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-

ing calls were managed in this way,[1] with a mean of 0.7 visits made in response to 2.6 calls in the weekday evening period.

In a comprehensive study of out-of-hours work in my practice (seven partners, 13 300 patients), one participant recorded 16 telephone contacts in one weekday evening between the hours of 18.30 and 23.00 and the mean for a six-month period was 6.1 per evening. Some of these are simple requests for advice, but it is clear that to visit all these patients would be difficult, and in addition, would reduce the availability of the doctor to the patient who needs immediate attention, a situation which may also lead to a complaint.

A selection of alternative ways in which out-of-hours work may be structured has been offered recently.[2] Contributions from the defence societies to this debate are important and relevent, and need to be made in the context of the realities of the workload.

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1. Marsh GN, Horne RA, Channing DM. A study of telephone advice in managing out-of-hours calls. *J R Coll Gen Pract* 1987; **37**: 301-304.
2. Pitts J. Hours of work and fatigue in doctors. *J R Coll Gen Pract* 1988; **38**: 2-3.

Night calls — the patients' view

Sir,

Roused during the night, the field marshal on active service might shave, bathe and take a cup of coffee before addressing himself to his new operational problems. And before getting out of bed at all, he will have quizzed his aide-de-camp to make sure that rising was really necessary.

The doctor on night call is more like the junior officer in the front line, who is expected to give clear-headed attention to local problems within seconds of waking.

We can all sympathize with the doctor whose sleep is disturbed when he is trying to recover from an exhausting day — except, that is, when we are the ones in need of help. Then, our expectations are rather different. Our problem is to keep those expectations within reasonable limits.

It seems to me to be quite reasonable to expect that the doctor answering the telephone in the middle of the night will begin by telling me his name and asking mine. The fact that I have telephoned at all at that hour is evidence that I believe an emergency to exist, and I quite understand that I might be mistaken. But if the doctor decides that a visit is not necessary I would like to feel that he has elicited sufficient information from me to enable him to reach a sound decision.

In short, I would like to be satisfied that his decision to go back to sleep is professional rather than merely human.

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Staff for general practice

Sir,

While in support of Dr Pritchard's editorial on general practice staff (February *Journal,* p.41) I would like to make the following comments.

Dr Pritchard is correct that no mention of practice managers is made in the government's white paper *Promoting better health*[1] nor is the Association of Health Centre and Practice Administrators included by name in the *Statement of fees and allowances.* Despite numerous approaches and appeals to the Department of Health and individual members of parliament, the association and the role of the practice manager remains unrecognized. However, it was gratifying to hear on a BBC Radio 4 interview that the Minister for Health recognizes that practice managers would play a key role in the implementation of the proposals outlined in the latest white paper, *Working for patients.*[2]

This association, with over 800 members, has been working voluntarily for 14 years in training managers in general practice in the tasks now specified in *Working for patients.* We will continue to train and educate our members to meet the challenges of the future and ensure that doctors are free of concerns over administrative details and able to devote their time to the skills in which they are trained — the treatment and care of their patients.

We are grateful for the support that the Royal College of General Practitioners has given us over the years and we look forward to working together to make the most of the new opportunities to improve the quality of patient care in general practice.

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1. Secretaries of State for Social Services, Wales, Northern Ireland and Scotland. *Promoting better health (Cm 249).* London: HMSO, 1987.
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'Brittle' diabetes

Sir,

With regard to Dr Buckley's comments on 'brittle' diabetes (Digest, February *Journal,* p.82), it has been possible to measure the Somogyi effect objectively for many years. A finding of hyperglycaemia in the morning associated with a headache in type 1 and type 2 diabetes should alert the practitioner to the possibility that nocturnal hypoglycaemia is occurring. A morning measurement of creatinine to cortisol ratio will confirm that there has been excess nocturnal production of steroids in response to hypoglycaemia.

It is not a particularly expensive test to do and may help determine treatment in 'brittle' diabetics.

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Quality of care

Sir,

Nick Bosanquet's editorial (March *Journal,* p.88) rightly gives great credit to the family doctor charter of 1965. As he says, quality has emerged 'as a result of professional cooperation rather than economic competition' and the best hope for further progress still rests upon that factor. The College's own drive for quality review throughout the last decade has paved the way; money comes into the equation as it did before the charter, when income was effectively reduced by just those measures which would promote quality.

However, change in medical practice is a continuous process and Bosanquet seems unaware of the earlier changes which made the charter possible. The Dankwerts award of 1952/53 first gave general practitioners a fair level of remuneration in the National Health Service. After negotiation, the additional money was deliberately distributed in a way that favoured group practices, lists of moderate size and the establishment of new entrants to practice. The profession voluntarily set aside some of the award money to provide interest free loans for the improvement of group practice premises, something the Pilkington Royal Commission said the government should have done and should reimburse. As a result general practice was substantially reorganized and the new development of associating health visitors and home nurses was far advanced by 1965. The Gillie committee of 1963 had produced the guidelines and the pressure for the