International travel medicine

Sir,

In response to Dr Peppiatt's editorial on international travel medicine (February *Journal,* p.42), it is perhaps worth clarifying some aspects of the alternative information sources available to both general practitioner and traveller.

On the one hand the interested general practitioner can provide his patient with all the pre-travel health information required from readily available sources (weekly charts; the Department of Health book *Immunization against infectious disease;* Communicable Diseases (Scotland) Unit data base) which do not incur any fees for usage. The traveller can also obtain appropriate advice from free Department of Health leaflets (SA40 and 41). Alternatively a commercial information source can be used, or indeed the whole responsibility may be delegated to a commercial travel clinic, such as those being developed by British Airways.

Thus, although the general practitioner is primarily responsible for the health care of the returning sick traveller, he can choose whether to take responsibility for the traveller's pre-travel health advice. We would suggest he is likely to provide a better service to the patient if both aspects are included as part of the general practitioner's role.

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Sir,

I am writing to clarify a point in Dr Peppiatt's editorial. In his mention of rabies, he gives the DHSS as a source of advice on 01-200 6868. While the Department of Health international division will have an interest, the telephone number given is that of the Communicable Disease Surveillance Centre at Colindale, and is the most appropriate point of contact.

Callers expecting the Department of Health may be confused by getting the response 'Public Health Laboratory Service' from the common switchboard at Colindale. In order to get appropriate advice, they will need to ask for the duty consultant or senior registrar at CDSC. The duty doctor will be able to give advice and possibly help to trace the animal in question through the international links of the Department of Health.

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What influences doctor's prescribing

Sir,

I was interested to read the paper by Drs Pitts and Vincent on doctors' prescribing (February *Journal,* p.65). During my career in the Department of Health, I spent much of my time dealing with prescribing in general practice and became aware of the considerable differences in prescribing patterns within the same family practitioner committee area. I would like to quote some figures relating to the prescribing of drugs used in the treatment of infections (*British national formulary,* chapter 5) in 50 practices in one family practitioner committee area in the south midlands in one month (Table 1). The information was derived from data collected by the Prescription Pricing Authority from prescriptions dispensed by pharmacists during January 1987.

Table 1. Drugs used in the treatment of infections in one FPC area in one month.

Number of practices	50
Number of general practitioners	181
Number of patients on lists	348 477
Number (%) of patients aged 65 years or more	42 026 (*12*)
Number of prescribing units	432 529
Number of items prescribed	24 366
Net ingredient cost (£)	87 546

From the basic figures in Table 1 it can be deduced that the mean net ingredient cost per item was £3.59, that the mean prescribing rate per 1000 patients was 69.9 items per month, and that the mean net ingredient cost per 1000 patients was £251.23 per month.

The net ingredient cost per item ranged from £2.21 to £7.65 in the 50 practices. The prescribing rate ranged from 24.5 to 160.9 items per 1000 patients per month, and the net ingredient costs ranged from £125.62 to £586.23 per 1000 persons per month.

The net ingredient cost per 1000 patients, which combines the number of prescriptions with the net ingredient cost per item, demonstrates that the range of prescribing costs was from 50% below the family practitioner committee mean to 133% above the mean. Such a variation is unlikely to be due to variations in the prevalence or severity of infections in the same area during the same month. The most likely variable is the doctor himself and these data support Drs Pitts and Vincent's belief that there is a prescribing 'threshold' which differs from doctor to doctor. This may relate to a number of factors including the doctor's willingness to tolerate the uncertainties of general practice diagnoses.

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Computer prescribing

Sir,

Nick Booth's letter (February *Journal,* p.80) raises two important issues. First, the use of a computer to produce acute prescriptions during a busy surgery should not be made more difficult by the deficiencies of the drug dictionary available within the system. All concerned with the design of computer software for general practice should take this into account, particularly in the light of the proposals in the government's white paper for drug budgets for general practitioners.

Secondly, it is important that freedom to select a drug, by its proprietary or generic name, should never be overridden by the software. Computers are tools to assist doctors and should not remove doctors' freedom of choice other than to prevent harm to a patient from a drug interaction.

The computer software which is freely provided by the Scottish Home and Health Department to all general practitioners in Scotland (GPASS) not surprisingly encourages generic prescribing with consequent savings to the National Health Service. However, user practices have always had, and will continue to have, the same basic freedom of choice which is available to non-computerized practices, namely that of selecting the most appropriate drug by its generic or proprietary name. It is interesting to learn that it is commercial systems which are removing doctors' freedom of choice.

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Telephone advice in patient management

Sir,

It is wise to be cautious in the use of telephone advice in patient management and diagnosis, in view of the attendant risks of error or complaint as pointed out by Dr Halle (Letters, February *Journal,* p.79). In terms of out-of-hours contacts, one study has shown that 59% of incom-