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# *November Focus*

WE are proud to trumpet the publication this month of two angry letters on page 888. Unfortunately, these two authors are angry, not with some of the research we have published, but with the whole journal. That wasn't quite what was meant. However, the criticisms are familiar and do demand an answer. We're still working on a full reply to the comments we have heard in the last year or so. However, the research published this month, as always, test whether we can answer the charge of irrelevance.

The practice of giving antibiotic prescriptions for delayed dispensing has an interesting history, in terms of how research can influence practice. Paul Little's pioneering paper in 1997 on delayed prescribing for sore throats provided solid evidence to support and encourage a practice that many doctors had already been using. Since then, other studies have confirmed the findings in other areas and, in the way of research, each paper adds a piece to the overall picture. This month a systematic review on page 871 gathers this evidence together and delivers an interim verdict. The different studies all point in the same direction: that delayed prescriptions do reduce antibiotic use, but show less consistency in the size of the effect. That data is a summary of what can be achieved in research studies, with all the additional help, time, and motivation involved. The paper on page 845 reports the results of applying the research to routine practice. Approximately half of the patients who were given prescriptions for delayed dispensing collected them, and felt confident making their own decisions. A positive response by patients is also reported by Christopher Cates in the accompanying editorial on page 836.

If delayed dispensing has crept up on us all gradually, IT has invaded our lives — both personal and professional — with all the subtlety of a testosterone fuelled adolescent. Working with new technology demands much, promises much, but sometimes takes time to deliver any benefits. A scheme, described on page 838, was designed to support repeat prescribing. There were lots of problems with the coding, but even when they were ironed out, the software was unable to make the kind of inferences that many doctors would make. Even so, the participating doctors found the system useful. On page 898 there's a report about using videoconferencing in Australia. The authors give the new technology a cautious welcome, but warn that it cannot be used to cover up fundamental deficiencies in service provision. One advantage, they claim, is that it may enable teams, especially those in rural areas, to join in educational activities without closing the surgery. I wonder how many would consider that an advantage? The rural doctors seem to like travelling to meet each other as much as the rest of us, and two of their conferences are reported on pages 904 and 905. Looking ahead, the editorial on page 835 is clear that we haven't really begun to unlock the gains that technology will bring in terms of supporting clinical care, better communication, and our own learning. On page 866, one example of such a system, to improve the management of coronary heart disease, is discussed in detail. The authors suggest that such systems will help patients and professionals to tailor care to individual needs much more than we do at present. Whether we ever get to the kind of systems described on page 900, which do all the thinking for us, remains to be seen. Anticipating the reactions of angry readers, we admit that much of this material is not directly relevant to general practitioners' professional lives today. But it's likely to be relevant to anyone still working in medicine in a few years' time.

Back to the letters. On page 886 there is a response to last month's paper exploring barriers to the prescriptions of statins. This month, we carry another study dealing with the same topic on page 851. Publishing this paper brings two special delights. First, it is from the Salpêtrière, the renowned institution founded in Paris in 1656 on the site of the gunpowder factory, after which it is named, where Pinel, Charcot, Marie, Guillain and Babinski all worked. It's an honour to feel their shades looking down on the *BJGP*. And then, much less worthy, there's the schadenfreude. This is France: much less coronary disease than we have in the UK, or so we are reliably informed. That's in spite of French dietary habits. It has always felt as if our French friends were getting away with, if not murder, at least a modern equivalent of suicide. And now we learn that they too worry about not prescribing enough statins. It does one's heart good to read it.

DAVID JEWELL
*Editor*

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