

A national code for drugs used in general practice — an identified need?

T. A. CARNEY, MRCP
General Practitioner, Northumberland

AS part of a study into the workload and clinical content of general practice in the north-east of England, 37 general practitioners were asked to complete a proforma for each consultation; there were sections on diagnosis and prescriptions.

The diagnostic section was coded using 'A classification of morbidity for morbidity statistics from general practice — third national study 1981–82',¹ a three figure coding for diseases relevant to general practice adapted by the Royal College of General Practitioners from the *International classification of diseases (ninth revision)*. I was dismayed to discover that there is no equivalent classification for the drugs prescribed in general practice.

A number of studies have looked at prescribing in general practice²⁻⁶ and all of them have emphasized the importance of this area for future research. The introduction of the computer as a tool of general practice, especially for repeat prescribing, has highlighted the need for a national drug code.

Many different drug codes have been created and are used by research workers and those involved in computer software. No single standard code exists or is accepted. At present there are two main coding indexes and a number of individual codes.

The Department of Health and Social Services produces a *Drug master index* annually, which includes all the drugs which have ever been prescribed.⁷ It is a seven digit code and was not applicable to my needs and almost certainly would not be suitable for use with the many microcomputers used in general practice. Many of the drugs it lists have never, or rarely been used in general practice and a large number are now no longer available. However, it is available in alphabetical, numerical and drug group versions, but is quite expensive to buy.

The Prescription Pricing Authority (PPA) uses a prescription analysis which is a therapeutic classification based on two figures.⁸ This does not, therefore, distinguish between any single drug within a therapeutic group nor between generic and proprietary prescribing. The PPA is now developing a seven figure code based on the *British national formulary*.⁹

Freeman describes a four figure code which is drug specific and gives information as to the route of administration but does not include proprietary names.⁶ Sheldon used a method developed from the Oxford Drug Monitoring Study.²

All these codes and the many created by individuals are totally different and are therefore neither comparable nor computable. None of these codes are adequate; the two codes using seven figures, while comprehensive, are too large and cumbersome for the needs of the average general practitioner. They also include many drugs that are never likely to be prescribed in general practice or are no longer available. Freeman describes a system which may well form the basis for a national code, but limits itself to nine individual drugs in each therapeutic class, and one group class. It does not differentiate between generic and proprietary prescribing.

What are the criteria that a new standard drug code would have to satisfy?

1. Each drug would have a single code.
2. It would be limited to drugs used in general practice.
3. It would be coded by therapeutic (pharmacological) class.
4. It would identify between proprietary and generic prescribing.
5. It would be flexible enough to cope with the constantly changing drugs available and prescribed.
6. It would be available in alphabetical, numerical and therapeutic group form.
7. It would be suitable for use by medical, pharmacological, paramedical and lay personnel.
8. It would be computer compatible.

9. It would give information about the route of administration.
10. It would consist of a three or four digit code (numerical and/or alphabetical) in order to be suitable for the microcomputers being used by many practices for repeat prescribing systems.

11. It would be readily and cheaply available to all general practitioners interested in research and/or computer use.

The Manchester Research Unit of the Royal College of General Practitioners has recently produced a new classification of diseases likely to be used as the national standard.¹⁰ However, even this has been criticized by Cameron and Stanley and Hart,¹¹ because, as they forcibly point out, not only those interested in research but the ever increasing numbers of general practices using computers require computer compatible nationally standardized coding systems.

Only by creating a national code for the drugs used in general practice, to compliment the classification of disease mentioned above,¹⁰ can research papers and computer programs be compared.

I would ask this *Journal* to allow its correspondence columns to be used to air the many different views there will be on this subject. If it is agreed that there is a need for a national drug code in general practice then this should be brought to the attention of the Council of the Royal College of General Practitioners.

In the interim, if any research workers find, as I have done, that they require a three digit code for drugs at present used in general practice, then copies of my code (a three numerical digit code, utilizing the drugs used by 37 general practitioners in 16 000 consultations, and easily updated, in alphabetical, numerical and drug group form based on the *British formulary and the Monthly index of medical specialities*) are available from Mrs A. Race, Practice Manager, Burn Brae, Hexham, Northumberland NE46 2ED. A charge of £4.00 has to be made to cover printing and postage.

References

1. Royal College of General Practitioners/Office of Population Censuses and Surveys. *A classification of morbidity for morbidity statistics from general practice. Third national study 1981-82*. HMSO, 1982.
2. Sheldon MG. Self audit of prescribing habits and clinical care in general practice. *J R Coll Gen Pract* 1979; 29: 703-711.
3. Taylor RJ. General practitioner prescribing. *J R Coll Gen Pract* 1977; 27: 79-82.
4. Grace JF, Goulds RK. An examination of the prescribed therapeutic experience of five year olds in general practice. *J R Coll Gen Pract* 1980; 30: 529-532.
5. Murdoch JC. The epidemiology of prescribing in an urban general practice. *J R Coll Gen Pract* 1980; 30: 593-602.
6. Freeman GK. Analysis of primary care prescribing — a 'constructive' coding system for drugs. *J R Coll Gen Pract* 1978; 28: 547-551.
7. Department of Health and Social Services. *Drug master index*. London: HMSO, 1985.
8. Prescription Pricing Authority. *Therapeutic classification prescription analysis*. London: DHSS, 1975.
9. *British national formulary*. London: British Medical Association and The Pharmaceutical Society of Great Britain.
10. Royal College of General Practitioners. *Classification of diseases, problems and procedures. Occasional Paper 26*. London: RCGP, 1984.
11. Cameron A, Stanley I, Hart A. *New RCGP classification*. *J R Coll Gen Pract* 1984; 34: 495-496.

Acknowledgements

I wish to acknowledge a grant from the Northern Regional Health Authority, 1981.

Address for correspondence

Dr T. A. Carney, Burn Brae, Hexham, Northumberland NE46 2ED.