peer reviewed) journal. Attributed to Oscar Wilde, I eagerly rushed to consult my 'complete works'. Unsuccessful in my attempts to locate this gem, I pursued the author, a GP tutor, and was disappointed to discover that even this quotation lacked an evidence base after he announced, 'I'm afraid I made it up!' Is this the real problem with EBM?

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Sir,

The discussion paper by Jacobson *et al* (July *Journal*) raises some interesting issues about the application of evidence-based medicine in general practice. While I entirely agree that the evidence from randomized controlled trials is not in itself sufficient to determine the management of individual patients in practice, it seems to me unwise not to keep up to date with the best evidence available so that this can be taken into account in making clinical decisions.

One of the purposes of publications like the *Journal of Evidence Based Medicine* is to pick out trials that are less open to bias and present them with a commentary from an expert. Time is too short to read everything that is currently published and I find this format very useful. Moreover, it is now available on CD-ROM (*Best Evidence*), which has the great advantage of allowing speedy searches to be carried out when seeking to answer questions raised in daily practice. Used in conjunction with the growing number of systematic reviews on the Cochrane Library (and the 130 000 randomized controlled trials listed with abstracts on the CD-ROM version of the Library), it is now possible to obtain more reliable answers to clinical questions than ever before.

The essence of an evidenced-based approach to general practice is to ask questions generated by uncertainties in daily practice (of which there are many) and to search for answers to the questions using the most reliable evidence available. I have found this a good way to regenerate enthusiasm for day-to-day work, and much more rewarding than attending lectures.

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Hospital admissions and quality of chronic illness care

Sir,

The increasing availability of routinely collected data provides tempting material for prospective researchers, but the quality and relevance of the data must be assured to make analysis useful. Paul Aveyard's paper (July *Journal*) demonstrates this point.[1] His hypothesis that there is a link between hospital admissions for asthma and the quality of general practice care as measured through routinely collected data is dependent on a number of unlikely assumptions.

While it might seem reasonable to postulate a link between the number of asthma admissions and the quality of general practice care, such a link has not been demonstrated. Of the 120 patients with asthma on an average GP's list, two to four are likely to be admitted with asthma each year. Is it likely that the overall care of the GP's 120+ asthmatics will be accurately reflected in the care of the two to four patients admitted? Aveyard focuses on three categories of routinely collected data to describe the performance of general practice. The validity and reliability of the first of these (chronic disease management annual reports) has not been examined. The new contract for GPs, introduced in 1990, required GPs to collect information on chronic illness care. GPs have not had the resources to ensure the accuracy of these reports, and health authorities have been unable to check them. It seems unwise, therefore, to assume that chronic illness reports give a good reflection of the quality of GP care without further examination.

Prescribing analysis and cost data (PACT) is the second category of routinely collected information to which Aveyard refers in this paper. A high asthma preventer/reliever ratio in PACT has already been shown to be associated with lower rates of admission for asthma.[2] A low asthma preventer/reliever ratio in PACT is associated with lower socioeconomic status and may be an indicator of need.[3] It is not necessarily an indicator of lower quality care. High levels of reliever use and low levels of steroid use may be the result of low compliance with steroids, lower uptake of structured care, or lower uptake of return appointments. All of these are associated with lower socioeconomic status.

The third measure used by Aveyard — the Townsend score — is itself a measure of socioeconomic status. As has been shown before, hospital admissions for asthma are related to the socioeconomic status of the patient, which Aveyard's paper confirms.

The relationships identified by Aveyard deserve more examination, but it is unlikely that routine data of the sort he has used will throw any light directly on the quality of GP care. At best they may act as proxy measures after they have been compared with more direct assessments of GP quality.

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Summative assessment

Sir,

Willis and Robinson (July *Journal*) raise issues concerning summative assessment in general, and methodological issues about our paper in the May *Journal* in particluar.[1]

As a result of summative assessment there has been a 25-fold increase in GP registrars not reaching minimal compe-