criticised, and grossly underpaid. Is it any wonder that the average young doctor feels disillusioned, demeaned, and depressed? How did the profession allow this state of affairs to occur?

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1 Salisbury C. Visiting through the night. *BMJ* 1993;**306**:762-4. (20 March.)
2 Berkshire Family Health Services Authority. *Analysis of complains against general medical practitioners.* Reading: Berkshire FHSA, 1993.
3 Anokar M. GPs under attack on the home front. *Doctor* 1992 Nov 12:27.

EDITOR,—Chris Salisbury reports an increase in night calls between 1982 and 1992 and refers to studies showing increases from 1967.[1] Salisbury's discussion about the reasons for this trend, and Brian Williams's editorial,[2] do not mention the general fall in home visiting since 1964.[3,4] A fall in visiting at home people who are too ill or frail to go to the surgery may well contribute to an increase in emergencies and night calls.

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1 Salisbury C. Visiting through the night. *BMJ* 1993;**306**:762-4. (20 March.)
2 Williams BT. Night visits in general practice. *BMJ* 1993;**306**: 734-5. (20 March.)
3 Cartwright A, Anderson R. *General practice revisited.* London: Tavistock, 1981.
4 Cartwright A. Changes in life and care in the year before death. *J Public Health Med* 1991;**13**:81-7.

Rate of asthmatic attacks

EDITOR,—R G Neville and colleagues are incorrect in asserting that no comparable figures to theirs on asthmatic attacks have been published.[1] The weekly returns service of the Royal College of General Practitioners Research Unit has been collating data on acute asthmatic episodes since 1976, and these are published in the weekly monitor of the Office of Population Censuses and Surveys. Data from 1975 to 1990 have been summarised.[2] From 1976 to 1983 there was a significant rise in acute episodes of asthma,[3] and since that time further increases have been seen.[4]

For the period covered by Neville and colleagues' study (September 1991 to January 1992) the overall rate (all ages) of acute asthmatic episodes recorded by the weekly returns service was 58/100 000/week, compared with 27·5/100 000/week in Neville and colleagues' study. The age breakdown is different in the weekly returns service (table), and it is thus impossible to compare age specific rates, although Neville and colleagues should be able to present their data in this form.

Average number of acute asthmatic episodes/100 000 people/week related to age according to weekly returns service, September 1991 to January 1992

Age (years)	Rate
0-4	193·6
5-14	115·1
15-44	40·3
45-64	35·1
≥65	36·1
All ages	58·1

The incidences reported in the weekly returns service are roughly twice those of Neville and colleagues' study, but their definition of an acute episode, linked as it is to inability to work, underestimates the total burden of asthma. Attacks of lesser severity will have been excluded from their study but would be included in the datasets of the weekly returns service. The weekly returns service is useful for following trends in acute asthma, but because of difficulties of case definition it has been difficult to determine how well this reflects the true overall picture for England and Wales. The differences in case definition between Neville and colleagues' data and the weekly returns service highlight the difficulty in comparing different datasets.

The statement about the apparent high number of women aged 20-29 suffering acute attacks deserves comment. Without population denominators and appropriate rates no statement about a higher prevalence of unstable or brittle asthma in that group can be made. Of the 78 patients in the west midlands brittle asthma register, 54 are women. The mean age (range) of these patients is 44 (17-72), somewhat older than the group highlighted by Neville and colleagues. It would be unwise to attribute an apparently high number of attacks in 20-29 year old women to brittle asthma without full characterisation of the patients.

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1 Neville RG, Clark RC, Hoskins G, Smith B for General Practitioners in Asthma Group. National asthma attack audit 1991-2. *BMJ* 1993;**306**:559-62. (27 February.)
2 Fleming DM, Norbury CA, Crombie DL. *Annual and seasonal variations in the incidence of common diseases.* London: Royal College of General Practitioners, 1991. (Occasional paper 53.)
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Methodology in health services research

EDITOR,—We hope that the debate on methodology in health services research will continue in the *BMJ*[1] and more broadly as the new agenda for this research requires a diversity of perspectives and methods. We wish to make two observations about the conversation between the fictional medical sociologist and director of a research unit.[1]

At first sight their views seem to be quite different. We were struck, however, by the apparently unacknowledged similarities in the positions they were taking. Firstly, they seemed to share the assumption that health services research is and should continue to be focused primarily on hospital based care. This is certainly the impression given by the examples of research that were discussed. Though this may well have been the case to date, health services research will be left in the cold if it does not recognise the importance of work on community based services and preventive interventions.

We were particularly fascinated with the apparent agreement between the two protagonists that sociological research on the experience of health and illness is not relevant to health services research. Indeed, the medical sociologist implied that her colleagues are doing that sort of work only because they cannot get into health services research. Other medical sociologists would argue the opposite—that research into the experience of health and illness is of central relevance to our understanding of both the process and the outcomes of health and social care, including initiatives in health promotion and prevention. This research has a major contribution to make, particularly in the assessment of health and social need, the measurement of patient assessed outcomes, and the assessment of the public's views of priorities in health care.

Readers may be interested to know that these issues are being discussed by researchers and practitioners at a series of seminars on social research in public health, funded by the Economic and Social Research Council, which we are organising. Further information about these is available from GW.

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1 Pope C, Mays N. Opening the black box: an encounter in the corridors of health services research. *BMJ* 1993;**306**:315-8. (30 January.)

Positive discrimination in India's medical schools

EDITOR,—Guru Nandan's news item on private medical colleges in India fails to mention one of the main reasons for their continued growth and popularity.[1] All the states of India mentioned in the report (Maharashtra, Karnataka, Tamil Nadu, and Andrha Pradesh), especially Tamil Nadu, operate a policy of positive discrimination whereby up to 60% of places in colleges run by the government are reserved for candidates from "backward" communities.

Communities are defined as backward solely on the basis of caste. An economically well off student with low grades from a so called backward community often secures a place in a government medical college whereas a candidate from a "forward" community with much higher grades finds it difficult to do so. Thus many deserving students find themselves denied a seat owing to the sheer accident of having been born into a particular caste. They then seek admission to private medical colleges. Contrary to the image conveyed by Nardan's report, students in private colleges are not just the rich. Quite often they are the meritorious poor and middle class from forward communities who have been hard done by the shortsighted government policies.

It is incorrect to say that after abolition of the capitation fee system merit will be the sole criterion for entrance to medical colleges in India. So long as primitive laws with a policy of positive discrimination based on caste are in force merit will remain a secondary criterion in the selection procedure.

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1 Nandan G. India to check sale of places in medical colleges. *BMJ* 1993;**306**:604-5. (6 March.)

EDITOR,—Guru Nardan reports that the Indian Supreme Court has ordered an end to students buying their way into private medical colleges regardless of merit.[1] The court's judgment, although a landmark one, is flawed because it has failed to consider a few vital issues.

Firstly, admission to medical colleges in India, at least since independence, has never been solely on the basis of merit but is based on an arbitrary and obsolete system of reservations based on the caste system. The percentage of seats reserved on this basis has reached mammoth proportions—even 70% in certain Indian states.

Secondly, the judgment seems to be based on the premise that all that is government run is good and