I began to wonder whether my project was valid. A further questionnaire given to 100 consecutive patients attending the surgery asked whether they were satisfied with the premises, access to the doctors on the telephone, waiting times for an appointment, waiting times in the waiting room and the quality of the consultation with the doctor. Happily the majority were again entirely satisfied with all aspects of care.

Unless the profession wants outside interference in clinical matters it is vital that all members of the profession take the initiative and perform such audits for themselves and also cooperate with any locally arranged peer reviews and projects.

The only accepted review system available in this country at the moment is that arranged by the Joint Committee on Postgraduate Training for General Practice for the assessment of doctors and the practices of doctors wishing to become trainers. The standards of training have risen gradually over the last 10 years as a result of this. Thus, the profession can be responsible for keeping its house in order, and I hope that the questions the editorial raised will stimulate others to intensify their efforts at audit in order to prevent outside influences destroying the standards we have achieved.

A.P. PRESLEY

St Michaels Surgery
St Michaels Square
Gloucester GL1 1HX

Prescribing research: PACT to the future

Sir,

The editorial by Spencer and van Zwanenberg (July *Journal*, p.270) is timely and thought provoking and the equivalent Scottish Prescribing Authority statistics are awaited with interest. However, the authors do not focus on the main dilemma currently facing the profession. That is, should we rely on centralized data like PACT (prescribing analyses and cost) for our information or should we channel our energies and money into producing in-house feedback. As the editorial points out, PACT has many disadvantages — slow feedback, incomplete data in terms of consultation rate and links with diagnosis, and no distinction between repeat prescriptions and drugs for acute illness. It will also require a major revision to comply with the requirements of indicative prescribing budgets.

It would therefore seem sensible for development to be directed towards computerizing all practices and providing appropriate software so that all prescriptions can be issued by computer and immediate feedback of personal and practice prescribing statistics provided. This would solve the problems mentioned above, although a relatively crude system such as PACT would still be necessary to allow peer group comparisons on a wider scale and for those in single handed practice.

The editorial also strongly advocates the use of agreed local formularies. There is no doubt that these are of great benefit to doctor, patient and government but the widespread adoption of such formularies has been slow since they were first proposed for general practice nearly 10 years ago.[1] It is not hard to find the reason for this — how many doctors want to refer to an unfamiliar list of drugs during a consultation or memorize a locally agreed formulary? Prescribing is a personal activity and acceptance and compliance with formularies will only be adopted if doctors can construct their own personalized formularies. There is great educational value in constructing a personal formulary which should include not only the drug but the standard regimen, quantity and cost. Doctors are often ignorant of the cost of drugs[2] and for many it would be interesting to see the actual costs of their prescribing.

In the consultation prescribing is often not optimal in terms of drug choice, quantity, regimen and instructions, owing to time restraints and interruptions. If the process were automated by a computerized personal formulary then these problems would be resolved. In addition, legible prescriptions would be issued and accurate, relevant data produced for analysis. The construction of such a formulary is not difficult[3] and results in impressive cost savings.[4]

Computers surround us everywhere and we should accept the use of consulting room computers as an inevitable fact of modern day practice.

JOHN B. DONALD

Howden Health Centre
Livingston, West Lothian

References

1. Jolles M. Why not compile your own formulary? *J R Coll Gen Pract* 1981; **31**: 372.
2. Rowe J, MacVicar S. Doctor's knowledge of the cost of common medications. *J Clin Hosp Pharm* 1986; **11**: 365-368.
3. Donald JB. On line prescribing by computer. *Br Med J* 1986; **292**: 937-939.
4. Donald JB. Prescribing costs when computers are used to issue all prescriptions. *Br Med J* 1989; **299**: 28-30.

Dispensing costs

Sir,

I am afraid that the figures quoted in my letter about dispensing costs (July *Journal*, p.303) were incorrect. These figures were supplied by Suffolk family practitioner committee. I have now received amended figures and have also been given a breakdown of the dispensing costs for Suffolk for 1988 from the Department of Health. Although the figures are considerably different from those I was originally given, there would still have been an overall potential saving to the exchequer of £3 184 250 if all dispensing in Suffolk had been provided by general practitioners, a saving in excess of 12% in the cost of drugs and 27% in dispensing fees, and an overall saving of 15%.

I recently submitted a detailed paper to the General Medical Services Committee of the British Medical Association illustrating the advantages of universal dispensing by general practitioners. Regardless of the relative costs of dispensing there is little doubt that the current chemists' monopoly causes patients considerable inconvenience because of the chemists' limited opening hours and the travelling involved.

The current system, based on the Lloyd George act of 1913, which separates prescribing and dispensing in time, place and person is antiquated, inefficient, costly and indeed dangerous, as the Daonil (Hoechst) case illustrates. It would be far more sensible if all dispensing were to take place within the general practitioner's surgery, since here patients can receive their medicines without the need for a written prescription. Indeed, in dispensing doctors' surgeries, particularly those with computers, the FP10 would be superfluous were it not required as a voucher for reimbursement of the cost of drugs supplied.

The time has indeed come for review of the chemists' monopoly, particularly the arbitrary one mile rule.

PAUL THOMAS

The Medical Centre
Tillingham, Southminster
Essex CM0 7TH

Sir,

It has been stated that doctor dispensed items are much cheaper than chemist dispensed items (Letters, July *Journal*, p.303). The figures quoted are likely to be inaccurate. Approximately half of the patients in our practice are on the dispensing list. The latest prescribing analyses and cost (PACT) figures show that the number of items prescribed by the practice is 19% above average, but the cost per item is 3.4% below average. However, the number of items dispensed by the practice is 12% below average, with the cost per item 8% below average. The only reasonable explanation for this is that some patients who are on our dispensing list either go