After a few painstaking months my suspicions about my level 1 soft disc system were confirmed by a more knowledgeable user. The system was inadequate for the task. It ran out of available space with less than half the data entered and the retrieval time with 2000 patients entered was a joke. Not only was the experts' advice wrong, they did not seem capable of even simple addition. Sadder and a little wiser, I converted, cheque book in hand again, to a much larger hard disc system.

Three years later I am reviewing the use of a computer in my practice and the wider implications of computerization in the health service. There have been several reports on the use of computers in the health service and in general practice in particular.[1-8] I have attended meetings of user groups, listened to Department of Health and Social Security speakers on current progress and plans and read College policy statements. I am appalled at the present lack of coordination and central direction.

The worsening chaos relating to computer use in the health service is obvious. At the simplest level of patient registration an increasing number of family practitioner committees are using computers and the DHSS project that all will be using them by the late 1990s. However, not all the systems in use are compatible and there is no clear guidance for future integration or provision for accessability of information to assist planning at district or regional level. In recording of prescriptions where computerization is centralized and at an advanced and sophisticated level, the situation is little better. In my view the government would be more likely to achieve rationalization and savings on prescriptions by providing more information for individual doctors, than by ill-conceived limited lists.

For a disease classification I consulted the College and following their advice commenced to use the international classification compatible with that of the World Health Organization. I now find the College's own research group have come up with a new classification which is incompatible with all others.

In the business of health care delivery we appear to be in competition not collaboration. The lack of coordination between colleges, the BMA and the DHSS in the use of computers means that even at the simplest level where there could be great increases in efficiency and cost savings, we have made no start.

My local FPC, health authority and hospital laboratory all use computers but I cannot receive or transmit information to any system in my area other than to those few practices using a compatible system. We have had many pilot projects and a wealth of information has been generated. There comes a time when information seeking should be replaced by evaluation and implementation. The longer we allow diversification to proceed the greater the danger that the use of integrated systems will be impossible in the reasonable future.

I would argue that now is the time to select at district level interactive systems across the whole health care field and to provide the necessary resources. At present the answer to the question 'Whither goest we?' is clear. In many different directions and largely to no good purpose.

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HIV infection in a rehabilitation unit

Sir,

One of the most interesting parts of Dr R.T.A. Scott's paper on the medical aspects of drug misuse in a rehabilitation unit (November *Journal,* p.514), relates to human immunodeficiency virus (HIV) infection.

As medical officer of a similar but drug-free rehabilitation unit in the Northern region of England, I have been providing counselling and blood testing for HIV infection for the last 19 months. Of 106 residents counselled 100 (94%) elected to have the test, seven (7%) of whom were positive. Positive residents come from Edinburgh, Glasgow and the North of England. To date, one of the seven has developed the acquired immune deficiency syndrome (AIDS), one AIDS-related complex, one persistent generalized lymphadenopathy and four remain healthy. It is also known that someone who was originally seronegative has since developed AIDS. Our rate of HIV positivity is much higher than Dr Scott's but comparable with the rate in Glasgow (7%)[1] and much less than that of Edinburgh (51%).[2]

Dr Scott makes no mention of the practical or personal problems that HIV presents to residential units. Our experience is that it has totally eclipsed many of the traditional medical problems that drug addicts have. When our first positive resident was discovered in 1985, this created anxiety and concern for personal safety among staff members and panic among residents. Much of this fear stemmed from ignorance. Since then staff members have received training in counselling and are now active in educating other professional groups.

Today we have a policy for health education, counselling and blood testing within the unit.

Several lessons have been learnt from our experience which also apply to general practice:

1. General practitioners should be knowledgeable about HIV infection. Facts help to reassure, correct misinformation and are essential for accurate health education.
2. Blood testing should always be preceded by a discussion of the advantages and disadvantages of having the test. Whether the test is chosen or not, it is always an opportunity to provide health education to try and initiate a change in life-style.
3. Blood testing should only be performed where there are adequate resources for counselling those with a positive result. This is 'bad news' and needs careful handling.
4. As doctors and health professionals we have our own anxieties and problems in dealing with people who may have HIV infection. It is important that these are recognized and discussed.

In the future we will encounter more people with illness from HIV infection. This is something we will have to learn to manage.

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