amenable to management by the primary care team.

Cost is the bugbear of this therapeutic development. Artificial nutrition accounts for 1% of the pharmaceutical market in the UK. Home total parenteral nutrition for one year costs approximately £40 000 per patient, home enteral nutrition £3500. No uniform policy currently exists as to who bears the costs of home nutritional support. Some units lean heavily upon the general practitioner to pick up the responsibility, others continue to provide supplies but may now seek reimbursement from the patient's district health authority. The principle that the act of prescribing implies acceptance of clinical responsibility must surely be pre-eminent.

There is a need at district and regional level to identify funds specifically for artificial nutrition, though the concept of allocating part of the national drug budget to the development of this facility finds favour in some quarters. A national fund would stop the present wrangles over treatment costs but would mean difficult allocation decisions would have to be made.

A policy document on artificial nutritional support is at the draft stage, defining ways in which a national service should be planned, coordinated and financed. The role of home care will be an important feature of the report and the views of general practice need to be made clear at this stage. Those wishing to make representations on this subject should write to me at the address given.

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Salmeterol therapy in mild asthma

Sir,

Dr Weaving's letter makes a number of useful points about the treatment of asthma (August *Journal,* p.346). However, by making these points in the form of a criticism of our study (letters, May *Journal,* p.214) he misinterprets our research.

Our study simply showed that the addition of salmeterol to a patient's standard therapy (with and without prophylactic drugs) improved quality of life as measured by the living with asthma questionnaire.[1] Dr Weaving writes 'It would be logical that such a group of patients would feel better with additional bronchodilator therapy'. First, our dependent variable was quality of life, not 'feeling better', and although there are affect-related items in the living with asthma questionnaire, these items did not show any greater improvement than items describing functional limitation. A 'feeling better' question was included in the study, and showed a significant improvement with salmeterol, but that was not what we reported in our letter. Secondly, the relationship between a drug and its effect is an empirical not a logical relationship. Quality of life trials among patients with other diseases sometimes fail to produce significant effects, and there is a good possibility that it is the method of measurement rather than the treatment which is responsible for this failure. Our study is the first to report that the living with asthma questionnaire is capable of detecting differences in a clinical trial.

Dr Weaving goes on to write 'It would be more appropriate, however, and in keeping with the British Thoracic Society guidelines, to treat them with increased doses of anti-inflammatory drugs such as disodium cromoglycate or inhaled steroids'. We did not make any treatment recommendations in our letter, we merely reported the first quality of life study with an asthma specific questionnaire. Whether it is more 'appropriate' (presumably this means that a similar improvement in quality of life would be obtained) to use steroid therapy is an empirical question to which the answer is as yet unknown. The British Thoracic Society guidelines were drawn up before the development of a quality of life assessment for asthma and before salmeterol became available.

More research is needed on quality of life among asthmatics and on the effects of salmeterol before treatment recommendations can be based on quality of life as an outcome variable. Quality of life is just one outcome variable, which provides the patient's perspective. It should be considered by the physician when selecting therapy in addition to the outcomes of morbidity and mortality.

Finally, Dr Weaving mentions the cost implications of salmeterol therapy with an estimate of cost which was not based on data from a study of cost effectiveness which examines both costs and benefits. Our study did not address the question of cost effectiveness and valid discussion of this topic must await the results of future studies.

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Asthma care in general practice

Sir,

The editorial by Jones and the papers by Charlton and colleagues and Barritt and Staples (June *Journal,* p. 224, 227, 232) stress the benefits of treating asthma. However, there is a catch in the form of over-diagnosis and over-treatment which readers may not have met. Many candidates for the armed forces have to be rejected because of a history of use of an inhaler in the previous four years (the forces' limit for acceptance). Only too often the inhaler was prescribed on what now seem flimsy indications or was allowed to continue long after it was no longer needed, leaving the individual labelled as 'asthmatic' and later disappointed because he or she cannot follow his or her chosen career.

I am not expressing the views of the armed services but write as an individual medical examiner.

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Sir,

Dr Charlton and colleagues have carried out an interesting study on asthma clinics which has produced impressive outcome data (June *Journal,* p. 227). However, the study has one major flaw that was not addressed by the authors — no external controls were provided during the period in which the clinic was in operation. It could well be that there was a reduction in the profile of asthma in the catchment population resulting from other factors, such as reduced atmospheric pollution. Thus, possible confounding factors would have been controlled for had the authors used the experience of asthma consultations in an external practice as a standard

or control measure of the incidence of asthma in the catchment population.

If such data were available, it would strengthen the epidemiological validity of these impressive results.

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Quality or inequality in health care?

Sir,

William Fulton's pertinent letter (July *Journal,* p.303) raises a number of important issues about general practice on peripheral council housing estates — the 'forgotten areas of deprivation'.[1] Bosanquet and Leese have shown clearly that the often overwhelming reactive workload facing practices in deprived areas militates against their showing 'innovative' characteristics (practice nurses, trainees, a practice manager and new premises), which are more common in affluent suburban areas where patient demand is less, and is more proactive.[2]

We practise on a large peripheral post-war council housing estate (population 25 000), where high morbidity, unemployment, poor housing and large numbers of pre-school children lead to a heavy workload. Our five full-time partners (plus a trainee) practise from a health centre and in the past year our annual consultation rate has increased from 4.38 per patient (1989/90 with list size 7500) to 4.71 (1990/91 with list size 7400). We offer 10 minute appointments and morning surgery (five doctors working) lasts from 08.30 hours to past noon, with a 20 minute mid-morning 'coffee recovery period'. Our mean consultation length is 9.2 minutes. Sixty five per cent of the babies born in the practice have birthweights below the 50% centile, and 48 pre-school children are on the child protection register. Our night visit rate, at 44.5 per 1000 patients per year, is about two and a half times the national average.

We receive no deprivation payments, because of the anomalies of the UPA8 score, although our practice area is reported to be the second most deprived in Bristol (letters, May *Journal,* p.217). We have only managed to reach the high targets we set for cervical smears and primary immunizations because of our low list size (doctor:patient ratio 1:1500), our committed primary health care team and our past history of screening and preventive work.

In the new contract for general practitioners[3] the population is treated as though there were no demographic difference across the social classes. Deprivation payments, the one exception, are excellent in concept, but inaccurately targeted with regard to need.[4] The increased capitation element has militated against the high ratio of doctors to patients needed to deliver high quality care in areas of deprivation. The Prince of Wales has described the peripheral council estates as 'islands of unemployment and helplessness', saying 'What we need to do is to break the vicious cycle of poverty, hopelessness and depression' (*The Times* 10 March 1989, p.2). Professor Maclennan of Glasgow university has identified the large post-war peripheral council housing estates as the pivotal areas of deprivation of the 1990s, supplanting the inner cities.[5]

It is essential that resources to family doctors, to the whole primary health care team, and to housing, education and social services, should be targeted to where the real needs lie, if Tudor Hart's inverse care law[6] is to be reversed in these 'forgotten areas of deprivation'. In the 10 years since the Black report on health inequalities,[7] the health–wealth gap has widened in the United Kingdom, but has narrowed in most of the rest of Europe.[8] This is the most important issue in health in the UK today, and resources must be targeted to where the morbidity and need are, to give the disadvantaged an 'average chance of health'.[9]

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Hospice care

Sir,

We were interested to read the letter regarding general practitioners' opinions of hospice care (May *Journal,* p.213). All who rely on hospice care are entitled to demand exacting standards. These standards must be judged in relation to what hospices do. They are not 'death houses' which simply receive dying patients for the last 24 or 48 hours of care. A flexible and responsive service depends on accepting that hospice care, whether in the patient's home or elsewhere, is concerned with improvement in quality of life. One important component of this is the development of a relationship based on trust between patient, family and the professional carers. A late first contact with a hospice precludes this humanistic approach and results in fraught situations which stretch the coping skills of all involved.

Thus registering early with a hospice is not a pre-emptive device, but the first step in developing a caring relationship concerned with quality of life and ultimately with a peaceful, dignified death. Hospices do not aim to take over from the primary care team. They offer support when the patient is at home, forging a caring link in preparation for hospice admission if required.

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Factors influencing prescribing habits

Sir,

I read with interest the paper by Taylor and Bond (June *Journal,* p.244) regarding the factors leading to change in the established prescribing habits of general practitioners. The authors are to be congratulated on what is an attempt to examine an important area of therapeutics. However it is a little disappointing that it has taken so long for their results to be published since the major influence on doctors' prescribing habits — the limited list — is now somewhat dated.

They state in the summary that general practitioners were not unduly influenced by commercial sources of information. I would question this since if the effect of the limited list is disregarded the next commonest influence was found to be the pharmaceutical company representative and then the hospital doctor. There is no doubt that hospital doctors are targeted