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

by the pharmaceutical industry in exactly the same way as general practitioners and so it is likely that this effect spills over into the advice given to general practitioners. Furthermore, there is a commercial interest in that many hospitals are able to buy drugs at a difference price to that charged in the community and this 'loss leader' approach to pharmaceutical selling has a profound influence on the patterns of prescribing by general practitioners.

It is rather sad to see that more unbiased sources of information, such as the *British national formulary,* ranked low down on the list of influences on doctors' prescribing. Therapeutics is an important subject which is highly undervalued in schemes of both undergraduate and postgraduate medical training. It seems a pity that the same techniques used to sell washing powder are still more successful than providing more detailed, unbiased and factual information.

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Patient participation

Sir,

We read with interest the paper on patient participation in general practice (May *Journal,* p.198). Dr Agass and colleagues suggest that the level of awareness of their patient participation group might have been higher had patients over 65 years of age been included in the study. Why were they excluded? Results from the study show that awareness and interest tended to be greatest in older women and among those who consulted more than four times per year. Older people are known to consult more frequently, so why were they not asked to participate in the survey? Will not this kind of discrimination against elderly people perpetuate inequalities in health in the practice population?

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Patient education and attendance rates

Sir,

Dr Grundy-Wheeler's excellent paper (May *Journal,* p.210) has confirmed my own findings that effective patient and parent education, provided in comprehensive care programmes for children under five years of age, reduces both out of hours attendance rates and total attendance rates in practices running such programmes.

However, I suspect that at least some of the beneficial effects found in this study may have been reduced by the one doctor who continued to prescribe antibiotics for 80% of the children presenting with upper respiratory tract infection. Although not in the results I suspect that he or she may also have had the highest consulting rates for this age group.

As more and more partnerships start to use indicative drug budgets and PACT (prescribing analyses and cost) data, such prescribing patterns may be recognized and dealt with appropriately. For can we, as a profession, allow such behaviour to go unchallenged, especially when it affects costs and probably workload adversely? Or will we continue to claim clinical freedom as a reason for this behaviour?

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Sampling endocervical cells on cervical smears

Sir,

The issue of improved performance of cervical smears in terms of endocervical sampling is an interesting one. The presence of endocervical cells indicates that the transformation zone, where most cancers begin, has been sampled and that the sample is therefore a good one. The paper by the Cumbrian practice research group (May *Journal,* p.192) confirms the results of a number of previous studies on the use of the brush for cervical sampling in primary care settings demonstrating superiority over the swab/spatula technique.[1-4] These report the presence of endocervical cells in between 84% and 90% of smears. The rate reported by the Cumbrian practice research group is still quite a bit lower than this and may be due to the position of the patient and the more limited visualization of the cervix that occurs in the 'frog leg' position often used in the UK. I had low rates of cervical smear adequacy (72%) despite using the brush until I switched to having the patient use leg stirrups. Now 90% of the smears I take are adequate and have endocervical cells. I find it interesting that in their discussion the authors do not review or quote the extensive literature on the effectiveness of brush sampling techniques.

In their report, the authors do not discuss the significant confounding effects of patient age and fertility status on the adequacy of cervical smear sampling. Endocervical cell sampling is adversely affected by pregnancy and the menopause. Without knowing the distribution of these variables among the two study groups, their conclusions are open to criticism.

In the final paragraph of the paper the authors suggest that increasing the detection of abnormalities will reduce the need for major surgery. The reference for the cervix brush increasing detection rates comes from a journal that is not refereed. In fact, there is controversy about the relevance of increased detection to outcome.[5,6] At least 30% of such lesions are reported to regress over time and better sampling might, in fact, lead to overtreatment.[7]

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Breast cancer screening

Sir,

In their discussion paper (April *Journal,* p.166), Drs Austoker and Sharp argue from contradictory premises. First they accept that 'the decision to mount the NHS Breast Screening Programme was largely political' and leave unanswered their rhetorical question, 'do the benefits of screening outweigh the adverse effects?' Then they exhort general practitioners to cooperate fully with the programme. General practitioners must choose