I began to wonder whether my project was valid. A further questionnaire given to 100 consecutive patients attending the surgery asked whether they were satisfied with the premises, access to the doctors on the telephone, waiting times for an appointment, waiting times in the waiting room and the quality of the consultation with the doctor. Happily the majority were again entirely satisfied with all aspects of care.

Unless the profession wants outside interference in clinical matters it is vital that all members of the profession take the initiative and perform such audits for themselves and also cooperate with any locally arranged peer reviews and projects.

The only accepted review system available in this country at the moment is that arranged by the Joint Committee on Postgraduate Training for General Practice for the assessment of doctors and the practices of doctors wishing to become trainers. The standards of training have risen gradually over the last 10 years as a result of this. Thus, the profession can be responsible for keeping its house in order, and I hope that the questions the editorial raised will stimulate others to intensify their efforts at audit in order to prevent outside influences destroying the standards we have achieved.

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Prescribing research: PACT to the future

Sir,

The editorial by Spencer and van Zwanenberg (July *Journal*, p.270) is timely and thought provoking and the equivalent Scottish Prescribing Authority statistics are awaited with interest. However, the authors do not focus on the main dilemma currently facing the profession. That is, should we rely on centralized data like PACT (prescribing analyses and cost) for our information or should we channel our energies and money into producing in-house feedback. As the editorial points out, PACT has many disadvantages — slow feedback, incomplete data in terms of consultation rate and links with diagnosis, and no distinction between repeat prescriptions and drugs for acute illness. It will also require a major revision to comply with the requirements of indicative prescribing budgets.

It would therefore seem sensible for development to be directed towards computerizing all practices and providing appropriate software so that all prescriptions can be issued by computer and immediate feedback of personal and practice prescribing statistics provided. This would solve the problems mentioned above, although a relatively crude system such as PACT would still be necessary to allow peer group comparisons on a wider scale and for those in single handed practice.

The editorial also strongly advocates the use of agreed local formularies. There is no doubt that these are of great benefit to doctor, patient and government but the widespread adoption of such formularies has been slow since they were first proposed for general practice nearly 10 years ago.[1] It is not hard to find the reason for this — how many doctors want to refer to an unfamiliar list of drugs during a consultation or memorize a locally agreed formulary? Prescribing is a personal activity and acceptance and compliance with formularies will only be adopted if doctors can construct their own personalized formularies. There is great educational value in constructing a personal formulary which should include not only the drug but the standard regimen, quantity and cost. Doctors are often ignorant of the cost of drugs[2] and for many it would be interesting to see the actual costs of their prescribing.

In the consultation prescribing is often not optimal in terms of drug choice, quantity, regimen and instructions, owing to time restraints and interruptions. If the process were automated by a computerized personal formulary then these problems would be resolved. In addition, legible prescriptions would be issued and accurate, relevant data produced for analysis. The construction of such a formulary is not difficult[3] and results in impressive cost savings.[4]

Computers surround us everywhere and we should accept the use of consulting room computers as an inevitable fact of modern day practice.

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Dispensing costs

Sir,

I am afraid that the figures quoted in my letter about dispensing costs (July *Journal*, p.303) were incorrect. These figures were supplied by Suffolk family practitioner committee. I have now received amended figures and have also been given a breakdown of the dispensing costs for Suffolk for 1988 from the Department of Health. Although the figures are considerably different from those I was originally given, there would still have been an overall potential saving to the exchequer of £3 184 250 if all dispensing in Suffolk had been provided by general practitioners, a saving in excess of 12% in the cost of drugs and 27% in dispensing fees, and an overall saving of 15%.

I recently submitted a detailed paper to the General Medical Services Committee of the British Medical Association illustrating the advantages of universal dispensing by general practitioners. Regardless of the relative costs of dispensing there is little doubt that the current chemists' monopoly causes patients considerable inconvenience because of the chemists' limited opening hours and the travelling involved.

The current system, based on the Lloyd George act of 1913, which separates prescribing and dispensing in time, place and person is antiquated, inefficient, costly and indeed dangerous, as the Daonil (Hoechst) case illustrates. It would be far more sensible if all dispensing were to take place within the general practitioner's surgery, since here patients can receive their medicines without the need for a written prescription. Indeed, in dispensing doctors' surgeries, particularly those with computers, the FP10 would be superfluous were it not required as a voucher for reimbursement of the cost of drugs supplied.

The time has indeed come for review of the chemists' monopoly, particularly the arbitrary one mile rule.

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Sir,

It has been stated that doctor dispensed items are much cheaper than chemist dispensed items (Letters, July *Journal*, p.303). The figures quoted are likely to be inaccurate. Approximately half of the patients in our practice are on the dispensing list. The latest prescribing analyses and cost (PACT) figures show that the number of items prescribed by the practice is 19% above average, but the cost per item is 3.4% below average. However, the number of items dispensed by the practice is 12% below average, with the cost per item 8% below average. The only reasonable explanation for this is that some patients who are on our dispensing list either go

to a chemist because it is more convenient, or because we do not stock the drug which is on the prescription.

I think that all comparisons between dispensing and prescribing costs are likely to be invalidated by the above points.

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Community hospitals

Sir,

In his excellent editorial (June *Journal,* p.226) James Grant urges us to take community hospitals seriously and to see them as important ingredients of the health service of the future. We wholly support his aims but would like to report the results of a survey carried out in Southampton which highlights some of the difficulties in developing community hospitals.

In an undergraduate fourth-year project 145 acute medical admissions to Southampton general hospital were studied. Hospital doctors, nurses and referring general practitioners were interviewed to determine their views about the feasibility of general practitioners caring for these patients in an imaginary community hospital, whose facilities had been defined. For the 90 admission referred by general practitioners the hospital doctors thought that 35% could have been looked after by general practitioners, the nurses 31% and the referring general practitioners 48%. However, consensus that the patient could be cared for by general practitioners in a community hospital was achieved in only 10% of cases. For the 55 admissions coming directly through casualty and the ambulance service the hospital doctors and nurses believed that a similar proportion, 31%, could have been cared for by general practitioners.

Interviews were conducted with over half of the patients admitted. Most lived within five miles of the district hospital and most of their visitors found access quite straightforward. Few had previous experience of a community hospital, but at interview, when asked if they would have felt better or worse knowing that they were going to be looked after by their general practitioner, 26% of the patients said that they would have felt worse, 8% that they would have felt better and 55% that they would have felt the same.

These results suggest that a substantial number of patients admitted to expensive district general hospitals could be cared for in general practitioner units, although the lack of consensus between health care professionals is concerning. Patients cared for in community hospitals tend to be appreciative and supportive of these facilities and it is likely that our results reflect lack of experience with this form of care. Nonetheless, patients' views about the place of care are important, not least because of the expectations they may reflect.

As James Grant points out, community hospitals have evolved in response to local needs and enthusiasms. Conversely, some attempts to get general practitioner units off the ground have foundered on the rocks of intertia and apathy, even before the government white paper[1] and the new contract[2] were published. Studies which will measure the cost effectiveness of community hospitals are urgently needed, as is the resolve not merely to sustain but to develop community hospitals as a precious and essential component of the National Health Service.

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Compulsory admission to hospital

Sir,

Dr McGhee's letter on the compulsory admission to hospital of an alcoholic patient under the 1983 mental health act (July *Journal,* p.301) raises a number of issues which need to be given serious thought before this practice is repeated by other doctors.

In the compulsory admission of a patient to an approved institution the doctor takes a paternalistic role and the patient is deprived of one of the basic human rights, namely the right of self determination. The use of the act is therefore to be regarded with the utmost gravity, as the loss of personal liberty and the subsequent compulsory treatment profoundly affects the doctor–patient relationship. This change in the normal relationship persists until society deems that the patient is capable of making a rational and informed decision as to his or her choice of health care.

In alcoholism the patient is deciding that he will consume alcoholic beverages to a level that other members of society might believe, quite rightly, is irresponsible and to the detriment of his health. Being irresponsible is not in itself a variation of human behaviour that allows the medical profession to intervene in a manner that deprives a patient of his liberty. To impose a medical model on a state that is more socially threatening than relevant to the spirit of the mental health act raises fundamental questions as to the role of the doctor in society.

The iniquitous practice of using psychiatry as a means of political or social control, which has been well documented in the eastern block countries, has been condemned by doctors. However well justified our concerns and fears for our patients, and despite the exhortation by friends and relatives that 'something must be done' if a patient does not satisfy the prevailing criteria for compulsory admission and treatment, we do not have the right to mould the acts of parliament to engineer social conformity, for to do so is not only unlawful but more pertinently unethical.

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Needs of elderly people in residential homes

Sir,

Dr Packham's paper (August *Journal,* p.335) raises an important issue, that lack of medical information hinders medical care, especially for the most disabled.

As a doctor who regularly visits residential homes to make assessments for attendance allowance I consider that access to patients' notes would be most helpful, particularly for obtaining the recent history prior to admission to the home or hospital, information which the staff often do not have. Patients might also benefit financially if earlier establishment of dependency leads to earlier payment of benefit.

The problem is presented as one of maintaining the confidentiality of patients' medical information and of respecting their autonomy. Confidentiality is not an absolute moral obligation and the General Medical Council's 'blue book' lists eight legitimate exceptions. A wide variety of health professionals, including administrative staff, have access to medical notes; allowing such access to residential nursing staff and visiting doctors would not therefore be a major departure.

The straightforward solution to respecting patients' autonomy would be to ask patients if they object to their notes being kept on the premises. The demented may lose a degree of autonomy but they