

cess are its validity, reliability and feasibility. The Manchester rating scales have serious drawbacks in all three areas. The paper quite rightly points out that the scales do have face validity and discusses the difficulty of determining predictive validity. However, it is striking that at four months into the trainee year 89 out of 134 trainees were rated by their trainers as being better than the average general practitioner. Few of us would accept that this number of trainees could be better at general practice than the average general practitioner. What then was the rating scale actually measuring?

As far as reliability is concerned the authors acknowledge that the trainer is the only person with enough information to carry out the assessment. If reliability means the ability to generate consistent scores on different occasions and with different assessors then it is clear that the Manchester ratings are not reliable in this sense. If the examiners were intensively calibrated, this problem would be diminished but some of the evidence presented to indicate that trainers were using the scales consistently, such as the variation in the number of points used by trainers, might well indicate that some people mark near the centre of any scale while others mark at the extremes, as is commonly observed. A simple way of elucidating this would be to look at trainer marking to see if the range varies with successive trainees.

From the point of view of feasibility it is pointed out that in the second year 38% of trainers carried out the assessment programme. In many regions trainee assessment now figures strongly in the criteria for reselection of training practices. In the light of this a response rate of 38% to a 'voluntary' assessment programme does not seem particularly high. In the west of Scotland region the response rate for our programme of multiple choice papers and objective structured clinical examinations is more than 80%. It must also be borne in mind that, as the authors acknowledge, the Manchester rating scale is an indirect assessment based on other assessment methods. The true measure of the feasibility of the rating scales is the feasibility of the methods used to obtain the necessary information.

An area that was not touched on was the perceived value of the rating scales by the trainers and trainees. In a survey of trainees in the west of Scotland<sup>1</sup> the Manchester rating was the only one of five assessment methods not rated to be useful by those trainees who had used it. An alternative approach to trainee assessment, which has now been established in this region, is the use of a balanced

package of assessment tools which are then looked at as a group rather than combined into a set of rating scales.

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#### Reference

1. Campbell LM, Murray TS. Trainee assessment — a regional survey. *Br J Gen Pract* 1990; 40: 507-509.

### Erythrocyte sedimentation rate and plasma viscosity

Sir,

The study by Dinant and colleagues of the discriminating ability of the erythrocyte sedimentation rate (September *Journal*, p.365) concludes that the test still deserves a place in the general practitioner's daily routine. Nevertheless, they acknowledge that problems with the test have led to alternatives being recommended. One of these is the plasma viscosity estimation<sup>1</sup> and since this test is provided by the local pathology laboratory I decided to assess its usefulness.

A plasma viscosity of 1.72 centipoise is generally taken as the upper limit of normality.<sup>1</sup> In the two year period August 1989 to July 1991 I ordered 140 plasma viscosity estimations as part of my normal work, usually as a screen for occult pathology; 42 (30%) were at levels of 1.73 centipoise and above. On follow up for at least three months (and often for at least a year) four patients have been found to have malignant or chronic inflammatory disease (one of these patients had a plasma viscosity less than 1.72 centipoise). However, in none of these four patients was the plasma viscosity helpful in making the diagnosis, and in several patients with elevated results unnecessary follow up and investigation was arranged.

A comparison of the use of plasma viscosity and the results of Dinant and colleagues for the erythrocyte sedimentation rate reveals: sensitivity 75% and 53%, respectively; specificity 71% and 94%; positive predictive value 7% and 48%; negative predictive value 99% and 91%. Thus these two tests are not greatly different in their value to general practitioners. They frequently produce false positives and cannot be relied upon to be positive even in cases of temporal arteritis,<sup>2</sup> one of the classic conditions they are supposed to identify.

Once again we return to careful history taking, judicious examination and selective investigation as the foundation of accurate diagnosis in our patients. Experienced doctors will also use a 'wait and see' approach to distinguish those patients with a high probability of disease from those with a low probability. A useful general screening test for occult pathology in general practice may remain an illusion.

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#### References

1. Harkness J. The viscosity of human blood plasma; its measurement in health and disease. *Biorheology* 1971; 8: 171-193.
2. Jundt JW, Mock D. Temporal arteritis with normal erythrocyte sedimentation rates presenting as occipital neuralgia. *Arthritis Rheum* 1991; 34: 217-219.

### Asthma care

Sir,

Dr Struthers (letters, September *Journal*, p.387) displayed a lack of understanding of the nature and management of asthma in his criticism of the papers on this subject (June *Journal*, p.224, 227, 232). Instead of criticizing those doctors who have helped pioneer improved community based asthma management as well as research, he should focus on the employers who fail to recognize that asthmatic people can lead a normal life given proper management.

Dr Struthers refers to overdiagnosis and overtreatment of asthma; I know of no evidence to support this statement. In fact there are good reasons for using the diagnostic label 'asthma'. First, it results in appropriate therapy with reduced morbidity for the patient.<sup>1,2</sup> Secondly, it is now accepted that children do not 'outgrow' their asthma,<sup>3-6</sup> and it is now regarded by many experts as a chronic incurable disease, subject to remissions of variable duration. Finally, by recognizing the chronic nature of asthma, with the responsibility of ensuring long-term follow up and the provision of emergency medication, health professionals may help reduce the unacceptably high mortality and morbidity from this disease.

If doctors do not take asthma seriously, how can patients be expected to act appropriately when symptoms arise? Retrospective studies on asthma deaths have shown that patients, their families as well as their doctors underestimate the symptoms and severity of attacks.<sup>7,8</sup>

How can Dr Struthers justify his com-