psychological distress[1] suggests that it is in such subgroups of the population that GPs can improve their performance. Work in our own practice also supports the feasibility of the Geriatric Depression Scale for use by practice nurses in screening assessment. However, the use of mental health-screening questionnaires in primary care remains uncommon.[2] If there is pressing evidence of underperformance, therapies available, and effective trainings[1,3] and instruments that exist which can improve detection, we must consider why primary care teams fail to avail themselves of these options. Several possibilities exist: the evidence has failed to reach them, the resources required (such as time with patients, time for training, drug budgets) are lacking, or there is attitudinal resistance from either staff or patients.

I would support the editorial's emphasis on the need to focus both research and training on the practice team, and new educational initiatives which encourage more active participation in planning our continuing professional development[4] may be helpful here. However, in recent education meetings within our own practice, we have had evidence of 'cultural clashes', in that many staff perceive increased medication (whether for depression or lipid-lowering!) as a further medicalization of a society which is becoming unacceptable. Some of these attitudes are echoed by the patients, who may prefer the 'listening ear'; indeed, some of the undertreatment mentioned earlier is known to relate to non-acceptance by patients. Those of us who engage with practice-based education will therefore need to accept a considerable level of 'critical dialogue'[5] with our peers, concerning not only specific trainings and treatments, but also the whole concept of evidence-based medicine, resource allocation, and the different professional attitudes of doctors, nurses, and practice counsellors. I would hope that the RCGP would support more evaluative research into the realities of practice-based education.

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Mental health care professionals and general practice

Sir,

Roslyn Corney's paper (April *Journal*) regarding the links between mental health care professionals and general practices attempted to address important questions. However, it appeared flawed in several ways.

As the paper was based upon a cross-sectional sample of practices rather than a longitudinal study, there was no evidence to support the assertion that practices changed *as a result of* fundholding. While it does appear that current fundholders have greater contact with specialist services, these links may have developed before the practices sampled became fundholding.

Furthermore, the concluding statement of the summary, that increasing treatment options to certain patients may reduce services available to people with long-term and severe mental illness, may be true, but was not, from this paper, evidence-based.

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Asthma in the community and in general practice

Sir,

We were interested to read the recent papers by Tirimanna *et al* and Frank *et al* (May *Journal,* p277 and p295), in which the population prevalence of asthma/COPD of 31% in the Dutch study is remarkably similar to that of reported wheezing (30.4%) in the British study undertaken in Manchester. While Tirimanna and colleagues commented that the high prevalence of asthma/COPD was likely to be due to a large number of people with very mild symptoms, Frank *et al* used a symptom scoring system to define a sub-population (13.8% of all subjects) who were judged possibly to have an asthma-like illness.

We have recently analysed data from 3 169 subjects aged between 29 and 69 years, randomly selected from six general practices on Teeside. We also found precisely the same prevalence of reported wheezing (30.5%, 95% confidence interval = 28.8–32.0), but (based on further questions concerning whether the subjects suffered from any four of the following: wheezing in the past 12 months, waking with a feeling of chest tightness, waking with shortness of breath, waking with an attack of coughing, or having hayfever), we found that only 6.6% (5.7–7.5) had an asthma-like illness, compared with 13.8% (13.0–14.5) as reported in Frank *et al's* paper.

We are concerned that both reported studies have overestimated the community prevalence of asthma; for example, only 9.6% (8.1–11.1) of our patients, compared with 14.1% (13.4–14.9) in Frank *et al's* study, woke during the night with shortness of breath. This symptom is a good predictor of response to histamine challenge testing, and this result appears to indicate that the prevalence of bronchial hyper responsiveness (BHR) is different in the two studies. Using the definition of BHR recommended by Burney *et al,* who validated the EC questionnaire, we found that 13.9% (13.5-14.3) of our sample had BHR, but of those who were BHR positive only 60.9% identified themselves as either having had an attack of asthma in the previous years, or taking medicine for asthma. Although we were unable to detect a gender effect, our results for smoking were similar to those of Frank *et al*; the odds ratio for asthma in smokers is 1.82 (1.34–2.45, $P<0.001$).

Without careful validation of postal questionnaires against respiratory function testing, it is difficult to be sure which are the 'best' measures of the community prevalence of asthma, or how to interpret and compare prevalence, time-trend and national history studies.

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Saving money in general practice

Sir,

Dr J Hill-Smith in his article (May *Journal,* p.271) has shown very clearly that, if a group of interested GPs spend time and gather together in the company of experts on therapeutics, they can