

Letters

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Editor's choice

Keeping the electronic care record locked: lessons from history

Professors Wallace, Delaney, and Sullivan provide us with an unsettling glimpse into the arcane world of industrial scale medical science.¹ I am reminded of the European Enlightenment, the birth place of this very scientific approach to the mysteries of nature. Between 1750 and 1770 the French philosopher, Denis Diderot, devoted himself to the creation of the *Encyclopédie*, a monumental attempt to capture every branch of human knowledge. He believed that comprehensive knowledge would 'give the power to change men's common way of thinking'.² The project was mired in controversy largely through fears from the church and the aristocracy of giving the power of knowledge to the common people; as it turned out the fears were justified. Will this latest incarnation of Diderot's project liberate the people from our contemporary 'aristocracy', the elites of big business and politics? I fear not. Amid the ambition for comprehensive data and the explicit desire to boost the UK economy, the suffering individual is lost within the beguiling binary world of the 0 and the 1. This uniquely ill man, woman, or child is anonymised, electronically dismantled and reassembled in a form that suits BIG PHARMA. This is Diderot's progressive project turned on its head. Let's have nothing to do with it until we have learned how to appreciate the value of our uniqueness and of our shared destiny.

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Antibiotic overprescribing: who are the bad guys?

The July Journal includes many articles on trying to reduce antibiotic prescribing in respiratory infections.^{1–5} May I bounce back a few obstacles?

Azithromycin to be taken three times a week? We have a growing cohort from secondary care of people with chronic airways disease, emphysema, and now also asthma, including children, who are put on this long term. Flares of chronic airways disease are poorly defined but antibiotics are considered good for this.

New syndromes like persistent wet cough in childhood seem to benefit from antibiotics. Ear, nose, and throat surgeons believe antibiotics work in sinus pain, despite vague NICE advice that seems to apply to primary care only.

There seems to be an epidemic of apparent urine infections diagnosed and treated with antibiotics in any ill older person in casualty. Any residential home resident where the staff can 'dip urine', and prescribing allied professionals are perhaps greater causes of current questionable prescribing.

Ill, hot children who attend hospital in our area always come out on antibiotics, usually co-amoxiclav.

All this makes it hard to stem the tide of antibiotic overuse. Add to this the failure of European or worldwide regulators to reduce pharmacy dispensing without prescription and it makes me wonder why we, as GPs, are seen as the bad guys.

The article on pharmacy advice also contrasts with the practice in southern Europe, where pharmacies appear to be pretty willing to sell antibiotics.

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The RTI clinical iceberg

The paper 'Expectations for consultations and antibiotics for respiratory tract infection in primary care: the RTI clinical iceberg'¹ has striking workload implications for GPs given that 58% of the UK population surveyed reported an RTI in the preceding 6 months, for which one in five had contacted their GP surgery. It is an important finding that over half of those patients contacting the GP expected antibiotics (53.1%).

However, exactly how big the problem of over-prescribing is cannot be determined from this study as the survey did not ask responders if they had been prescribed antibiotics for an RTI. Presenting data on expectations for antibiotic prescription for an RTI next to data on antibiotic prescription for any condition, as the 'clinical iceberg in RTI' (Figure 2 in the article), is perhaps misleading. Furthermore, although we are told that '97% of participants were prescribed an antibiotic when they asked for one', we are not told how many of the 74% who did not ask for antibiotics were prescribed them. Therefore it is not possible to attribute antibiotic prescription to patient demand.

Time pressures in primary care undoubtedly run counter to the need to minimise inappropriate antibiotic prescription as it takes longer to perform a full clinical and psychosocial evaluation of a patient, with education and safety-netting, than to issue an antibiotic. The paper overlooks the psychosocial drivers behind patients' attendance with minor RTIs, presumably because they did not emerge as themes in the qualitative interviews; that those of lower