

It is these dates which are not ordinarily before the doctor at consultation, and, although he sees them regularly whenever he signs a 'repeat', and may even remember the last one, we agree that this may be regarded as a disadvantage in the system, especially if other partners are seeing a patient. A remedy would be to extract the register card and place it with the notes when any appointment is arranged. On the other hand, the repeat register cards are kept at reception so as to be instantly available, and access to their information can be provided for the doctor very quickly.

Our system has operated in our six-doctor group practice since we suggested it in 1972, and we think it has stood the test of time very well. The most important feature which we found necessary was that when a doctor included a patient in the system, he or she alone was then responsible for signing the 'repeats' and for review consultations after a period usually not exceeding six months. The personal commitment of doctors to patients 'on repeat' in our shared-work group has meant that the drawback which Professor Drury describes as a major disadvantage has given us no trouble, and the above remedy has not been required.

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Reference

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Repeat Prescribing and Consultation Rates

Sir,
Professor Drury (January *Journal*, p. 42) discusses the likelihood of indirect repeat prescribing having increased during the last decade, when consultation rate remained relatively static.

There is powerful evidence from nationally representative studies to suggest that this has happened; otherwise the consultation rate would have been substantially greater than it is (Billsborough, 1981a). As well as showing that the consultation rate has remained relatively static during the 1970s, the study of OPCS data to which Professor Drury refers identifies important differences between trends in consultation rates of people of working age and over (Billsborough, 1981b). Among people of working age, the consultation rate shows little change during this period, but for older people the

rate fell substantially, due to downward trends of similar magnitude in both attendance and visiting rates.

This suggests that people over 65 years of age have either experienced a considerable change in morbidity during the last decade, an unlikely event, or that services previously provided by the general practitioner during a direct consultation, either in the surgery or the patient's home, have been obtained by some other means, possibly by requesting an indirect repeat prescription.

Although there was little overall change in the use made of repeat prescriptions during the 1970s, the comparison of two reliable nationally representative surveys by Anderson (Dunnell and Cartwright, 1972; Anderson, 1980) provides good evidence that the proportion of repeat prescriptions issued indirectly did increase, by about 50 per cent, a value of similar magnitude to those cited by Professor Drury.

These observations are consistent with the observed trends in consultation rate. The over-65-year-old age group is the one which includes the greatest proportion of people on long-term repeat regimes and an increase in indirect repeat prescribing would be expected to lead to a decrease in both attendance and visiting rates to this age group.

About one-third of adults receive repeat prescriptions and one-quarter are on a long-term repeat regime. The repeat prescription is the only way of providing continuing medication to the population and without indirect repeat prescribing there would need to be a substantial increase in consultation rate. The general practitioner alone provides this essential service and the points raised by Professor Drury are well worth careful consideration.

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Computers in Practice

Sir,
Bias is subjective. An atheist would call an evangelist a bigot (and vice versa!). Bias is not necessarily detrimental. As a doctor, I am biased towards the promotion of health in patients who consult me.

I am happy to reply to the letters commenting on the article "Computers in general practice: the patient's voice" (November *Journal*, pp. 683-685).

The preamble to the questionnaire contained two paragraphs. The first paragraph lists the advantages of using a computer, both for the patient and for the doctor. The second lists problems that have been voiced against their use.

The questions were designed to be those that an average patient might ask him/herself if he/she heard that his/her general practitioner was using a computer.

We would all agree that patients (and that includes ourselves) do not think or act logically or rationally much of the time. There are plenty of studies demonstrating that. The 'average' patient has probably little idea of what a computer can or cannot do. But this 'average' patient hears stories in the media that computers 'make mistakes' or can 'leak' information. It is not beyond belief therefore that such patients may be reluctant to confide in their general practitioner should they hear that 'he/she has a computer'.

Why, then, are we doctors not more sensitive to our patients fears and beliefs? Why are we persistently arrogant in assuming that what is good for us administratively is necessarily good for our patients? In any case, have computers proven to be of value to our patients? The practice to which I was attached as a trainee did not have a computer but undertook screening programmes for hypertension and cervical cancer and was exceptionally secure financially. Is this a 'grave handicap', (March *Journal*, p.195) Dr Minwalla?

It is just not true to state that computers are not used for storing patients' records nor that they are never linked outside the practice. Some are, some are not. Do patients know which practices are linked to a central computer outside the practice?

So then, I await with interest a similar study undertaken in a neutral practice with an 'unbiased' questionnaire, and let us then discuss the results.

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