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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