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

been seen as prophecy indeed. His inference must surely be that the computer is now adding a similar revolutionary dimension to our work.

We suggest that the College experiment with its computer appreciation courses at a regional venue, such as Newcastle, and then consider in what ways it might involve itself in other computer courses. We, and our colleagues of the Northern Regional Primary Care Computer Group, would be willing to act as the College's agent in this and are confident that we would have the full support of our regional adviser.

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Children's immunization records

Sir,

Pennington and Wilcox's review of the accuracy of children's immunization records (November *Journal,* p.515) has important implications for future record linkage. They maintain that, since district health authorities have a statutory responsibility to keep records, the master record should be held at district level rather than in the practice. They rightly point out that this record must be immediately available and correctable by the practice. However, they do not consider that this will not be attainable for some time yet.

Computer access to a common file is under trial in several districts. At Winchester, the use of the 'Healthnet' has been disappointingly under-used by most general practitioners. East Dyfed operate a 'community index' but have not yet publicized their use of shared records as regards child health. The Exeter family practitioner committee/general practitioner links include information on claims for vaccination fees but will not include those done in district health authority clinics. The Northampton OSI project will link only one trial practice in the next three years. So for the forseeable future, certainly until well into the 1990s, there will be no widespread electronic data sharing of this kind.

Meanwhile, child vaccination rates are in great need of improvement and this, in my view, is impossible without holding records in tandem in practices and in health authority clinics. Rates exceeding the 72% quoted by Dr Wilcox are often only attainable by opportunistic action in practices. We all look forward to online sharing of this information in the future but until that is possible, the practice computer should be the master record.

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Use of cotton buds in the ear

Sir,

I was interested to read the letter from Dr Fisher on the appearance of wax plugs in ears cleaned with cotton buds (August *Journal,* p.375). Ears which are regularly cleaned with cotton buds tend to have the following: a completely clear external auditory canal with shiny canal skin; a rim of polished wax at the junction of the bony and cartilaginous parts of the external auditory canal and an occlusive wax plug in the bony external auditory canal with a highly polished surface.

A recent study[1] has shown that the use of cotton buds for aural toilet does not result in increased incidence of visually occlusive wax plugs in children and adults. However, the use of cotton buds should be discouraged because it is recognized that their use can result in injury to the external auditory canal and tympanic membrane and impaction of pre-existing wax plugs into the bony external auditory canal or against the tympanic membrane can produce hearing impairment.[2,3]

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References

1. Sim DW. Wax plugs and cotton buds. *J Laryngol Otol* 1988; **102:** 575-576.
2. Barton RT. Q-tip otalgia. *JAMA* 1972; **220:** 619.
3. Anonymous. Wax in the ear. *Br Med J* 1972; **4:** 623-624.

AIDS and chastity

Sir,

'The most preventable war, but we did not prevent it' was Winston Churchill's comment on the second world war. A similar comment, in the present tense, could be said of our attempts at preventing the acquired immune deficiency syndrome (AIDS).

There is a 'no risk' option in preventing AIDS, but so far I have looked in vain in reputable medical journals to find mention of it. At a world AIDS day symposium in Nepal in December 1988 one of the speakers commended the traditional Hindu concept of *Ek nari brahmachari.* This refers to one wife who is chaste and implies a chaste husband also. It is a reflection of post-Christian western medicine that this 100% certain way to prevent the venereal spread of AIDS is noticeable only by its absence in contemporary literature. The doctor who is encouraged to advise lifestyle changes with respect to obesity and cigarette smoking then receives criticism if he suggests the lifestyle change involved in practising *Ek nari brahmachari.*

Our forefathers failed to prevent world war two and reaped the consequences. Our failure to act adequately to prevent AIDS with more than platitudes and condoms (with their high failure rate in the prevention of pregnancy) will result in a similar catastrophe.

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My husband is not a wife

Sir,

This morning I received my first regular College *Journal* after passing the MRCGP examination. I also received an invitation to the Brighton meeting. Just as I was considering if it would be possible to make the occasion into a break for my husband and me, my attention was drawn to the 'accompanying persons' itinery. Wonderful. Imagine my irritation therefore to read, 'The pressure and demands of general practice can be wearying for the family of the doctor as well. With this in mind, wives have arranged a meeting for themselves'. Under the social programme for 'Stress and the family' there will be a panel including wives of general practitioners and paediatric and family counsellors.

While I must applaud the efforts made to accommodate families, with creche facilities and baby listening, what about my husband? This is the first time I have been moved to write on this issue. I am not a 'rampant feminist', just a woman and a general practitioner. Surely the College should be more sensitive?

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