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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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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