that patients prefer intra-oral prostheses to CPAP? – does their opinion not count?

The authors of this paper are calling for a large expansion in sleep services on the basis of two randomised controlled trials with a total of 48 patients. We reiterate the conclusions of the Cochrane review: that further research is needed to identify which patients will benefit and by how much, and compare CPAP to other treatment options. Trials are underway to address some of these questions and until the results of these trials are known we would recommend that health commissioners should be cautious when allocating scarce health resources.

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In response

Editor – Wright and Baker correctly point out that the definition of the obstructive sleep apnoea syndrome is not universally agreed. In a relatively new and evolving field this is hardly surprising, especially when one considers that the definition of more venerable subjects such as chronic obstructive pulmonary disease, asthma and hypertension still await universal consensus! Their point that a causal relation between sleep apnoea and sleepiness becomes tautological if sleepiness is included in the definition is also correct. Perhaps this might be resolved by acknowledgement that sleep apnoea is a cause of sleepiness, with the term 'sleep apnoea syndrome' reserved for the combination of sleep apnoea and sleepiness. The alternative hypothesis, that sleep apnoea and sleepiness are usually coincidental, would not be tenable by physicians (or patients) with experience of the condition.

Wright and Baker restate their views on CPAP treatment and dismiss any evidence other than randomised controlled trials. This interpretation of evidence-based medicine is not shared by others in that field. The dramatic symptomatic improvement experienced by many patients with CPAP treatment delayed such trials and Wright's earlier paper has acted as a stimulus to increase their number. Five (not two) randomised placebo-controlled trials have now been published with a total of 205 (not 48) patients included. All support CPAP treatment, the most recent showing large improvements in quality of life and confirming common clinical experience.

Wright and Baker point out that in studies comparing CPAP and an introral device, more patients preferred the latter. Most patients included in these comparisons had mild disease and clinical experience shows that such devices are less effective in patients with more severe symptoms.

The decision to use CPAP inevitably depends on a trial of treatment in each individual. The hope that further research will clearly identify categories of patients who either will or will not respond to treatment is naive.

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Challenging evidence-based medicine

Editor – The most frequent criticism of evidence-based medicine (EBM) (May/June 1999, p249) is that you can never tell how an individual patient will react. True. But a higher percentage of successes with one remedy than with another in a randomised comparison is surely of interest to most patients. They are likely to feel (wouldn't we all?) that the first option probably gives them a better chance of doing well than the second one. The physician, armed with this useful information, is still free to tailor his or her advice to suit the individual. Are all generalisations based on what has happened to other patients to be regarded as irrelevant? Like everything else, randomised comparisons have their limitations. But they can show that the overall benefit from a treatment is less than had been supposed. They can reveal previously unsuspected harm. And they can demolish conclusions arising from previous comparisons that were unsafe (to borrow the legal term) because of defects such as failure to compare like with like.

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governance, need this every bit as much as new drugs or surgical procedures. However, EBM has plenty to offer doctors who make decisions at individual or population level and, in his determination to be properly cautious, Dr Goodman risks throwing the evidence-based baby out with the rhetorical bathwater.

One of the criticisms made by Dr Goodman is that EBM assumes one size fits all, with summary results of randomised controlled trials and meta-analyses applied indiscriminately to all patients, regardless of their individual characteristics. This is not the case. For instance, Rothwell and Warlow recently used data from the European Carotid Surgery Trial to assess which characteristics of individual patients indicate a capacity to benefit from carotid endarterectomy1.

Meta-analysis is not perfect, but it is undoubtedly less prone to bias than a conventional unsystematic review. Such reviews are usually written by experts who have a clear point of view to advocate which they judiciously support by selective citation of the literature. Sometimes their statements pay too little heed to published evidence and can be misleading. An example: by 1987, more than thirty trials of thrombolysis in the management of acute myocardial infarction had been published involving more than six thousand patients2, and a meta-analysis would have given strongly positive results. Yet, no meta-analysis was performed, with the result that the second edition of the Oxford Textbook of Medicine (OTM), published that year, opined that 'The clinical benefits of thrombolysis ... remain to be established.' The weaknesses of poorly conducted meta-analyses are much easier to discern than those of biased unsystematic medical writing. How many patients missed out on thrombolysis because their physician was swayed by the OTM and other authoritative but non-evidence-based reviews?

Having censured evidence-based medicine, Dr Goodman does not describe an alternative way of working out how to improve the effectiveness of clinical practice. Perhaps the reason evidence-based medicine has met with little outright opposition is that it is common-sense. The variations in clinical practice suggest differences in acceptance of the results of clinical research. However, the notion of answering clinical questions by finding research evidence, appraising its relevance and validity, assessing its potential implications and then making changes in practice to reflect one's conclusions is hardly revolutionary. I am sure Dr Goodman does it all the time. By giving it a catchy brandname and marketing it energetically, advocates of EBM have enabled more health care practitioners to be evidence-based, but have always emphasised the importance of adjusting the outputs of research to reflect the nature of one's individual patients, their differences from the average, and personal values3. To do otherwise is to practice evidence-tyrannised medicine, which is perhaps the best name for the Aunt Sally against which Dr Goodman rails.

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Lessons from dermatology

Editor – I was saddened by the views expressed in the editorial by Dr Martin Black, (May/June 1999, pp208–11). Whilst I accept that some GPs do not claim great interest or expertise in dermatology, the statement ... the care of dermatology in the primary sector is, generally, appalling ... is insulting to those GPs who retain enthusiasm for the subject. The attitude expressed in Dr Black's editorial is, I believe, based on a lack of experience of high quality primary care.

Most GPs with an interest in dermatology are not trying to usurp the role of a consultant dermatologist. Our knowledge of the patient, his family and the community, coupled with readier patient access than offered by our hospital colleagues, is a resource that should be embraced and not scorned. The current waiting time to see a consultant has become unacceptably long. A GP who comes to provide high quality primary care for his colleague's patient does so with benefit to patient and colleague.

Dr Black reminds us that 15% of a general physician's workload is for skin problems. The average GP may have as many as 1,500 dermatology consultations each year. Considering the relatively small number of referrals to secondary care our ability to manage dermatology should not be dismissed.

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Computer generated discharge summaries

Editor – The proposal to use computer generated discharge summaries reported above (May/June pp260–4) coincides with the demotivation of junior doctors as a result of fragmentation of the continuity of clinical care resulting from the partial shift system. The preparation of the discharge summary, previously a labour of love documenting the culmination of a clinical episode in which the trainee was justly proud to have participated, has now deteriorated into a sterile exercise, almost totally devoid of ‘ownership’ on the part of the supposed educational beneficiary. Almost in parallel with the erosion of the sense of clinical involvement in the total and uninterrupted care of the individual patient we have seen a shift in emphasis from the acquisition of clinical experience for its own sake to the acquisition of ‘membership facts’ for the sake of exams. Without a secure basis in continuity of clinical care, and a recognition of the educational value of a health record characterised by a disciplined and problem-oriented integration of contributions from the entire health care