in these papers, nine (3%) were published in journal supplements and the remainder were full citations (that is, not from conference proceedings or supplements) in peer reviewed publications.

Harrington suggested that unpublished references are "hardly the most impartial of sources" but failed to mention that companies are obliged to supply unpublished references used to support claims in advertisements to doctors who request them.¹ The impact and prestige of references in respected peer reviewed journals are well known to marketing departments, and it seems unlikely that companies would wish to suppress or restrict the publication of findings that expressly support the claims made in their advertisements. My findings therefore add support to Massam's suggestion that "there are many more studies done than can ever find space for publication" and Humphreys's view that "most editors of refereed journals are unwilling to publish the results of therapeutic trials sponsored by pharmaceutical companies."² I plan a further study of a larger number of advertisements to see if further light can be cast on this subject.

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Knowledge is not a disease

EDITOR,—I found Graham Hills's editorial on knowledge surprising for many reasons.¹ Firstly, Hills uses such terms as "knowledge," "learning," "skills," and "reality" without defining them or making clear the denotations he applies to them. I do not believe that Hills intended a discourse on the theory of knowledge,² but he should have made clear that he was writing about theoretical knowledge—that is, information—rather than practical knowledge.

He contends that information is bad for us because it decays (an inappropriate verb that conjours up images of radioisotopes) and because old information stored in our brains prevents us from acquiring new information (just as if our brains had a 50 megabyte capacity and we would no longer be able to take in new information once that capacity was used up). Hills even goes on to blame such phenomena as prejudice and adherence to tradition on an excess of information. To describe this article as ridiculous is to accord it wholehearted praise.

"Skills are rooted in reality," Hills writes, "knowledge is not." I wonder what he means by the word "reality" and why he thinks that information does not have a basis in reality. What is more, information is not, and cannot be, a disease, irrespective of the degree of abstraction we may choose to apply to the word disease.

Information, even false information, is not a problem in its own right and cannot harm us in any way. It is the uncritical acceptance of information that is the true enemy of humankind. This is the basis of prejudice, of adherence to tradition, of the political and economic tragedies to which Hills refers. This, not an excess of information, is the real obstacle to progress. As we learn how to think we become able to convert information into (practical) knowledge and eventually into wisdom.

Information is not luggage; its acquisition is the first step on the path to wisdom.

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Nicotine replacement therapy

EDITOR,—Jin Ling Tang and colleagues' systematic analysis of randomised trials of the efficacy of nicotine replacement therapy in helping people to stop smoking¹ is an important contribution to evidence of the effectiveness of nicotine gum and patches in stopping smoking. As the authors conclude, these aids have an important part to play in helping smokers who are motivated to stop, especially those who are highly dependent on nicotine. Studies in general practice in Britain support the authors' suggestion that, for all but the most heavily dependent people, the transdermal patch is probably the product of choice.^{2,4} I concur with their recommendation that patients with cardiovascular disease who are motivated to stop smoking should consider using nicotine replacement therapy.

Evidence does not, however, support the statement that the patch "is suitable for over the counter purchases, and, since the daily cost of replacement therapy is about the same as that of a packet of 20 cigarettes in Britain, there is no financial barrier to its use." There have been no trials of the efficacy of patches provided over the counter: all studies have included some support from doctors or nurses, and it is only in this context that efficacy has been shown. Furthermore, as was recently argued elsewhere,⁵ in view of the enormous burden of ill health caused by smoking, effective ways of stopping smoking should be encouraged and nicotine patches should be prescribable on the NHS, supplemented with advice and support from doctors and nurses.

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General practice fundholding

Delivers what patients want

EDITOR,—Steve Iliffe and Ulrich Freudenstein decry the lack of scientific evaluation of fundholding yet offer none themselves.¹ The costs of administering fundholding are less than the equivalent costs of managing a district health authority. During any period of transition some costs will be duplicated, but this will be rectified with the forthcoming changes in the configurations of both regional and district health authorities.

The political costs of "fast tracking" are a matter of opinion, perhaps coloured by ideology. My experience as a fundholder is that NHS providers, including consultants, are offering fast tracking to fundholders. We have not requested it specifically. It is surprising that so many specialists object to fast tracking (rather than it being the disadvantaged patients who object) but willingly fast track private patients.

Where is the evidence that fundholders cannot be ruthless as purchasers? Fundholders may be limited in choice, particularly in rural areas, but it is they who are making the most important changes to the way health care is provided for their patients. Increasingly they are managing extended services, providing consultant clinics and physiotherapy on site and more counselling. Many are also now developing services such as radiology, ultrasonography, colposcopy, and minor and day case surgery on site.

Fundholders will act in concert with local health policies but only if those policies have been discussed and are thought to be in the interest of their patients. It is up to district health authorities to include fundholding as well as non-fundholding general practitioners in discussions.

The changes made by fundholders, with increasing provision of services in the community, facilitate rationalisation (deinstitutionalisation) of the often inefficient secondary care system. In secondary care too many resources are tied up in underused and duplicated fixed items such as estates, equipment, and sometimes specialist staff. Patients want quick, efficient, and cost effective local services. Few district health authorities are yet delivering real change, with all their funds tied up keeping their district general hospitals solvent.

A moratorium on recruitment to fundholding is illogical. Fundholding practices are expanding and developing new services, which would be denied to non-fundholding practices, thus creating a considerable difference in their respective services. If we halt progress to keep pace with the least able we will deny patients the improved local care that many fundholding practices are achieving. Thus, far from having a moratorium we should be expanding and making fundholding easier.

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Unpopular with most GPs

EDITOR,—Steve Iliffe and Ulrich Freudenstein are right to point out the unproved claims for fundholding and to call for a moratorium on recruitment to fundholding.¹ Fundholding is still not the answer for most general practitioners: according to a recent poll, a majority of current fundholders do not support the scheme but have joined in a defensive posture.² Unfortunately, the profession's official leaders have not been in the forefront of promoting other routes whereby all general practitioners can participate in the commissioning process. Other organisations have had to do so.³

During the past year I have spoken at 16 meetings of general practitioners looking for viable alternatives to becoming fundholders. I have also participated in a local alternative scheme which involves fundholders and non-fundholders in a commissioning executive of 12 representative general practitioners. This executive liaises and negotiates directly with the district health authority on behalf of 500 000 patients. The cost for this was £16 000 in 1993 and this will rise to £50 000 in 1994—less than the cost of two fund-