels of recording have improved in a subsequent audit. High levels of recording are feasible, but considerable variation will remain as long as paper medical records are maintained. Quality assurance is an outstanding issue and needs to be addressed in both fully computerized practices and those still maintaining paper records.

JOHN ROBSON

LINDA MCFARLANE

MAGGIE FALSHAW

Healthy eastenders project
Department of General Practice
Basic Medical Sciences Block
Queen Mary and Westfield College
Mile End Road
London E1 4NS

Health promotion

Sir,

In their paper on health promotion (December *Journal*, p.665), Langham *et al* state that, in the 1990 'New Contact',[1] 'a fee was introduced for each clinic provided'. This implies that additional money was invested in health promotion. They do not consider the fact that this contract entailed the loss of a considerable proportion of other income; for example, through the removal of supplementary practice allowance and supplementary capitation fees, and the reduction of seniority increments. Opportunities had to be taken to try to recoup these sums, and it is well known that there was a high degree of creativity in the development of so-called health promotion clinics. While perhaps representing a therapeutic means of addressing the anger evident within the profession, it is not surprising that no clear evidence within the profession, it is not surprising that no clear evidence of beneficial outcome exists.

The concept of winners and losers is ameliorated through the pool system of remuneration because earnings above target net income are clawed back later anyway! The real losers are the tax-payers who have funded the management of this ill-planned saga.

JOHN PITTS

Waterside Health Centre
Beaulieu Road
Hythe
Southampton SO45 5WX

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1. Department of Health and the Welsh Office. *General practice in the National Health Service: a new contract.* London: HMSO, 1989.

Anecdotes and empiricism

Sir,

I appreciate what Jane Macnaughton was trying to say in her editorial on anecdotes and empiricism (November *Journal*, p.571), but I found the editorial to be both misleading and untimely.

It was misleading in that the anecdote seemed to be set up as a form of knowledge distinct from empirical observation. Science then becomes an ingredient in some wider intuitive, and no doubt ancient, wisdom which is arrived at largely by non-scientific means. So Macnaughton writes, 'Learning the scientific basis for understanding people is only one part of the holistic approach to which students must aspire.' This would be a false dichotomy. For example, the anecdote about the man aged 80 years who was active despite smoking 30 cigarettes a day is actually part of the empirical knowledge that we need to take on board when trying to evaluate the dangers of smoking.

Every experienced teacher knows the importance of bringing lessons to life with interesting examples. If teachers understand the significance of anecdotal evidence, they will realize their responsibility for choosing examples that are typical of the point being made. Thus, breathlessness when carrying shopping upstairs is a good example of exertional dyspnoea but it should not be used to contend that the air is thinner at the top of the stairs. Teachers who lapse into specious argument will know that a good anecdote is the best way to persuade an audience into thinking that this particular story proves a dubious point.

The editorial was untimely because the biggest danger to medical practice today is not pre-occupation with audit or evidence-based medicine, but the all-pervading relativism that dominates public perceptions of truth. 'It works for me, see if it works for you' has become the sales pitch of every alternative therapist. The majority of patients believe such testimony to be incontrovertible and the Advertising Standards Authority offers no protection against it. Outrageous claims are being justified on the basis of anecdotes.[1]

General practitioners seem to be par-ticularly vulnerable to this current anti-science shift. They are being held to ridicule by rationalists — and rightly so. Health commissions are being asked to fund therapies without any basis in science and with only anecdotal evidence to support them. If the patient seems happy and the treatment costs less than evidence-based treatments, general practitioners are being heard to say, 'Who cares if it actually works?'

It seems to me that we should care. The scientific soul of medicine is at stake. It is not the importance of the anecdote that is being neglected today but its significance in the wider picture. Medical science must certainly engage with human faces and individual histories — that is what general practice is all about — but in the current climate, those human faces could lure us all back to superstition and medievalism.

PETER MAY

The Grove Medical Practice
Shirley Health Centre
Grove Road
Southampton SO15 3UA

Reference

1. Royal College of General Practitioners. Alternative medicine. In: *Members' reference book 1995.* London, Sabrecrown: 1995: 571-598.

Anecdotes and empiricism

Sir,

I think Dr May (letter, March *Journal*, p. 201) might have misunderstood my use of the word 'empiricism'. In my editorial, I was contrasting knowledge obtained from anecdotes with empirical knowledge. The difference between them is that empirical (or scientific) knowledge is testable and repeatable, while that obtained from anecdotes is not. Therefore, anecdotal information is not part of empirical knowledge, but is one of the different ways in which doctors gain an understanding of patients. Both modes of knowledge, the scientific and the anecdotal, are equally valuable and available to GPs.

JANE MACNAUGHTON

Department of General Practice
University of Glasgow
Woodside Health Centre
Barr Street
Glasgow G20 7LR