deprivation and the two measures of workload, which at least raises questions about the assumption that doctors working in deprived areas work harder than those who do not.

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Benefits of the Internet

Sir,
I am trying to interest my general practice colleagues in becoming more aware of the benefits of the Internet. Overall, general practitioners are conservative in their outlook and cautious of new ideas.

The development of computerization in general practice over the past 12 years has shown a complete lack of coordination, with no overall national policy or integration. The various large computer software suppliers to general practice have mainly guided the development of the software, with some standards set by the government. The result is that computerization has been allowed to evolve haphazardly in general practice, but at what cost? A huge sum of public money has been spent on administration, hardware, software, and maintenance contracts. Overpriced hardware and maintenance costs continue to be an obvious ongoing drain on National Health Service (NHS) resources. The erratic links between hospitals and general practice continue to frustrate GPs, who are drowning under the deluge of paperwork.

The Internet is being ignored, underused, and poorly understood by general practices. Doctors and administrators alike are baffled and short-sighted about its benefits, and consequently choose to ignore the tide sweeping towards them. When the dust settles and the mist clears, I fear I shall see another missed opportunity. GPs and the NHS as a whole will fail to go forward together and capitalize on the Internet revolution.

The problem should not be underestimated, as it will have an impact on all of us who work for or need the NHS. The efficient use of resources continues to exert severe pressure on GPs. Lack of expertise and a coherent centralized policy, hidden behind wasteful experimental mistakes, makes a fiasco in the developing Internet technology inevitable.

I had the same uneasy feelings 12 years ago when my colleagues talked in a condescending manner about the likely benefits of computerization. I do not claim to foretell the future, but I do recognize an illness I have seen before.

I hope to reach a wider audience and perhaps stimulate a greater awareness of how the NHS, and specifically my GP colleagues, needs to focus on and grasp the positive potential of the Internet.

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Repeat radiographs

Sir,
Ian Beggs highlights one aspect of referral letters where a lack of information can lead to inefficiency and potential harm from unnecessary radiation (May *Journal*).[1] It would be interesting to know the measures he refers to that have been introduced to increase awareness of the problem.

However, there is another side to the picture. We may legitimately ask how many of the clinic radiographs are necessary. I am surprised to learn that 'almost all new orthopaedic patients are examined radiographically.' In my own orthopaedic clinic, the annual rate for radiographs has varied from 27% to 45% of new patients. The practice of X-raying new patients on arrival at a clinic, before they are seen, may help the organization of the clinic but cannot be in the patients' interest. I do not support this practice. If it transpires that recent radiographs are available that were not mentioned in the referral letter, it is always possible to request them after seeing the patient, and I have to do this regularly.

I strongly support the plea for relevant information in GP referral letters, but perhaps hospital practice also needs to change.

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Resuscitation equipment and GPs

Sir,
Kathryn Griffith and her co-workers conclude that the patient should call '999' rather than their GP when they have chest pain (Letters, June *Journal*). Their evidence appears to be urban-based and atypical of the conditions in rural areas and small towns.

I practised in a rural area for 30 years and saw a case of myocardial infarction about every six months. I rapidly learnt that immediate response, leaving my wife or receptionist to inform the ambulance service, was the best approach.

In the majority of the 50–60 cases attended, I was with the patient approximately 10 minutes before the ambulance — long enough to have inserted a Venflon, given intravenous analgesia, and then commenced cardiac monitoring with a monitor/defibrillator. There were two occasions when the ambulance arrived first, but there were also two occasions when the patient was defibrillated before the ambulance was on the scene.

Attendance at acute myocardial infarctions is inconvenient, stressful, and unremunerative, but, outside heavily-populated urban areas, a joint approach by the GP and ambulance service, both carrying a defibrillator and oxygen, is surely a safer response.

A second reason for a medical presence is that the presenting symptom in most of these patients is severe chest pain, which only adequate intravenous analgesia can relieve.

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