the necessary conditions for sterilization have been reached which deserves to be better known. Albert Brown Ltd, Chancery House, Abbeygate, Leicester, produce colour-change control strips which are comparatively inexpensive and simple to use. A coloured dot changes from yellow to purple in 15 minutes at 121°C or in 5.3 minutes at 134°C. The strip is placed in the pressurized chamber with the instruments to be sterilized. Our advice is that these conditions are sufficient to kill the more resistant organisms.

The adoption of this simple procedure has enabled us to feel very much more confident about the sterility of our reusable equipment without involving us in great inconvenience or expense.

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Medical indemnity

Sir,

In your editorial (November *Journal,* p.490) you conclude that the major cause of lower subscription rates to the Medical Defence Union of Scotland is the selection and education of undergraduates in Scottish medical schools. I agree that Scottish medicine is in many ways in a healthier state than English medicine, but would argue that a greater factor in the lower rates is likely to be the exclusion of non-Scottish graduates, which includes both English and overseas graduates. Overseas graduates have more claims made against them and appear before more disciplinary hearings. This is not a reflection of the ability of individual doctors who graduated overseas, but more often a language or cultural misunderstanding.

If there were regional defence unions composed solely of graduates from, say the south west of England or Northern Ireland, then I speculate that they would have subscription rates as low as the Medical Defence Union of Scotland.

Drawing conclusions of cause and effect from comparison of two unmatched populations is invalid in the rest of the *Journal.* It is a shame that in your attempt to score a point off 'the auld enemy', you have lowered your usual high standards.

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Telephone consultations in general practice

Sir,

I refer to the letter by Drs Bhopal and Bhopal (December *Journal,* p.566). As the immediate past treasurer of the Medical Defence Union I am aware that the management of requests for visits by giving advice over the telephone has led, and appears likely to continue to lead, to many complaints to family practitioner committees and to negligence claims in the courts. Diagnosis without seeing the patient is potentially dangerous.

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Sir,

The review by Drs Bhopal and Bhopal of telephone consultations in office hours is a welcome baseline for the study of the value of this mode of patient contact. However, it begs more questions than it answers, and the only conclusion drawn is the subjective one that the disadvantages are exceeded by the advantages. An attempt to ascertain the opinion of the patients (particularly the 2.4 per session whose consultations may have been interrupted) would have balanced the authors' conclusions better, as would some kind of objective assessment of the short- and long-term outcome. For example, how many unseen patients given advice or prescriptions (86% of the total) returned later for a full consultation for the same problem? To what extent did the saving of time for both patient and doctor set a pattern leading to an increasing percentage of patients choosing this method of obtaining a medical opinion? If the authors agree that the telephone is not the ideal setting for a consultation in most circumstances, then should we be advocating it for the banal practical reasons quoted? Why do we need to make an inferior service available as a routine?

The consultation has been exhaustively studied in recent years and we have learned to ask ourselves questions such as: Why did the patient consult? What were his expectations? Was he given time to air his problems? Was he satisfied with the outcome? We should be prepared to subject telephone consultations to the same rigorous examination as the face-to-face contact.

If the patient is encouraged to regard a telephone call as an easy option, then

the consultation is devalued. If the doctor sees it as a means of avoiding a home visit, then the doctor is devalued.

Finally, I note that none of the telephone calls resulted in the patient coming to the surgery for examination.

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A car with flat tyres?

Sir,

Clive Richards (December *Journal,* p.535) is, of course, right to point out the problems that general practitioners face in dealing with the stresses of the job and of illness in themselves and their families. Seeking support in periods of personal and professional crisis is something that does not come easily to doctors, possibly because of the Rambo stereotypes cultivated in the medical school bar and junior doctors' mess.

I am not so sure that his rather bleak view of the inevitable dwindling of intellectual and emotional stimulation in general practice is one that is shared as widely as he suggests. From my, rather ivory-towered, perspective I am constantly disabused of the notion that NHS general practice is an intellectual and emotional wasteland and am always impressed and frequently humbled by the astonishing amount of effort that is put into not only teaching and training but also routine clinical work and patient care commitments way outside those conventionally required of a general practitioner, not to mention a wide variety of involvement in local community activities.

This is not to bury my head. I am aware that when the frequent isolation and constant, unshared responsibility of general practice is superimposed upon a medical culture which prizes invulnerability above all else, things may crack, either personally, professionally or both. Communication is, as usual, at the root of all this. Self-doubt, failure and anxiety are normal phases, isolated or recurrent, of undergraduate and postgraduate medical training and need to be recognized as such. People need to know where to go to talk about these things. Tutorial schemes for undergraduates need to be taken seriously and there is a parallel message for course organizers and vocational trainers. Practice meetings need to develop into something more than a time to discuss holidays and income.

General practice is certainly demanding and I imagine that we have all seen colleagues running into difficulties. Nevertheless, I feel disproportionately privileged to be enjoying it so much; I hope I am not alone.

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Online information

Sir,

I was interested to read about the accessibility to information on the acquired immune deficiency syndrome (AIDS) using a telephone and computer in a practice setting (Letters, September *Journal,* p.422). Ideally, this direct method of information retrieval should be standard procedure for future general practitioners. As Stuart Librarian I have visited a number of practices during the last 18 months, talking to doctors and team staff about practice libraries, but have yet to find a practice which has seriously thought about introducing online facilities. There are a number of reasons for this — the cost, the difficulty of searching once access has been obtained[1] and the relevance of the information retrieved.

However, general practitioners have access (often without charge) to online services through medical libraries and I urge them to explore how they can use these services to help in day to day information work. The online systems are flexible; they can identify relevant references by subject, date, title of periodical and so on. General practitioners could experiment by using existing online systems as indexes to what they already have in their own practice libraries.

Doctors receive little training in the hands-on use of online systems. The introduction of a computer into a practice may lead to the identification of one person in charge of the technology, and this may not be the doctor — one practice I corresponded with earlier this year had employed an information officer. Although one person would carry out the direct online searches, doctors need to be aware of how to use data bases.

OASIS (online AIDS support and information system) is likely to be one of the first of many direct systems prepared for general practitioners.

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Reference

1. Anonymous. Searching MEDLINE. *Lancet* 1988; **2**: 663-664.

The influence of computer software on prescribing habits in general practice

Sir,

Now that computer terminals on general practitioner's desks are commonplace, the need for sophisticated systems to allow the rapid issue of prescriptions by computer is being addressed by the major computer suppliers.

The Northern Primary Care Computing Group is concerned that difficulties may be encountered by general practitioners who wish to prescribe generically, as it seems that some systems make it more difficult to do this than prescribing a proprietary brand, especially where a generic alternative is not yet available. In busy periods it has certainly been my own experience that I have prescribed a proprietary brand owing to pressure of time and the slowness or incompleteness of a computer drug dictionary. Others have noticed that one software supplier has withdrawn a facility for generic substitution, without apparently discussing this beforehand, for example, with its user group.

There is no evidence that these problems are the result of any commercial pressures, but they cannot have escaped the watchful eye of the Department of Health. If the department wishes to monitor standards of computer software, especially where it has indirectly paid for the system, this will be one area of their attention. I would hope that the profession might ensure that its house is in order, in collaboration with our suppliers, before we become prey to constraints from governmental decree, this time in the field of primary care computing.

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Computer appreciation courses

Sir,

We enjoyed Dr George Taylor's letter (August *Journal,* p.376) suggesting car appreciation courses at the College as a natural development from the computer appreciation courses already running. Can we be sure that he is pulling the College's corporate leg or might his humour be a thin disguise for his Luddite instincts?

Were he to have been writing in 1888 when the internal combustion engine was yet to revolutionize the work of the rural general practitioner his words would have