LETTERS

Note to authors of letters: Please note that all letters submitted for publication should be typed with *double spacing.* Failure to comply with this may lead to delay in publication.

Prescription charges

Sir,

I share Dr Bhopal's concern (July *Journal,* p.330) that drugs should not be prescribed on demand regardless of the effectiveness or efficiency of their use. However, incentives to promote efficient drug consumption should be aimed at the party responsible for the prescription — the general practitioner. As another taxpayer I am not happy that doctors are apparently prescribing expensive drugs where such drugs are not warranted. The introduction of annual budgets on prescriptions by general practitioners might provide the necessary incentive for doctors to learn to say no where no is the appropriate response.

It is simplistic to suggest that reduced consumption among patients who are not exempt from prescription charges reflects only a reduction in patient abuse and that further increases in charges can be used as a method of promoting healthier behaviour. Is Dr Bhopal not concerned that patients for whom the charge of £2.20 per item represents more than a small financial responsibility may delay seeking advice from their doctor and as a result make greater demands on National Health Service resources as their condition deteriorates?

Furthermore, if we want to promote healthy lifestyles then policy should be aimed at the causes of unhealthy behaviour (low income, poor housing, poor employment prospects, tobacco promotions) and not at increasing the barriers to overcoming the effects of such behaviour.

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Personal lists

Sir,

Dr Archer (Letters, July *Journal,* p.332) appears to have misconstrued my letter (March *Journal,* p.134). The list of disadvantages of personal lists was not a condemnation of Dr Tant's leading article[1] which mentioned only the advantages, but sought to provide a counterbalance. All practices compromise over this issue and my plea is for tolerance. A rigid personal list will mean patients seeing doctors with whom they have no empathy and never will. Similarly a rigid combined list will mean patients seeing the doctor who happens to be most available rather than the one they wish to see so that they have little chance of forming a satisfactory relationship. The one is as bad as the other, and both deprive the patient of freedom of choice which is their right.

C.P. ELLIOTT-BINNS

Reference

1. Tant D. Personal lists. *J R Coll Gen Pract* 1985; **35:** 507-508.

Psychotropic drug prescribing

Sir,

I should like to comment on the paper by Professor Irwin and Dr Cupples (August *Journal,* p.366). Their retrospective study of a group practice's prescribing of selected psychotropic drugs was carefully carried out, but I find their interpretation of the findings questionable. In particular, the suggestion that the survey provides evidence that 'general practitioners are discriminating in their prescribing' is most extraordinary considering that the figures reveal that it is women, the elderly and the lonely who might be said to have been discriminated against.

The group practice under study had a comparatively low level of psychotropic drug prescribing: just one-third of the frequency of its neighbouring practices. It was surely not justifiable therefore for the authors to attempt to extend their argument beyond this particular practice and claim to provide evidence 'in defence of the general practitioner'. In fact I consider this apologetic tone to be quite unsuitable for a scientific paper. The impression given is of clutching at selected statistical straws, especially in the discussion section where 'perhaps', 'might', and 'may' occur half a dozen times.

Finally, how is it possible to write credibly about prescribing psychotropic drugs without saying a single word about the individual prescriber? The authors should recall the classic statement 'I feel that when my doctor writes me a prescription for Valium, it's to put him out of my misery'.[1]

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Reference

1. Curran V, Golombok S. *Bottling it up.* London: Faber and Faber, 1985: 35.

Seasonal variations in osteoarthritis

Sir,

I was extremely interested in Professor Harris' article on seasonal variations in osteoarthritis (July *Journal,* p.316).

Professor Harris confirms from two separate sources that the major prevalence of this condition occurs in April and May each year. He surmises that the weather might be a possible factor in this peaking of consultations but is uncertain as to how the weather exerts its effects on the body. Might the answer be simply this: the majority of sufferers from the condition are either retired or approaching retirement and episodes of pain in joints subject to osteoarthritis tend to be precipitated by increased activity. It follows that the normal increase of activity in the garden and elsewhere during the spring is probably enough to account for a moderate increase in the consultation rate during these months.

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