that it was about the health of general practitioners rather than that of patients. At a time when there are so many articles on burn-out and depression among our profession, I expected it to provide further evidence that health promotion and the screening of healthy adults are a rod for our own backs. The government wish regular screening programmes to be set up when there is scanty, if any, evidence in their favour.

We now have the facility to scare people on an unprecedented scale and the raising of awareness of health problems together with its usual bedfellow, heightened anxiety, cannot really be viewed as healthy. If we are going to mention asymptomatic conditions, which the doctor rather than the patient defines as important, then we had better prepare ourselves for more work, counselling people through years of worry.

After all the hard work we may put in, people will eventually move house or die. We may like to feel that we are indispensable, but the truth is otherwise. Feelings of frustration, anger, loss and guilt are as much a part of our experience as that of our patients. Burn-out as a result of performing medical work which is not proven to change the course of disease or its outcome, is of no use to the doctor or his patients.

We should be spending at least as much time looking to meet our own needs as we spend looking after those of our patients and as a profession we should be far more zealous in the care of our fellow members than we are at present.

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Asthma — still a challenge for general practice

Sir,
In his discussion paper Kevin Jones gave a comprehensive overview of the primary care management of asthma (June *Journal,* p.254). One omission was that of drug-induced or exacerbated asthma. The drugs most commonly involved are beta-blockers, and non-steroidal anti-inflammatory drugs including aspirin, both of which are widely prescribed. The Committee on Safety of Medicines continues to receive reports of deaths owing to bronchospasm in patients receiving beta-blockers.[1] Most of these deaths occurred in patients with asthma or a history of obstructive airways disease, and were therefore preventable.

In 1986 I undertook a retrospective survey of all patients aged 17 years and over discharged from Selly Oak hospital in 1985 with a primary discharge diagnosis of asthma. One hundred and sixty five patients were identified, and the notes of 136 (82.4%) were traced. Four patients, aged between 63 and 75 years, were taking beta-blockers on admission. Propranolol was the agent involved in each case and it had been taken for between one week and 18 months prior to the onset of asthmatic symptoms. The asthmatic symptoms had lasted from one to four weeks before admission, and in two patients had worsened suddenly over one and five hours, respectively. Two patients were moribund on admission and would have died but for immediate medical intervention: one required ventilation for one day. All four patients left hospital alive and well. The patient who required ventilation was known to be asthmatic and had received propranolol on the advice of the hospital in spite of this. The other three patients were undiagnosed asthmatics.

It is impossible to predict from the chronicity or severity of asthma which patients are likely to bronchoconstrict with beta-blockers, nor whether the induced bronchospasm will be minimal or life threatening. The period between starting beta-blockers and a severe attack of asthma is similarly variable. Although cardioselective agents are considered to be safer, the degree of bronchospasm produced in asthmatics is unpredictable.[2] Thus all beta-blockers should be contraindicated in patients with asthma. In addition, all patients for whom beta-blockers are being considered should be screened for symptoms suggestive of asthma and undiagnosed asthma should be considered in any patient who becomes dyspnoeic while taking beta-blockers.

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2. Skinner C, Palmer KNV, Kerridge DF. Comparison of the effects of acebutolol (sectral) and practolol (eraldin) on airways obstruction in asthmatics. *Br J Clin Pharmacol* 1975; **2:** 417-422.

Sir,
Dr Kevin Jones (June *Journal,* p.254) highlights some of the main deficiencies of asthma care and suggests three major points that practices should address — prevalence of asthma, asthma therapy and follow up.

As general practitioners we should ask ourselves several specific questions concerning the management of asthma in our practices:

1. Is the cumulative prevalence of asthma in the practice between 10 and 15%?[1,2]
2. Is the incidence of new cases of asthma in the practice over 9% per year per partner with an average list size?[1]
3. Is the therapy asthmatics receive appropriate? Are their drug delivery systems and inhaler techniques suitable? Are patients who use symptomatic bronchodilators regularly receiving preventive regimens?
4. What percentage of acute exacerbations of asthma requiring emergency treatment are successfully treated in the practice? (Over 80% in some trials.[3])
5. Do the asthmatics who experience recurrent exacerbations requiring emergency treatment despite adequate prevention regimens (approximately 8% of the asthma population) know when to obtain medical advice? Do they possess a peak flow meter? Do they know their predicted and best ever peak expiratory flow readings (often considerably different in this group) and have they been instructed to act accordingly if the value is less than 60–70% of normal?[4]
6. Is there a recall and follow-up system appropriate to the needs of the whole spectrum of the asthma population in the practice?

The answers to these questions not only reflect the standard of care we provide for our asthmatic patients but also provide a measure of one important aspect of clinical care that is suitable for internal or external monitoring.

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Sir,
Kevin Jones (June *Journal,* p.254) has written a plea for improved asthma care in general practice. What has been omitted and is absent from most review articles on this subject is the reluctance of many general practitioners to implement this

sort of care. This may in part be due to a set of assumptions that designate asthma as a chronic condition worthy of the sort of care given to hypertension. Does underdiagnosis matter? Do these patients die? Do they suffer subsequent deterioration in airways function later in life that could have been prevented? Does early treatment make any difference to long term sequelae? Does prophylactic treatment in all but the most severe cases prevent acute severe asthma or hospital admission? Has the recent upsurge in the prescribing of beta$_2$-agonists in some way contributed to rising asthma mortality, perhaps by desensitization of beta-receptors? These anxieties have not been resolved because long term studies are necessary, although the articles by Kelly,[1] Markowe[2] and Strachan[3] provide interesting reading. Finally, the patient may not want to adopt a sick role and have to take prophylactic treatment for a condition that may not deteriorate, or which may disappear if they are children.

The gold standard of care advocated by Kevin Jones has to be sold to health care workers in a more convincing style before it will be widely adopted.

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3. Strachan DP, Anderson HR, Bland JM, Peckham C. Asthma as a link between chest illness in childhood and chronic cough and phlegm in young adults. *Br Med J* 1988; **296**: 890-893.

Effect of small group education on the outcome of chronic asthma

Sir,
The recent study by Dr White and colleagues (May *Journal*, p.182) demonstrates the failure of small group learning to reduce morbidity in a sample of Croydon patients which chronic asthma. This is not surprising: the general practitioners in the study did not use peak expiratory flow meters, they were obsessed with acute asthma and unsure about asthma management in general, they did not have the contents of the morbidity questionnaire revealed to them and they had group leaders who seemed unable to lead.

To state that there is 'little agreement among general practitioners or specialists' on asthma management is passé. It depends on the doctors you ask. I continue to be pleasantly surprised at the remarkable uniformity I have found over the last nine years; good doctors do a good job of handling most common things.

Only 27 out of 53 general practitioners took part in the study and 338 of 565 patients were followed to the end. Perhaps 200 or so of the missing patients improved considerably and the rest had irreversible airways obstruction, denied their condition to the extent of refusing to fill in questionnaires, did not take their drugs or were genuinely difficult cases. This is unlikely, but not impossible.

The recorded morbidity is quite shocking; the doctors involved have a long way to go and much more education is needed to make a noticeable impact. The postulated effect of face-to-face contact (or the lack of it) on these patients deserves more study. I have observed patients happily picking up their monthly prescriptions for asthma treatments for a year or more, with only a perfunctory 'review' once a year.

This study shows that there is considerable unmet need among this group of patients and that 27 Croydon general practitioners could do a lot better. It is not possible to make any comment on small group learning as an educational method under the conditions of this study.

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GPs' use of hospital investigative facilities

Sir,
In their leading article (April *Journal*, p.135) Hobday and Price suggest that 'a low level of general practitioner usage of pathology services has been demonstrated'. This is misleading, probably because the reference quoted is from 1973.[1] General practitioner use of our district general hospital laboratory (which serves a population of 300 000) has increased and is growing much faster than hospital requests (Table 1).

This rapid increase causes problems to pathology laboratories, whose budgets have not increased in line with workload. Automation has enabled us to cope so far, but the rise in workload is outstripping this. We may soon have to restrict laboratory use by general practitioners or hospital users, or both, unless we can find a way of charging practices or the family practitioner committee for this work.

Table 1. Use of investigative facilities 1979–88.

	No. of pathology requests		% increase
	1979	1988	
GP	111 737	166 313	*49*
Hospital	235 322	261 626	*11*

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Reference

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Practice annual reports

Sir,
I read with interest the article by Dr Wilson and colleagues (June *Journal*, p.250) on practice annual reports. As the instigator of an annual report myself I can wholeheartedly concur with most of the sentiments expressed in the survey and the resulting conclusions.

However, I think that it is vital that there is a long term strategy for the annual report prior to instigating the collation of information. Further, the amount of information collected can be so burdensome that some form of rota collection by partners and staff over two or three year periods seems appropriate. I was fortunate to obtain information from outside the practice allowing a comparison of our position with that of our peers; without this information practice annual reports are of little instructive benefit.

Lastly, after looking at the bare bones of the white paper's suggestions for practice annual reports,[1] it seems that the essence is little more than a practice leaflet, although I await with interest, further developments.

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