Table 1. Mean differences in patients immunization rates (%).

	Confidence interval		P (pairs method of Schwartz)
	1991 rate 95% (2898 patients)	1992 rate 95% (2919 patients)	
Tetanus immunization	55.8 (52.2–59.4)	66.5 (62.9–70.1)	<0.001
Influenza immunization	76.7 (74.5–78.9)	80.9 (78.6–83.2)	<0.01
Double immunization	45.0 (41.3–48.7)	57.6 (53.7–61.5)	<0.001

marked deviation from the pre-defined standards for tetanus and double immunization (Table 1). This led to the development of consensus recommendations distributed in July 1992 to all participating physicians. The second data collection was carried out in December 1992. In 1992, 2919 and 2135 patients were recorded, respectively. The immunization rates are show in Table 1.

Regression analysis of the change in immunization rate compared to the 1991 immunization rate in the patient groups seen by each physician showed an improvement in the rates for tetanus alone, influenza alone, and for double influenza and tetanus immunizations. The improvement was more obvious when the physicians had a low percentage of immunized patients during the first year.

We have shown that it is perfectly possible to conduct a self-administered clinical audit in the special setting of general practice in France. Data collection was prospective. Use of a rapidly completed notebook (30 per patient in our study) facilitated both the conduct of the survey and acceptance of the additional workload during the consultation. We observed considerable modification of the physicians' clinical practice. In accordance with the recommendations, the tetanus immunization rate and double immunization rates increased significantly from 1991 to 1992. The increase was greater for physicians who had a low percentage of immunized patients during the initial data collection.

In the absence of a randomized control group, the observed increases cannot be definitively attributed to the audit, to a spontaneous trend or to other factors. For influenza, the changes in immunization rates from 1991 to 1992 could have been caused by the impact of influenza immunization campaigns. This is certainly not the case for tetanus since there was no large-scale public campaign during the study period. The volunteer physicians who accepted the initial guidelines may have thought that their practice was close to these standards. The discovery of a considerable difference between the standards and their actual practice, as observed during the first data collection, may have been the deciding reason for them to modify their clinical practice.

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Night visiting rates

Sir,

The paper by Majeed *et al*[1] examining night visit rates in 129 practices in Merton Sutton and Wandsworth FHSA uses a similar method of analysis to work which we have been doing in East London, and raises comparable questions about the potential sources of bias in this type of analysis.

Our analysis is based on 2 years (1992/3 and 1993/4) of FHSA night visit claims data from 155 practices in East London and the City Health Authority. Unlike Majeed *et al's* data, we were able to categorize claims into high and low payment rates (corresponding to visits done 'in house' and by a deputizing service, respectively).

Our data showed no association between the total night visit rate and practice characteristics (partnership size, practice manager, practice nurse, training status and computerization), but suggested an inverse relationship with indices of social deprivation. Like Majeed *et al*, we have used crude rates, as data is not available that enables us to age standardize; however, we found no relationship between the total night visit rate and percentages of the population in different age bands.

All practices for which we have data claim for some visits done by a deputizing service. The correlation between total night visit claims and proportion claimed as deputized (r = -0.29, P<0.01) suggests that, contrary to commonly held opinion, practices using a deputizing service for the greater proportion of their visits have lower total night visiting rates. Whether these are valid findings, or simply relate to differences between practices in claiming rather than visiting is open to debate.

The potential sources of bias in this type of analysis need clear enumeration. The analysis is based on financial claims, which Majeed *et al* considers a reasonably accurate estimate of the number of visits carried out, but in their study, four practices apparently claimed none, raising the possibility that claim rates may be associated with organisation within the practice. The claims analysed by Majeed *et al* were based on Merton Sutton and Wandsworth FHSA residents. Practices will have a variable mix of FHSA residents, depending on their boundary policies and their geographic location, but no account is taken of this in the analysis. A further source of bias lies in the estimate of list inflation for practice. Imputing list inflation from census variables takes no account of the influence practice organization may have;[2] for example, practices which achieve high targets are likely to have lower list inflation.

Descriptive studies such as this have the potential for explanatory power which needs to be carefully balanced against a range of sources of bias. Undoubtedly, further collection of individual patient and practice data would reduce many of these sources of inaccuracy.

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Setting standards of prescribing performance

Sir,

Bateman and his colleagues (January *Journal*, p. 20) describe setting and applying standards of prescribing performance in primary care. A consensus group of general practitioners agreed and set the standards which were then applied to the Prescribing Analyses and Cost (PACT) data of practices in their region.

The quality of prescribing is a reflection

of the decision making process. Many factors can influence this process, and PACT data are not linked to indication, characteristics of patients, doctors and practices. However, in our recent work, we have taken into account practice resources, general practitioner characteristics and patent sociodemographic factors in relation to prescribing activity.[1,2]

We have explored and partially validated the ratio of prophylaxis to bronchodilator prescription as an indicator of appropriate prescribing for asthma[1-3] and were surprised the group dismissed this ratio as a valuable marker. Their reasons include difficulty in setting a defensible numerical standard, changing prescribing patterns and differences in demography — all reasons which could be levelled against many of their other standards. Asthma prescribing ratios do have disadvantages. Like other suggested markers, there is not gold standard and it is difficult to set an absolute level. Ratios based on cost do not allow for generic prescribing and varying drug prices, and an item may include any number of inhalers. As Bateman rightly points out, ratios do not take into consideration the overall prescribing rate of asthma drugs. Compliance is another grey area, particularly with prophylactic medication. Nevertheless, prescribing ratios are conceptually simple, easy to calculate, and as ratios, they adjust for some demographic problems such as list inflation. More importantly, however, the asthma prescribing ratios can be validated against other criteria,[1] and especially, an important outcome like practice asthma admission rates.[3]

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Clinical trials of homeopathy

Sir,

I would like to take up some points raised by Ernst in his recent Editorial about complementary medicine (February *Journal,* p. 60). While I agree with the importance which he attaches to a careful and rigorous consideration of the real benefits and possible dangers of complimentary therapies, Professor Ernst takes a repeatedly sceptical stance towards homoeopathy which is not in fact justified by the evidence that he himself quotes. He states that Kleijnen's review of clinical trials of homoeopathy[1] shows that the evidence in support of the effectiveness of homoeopathy is insufficient at present. In his article, Kleijnen actually states that, 'the amount of positive evidence even among the best studies, came as a surprise to him and his colleagues, and that based on this evidence they would be ready to accept that homoeopathy can be efficacious'. Again, he says that, 'the evidence presented in the review would probably be sufficient for establishing homoeopathy as a regular treatment for certain indications'. The mechanisms of action remains uncertain, but this is a problem for science to unravel, not a reason for rejecting the result of high quality trials.

Secondly, he states that, 'even homoeopathic remedies have been associated with severe complications', and refers to his own leader in the *British Homoeopathic Journal.*[2] His main concerns there are actually, quite rightly, with the safety of homoeopathic practitioners how have not been medically trained. However, he does not refer to any specific instances of serious consequences of homoeopathic remedies, and therefore, his concern about the use of such medicines as arsenic is only theoretical, especially as there is no measurable quantity of arsenic in the 12C potencies which might be used on a regular basis by a well-trained practitioner.

Finally, although he relegates anecdotal evidence to the lowest level of the hierarchy of evidence, I would invite him to talk to any of a large number of our patients who have found great benefit from homoeopathy after many years of poor results with every available conventional treatment for their condition.

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Administration of state benefits

Sir,

I offer the following observations on the papers by Dowrick *et al* and Memel (February *Journal,* p.105 and p.109), both of which mention the role of the general practitioner in the administration of state benefits.

In the study by Dowrick *et al,* respondents indicated that 'bureaucracy', by which many of them meant requests for sick notes and disability forms, was inappropriate to a general practitioner's knowledge and skills. I believe it is important that we distinguish between the general practitioner's role as provided of medical advice to, or in support of, their patient who is claiming benefits and the role of a 'benefits adviser'. The latter could certainly be seen as a 'social' task which is inappropriate to the general practitioner role, but people rightly look to their doctor for professional advice concerning a range of activities and behaviours, such as advice regarding their fitness for work, or disabilities giving rise to care need and mobility requirements. This is surely in the medical tradition of the physician providing his patient with care and advice to enable recovery from, or management of, a disease or disability.

In his excellent review paper, Memel states, under 'Knowledge of disability and handicap', that general practitioners have a role as adjudicators in the social security and welfare benefits system. Unfortunately, he is wrong, although this is a common misconception. General practitioners give advice to their patients on the need to refrain from work, or factual clinical information to support a claim to state benefit. The decision on benefit entitlement is always made by an independent adjudication officer who will weigh all the available evidence.

As Memel correctly states, general practitioners are required to assess the extent of the disability resulting from disease in many areas of daily practice in order to advise and treat their patients appropriately. Despite the many changes which have occurred in the Health and Community Services over the last 10 years, general practitioners are still uniquely placed to provide factual medical information on patients under their care. This principal holds even though, as we recognize, they may not be aware of all of their patients' functional problems.

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