The prescribing of hypnotics in an urban practice

PAMELA STEVENSON, M.B., CH.B. AND P. G. GASKELL, M.D., M.R.C.G.P.

'BUT it has become increasingly clear that good clinical practice requires every doctor to undertake a searching review of his prescribing of hypnotic drugs.' This concluding sentence in a *British Medical Journal* leader of 8 August 1970(a), prompts us to report the results of such a review.

The review had been started some months previously when the trainee assistant in this single-handed practice expressed misgivings about the repeating of prescriptions for hypnotics without the patient's being seen by the doctor. Similar misgivings were then found in the Department of Health and Social Security Report No. 124 which states that 'There is abundant evidence that doctors prescribe barbiturates in large quantities without very much regard for the risks which attend their use.'

A small exercise in applied research appeared to be indicated and was arranged, first to define the situation which existed and take any corrective action called for and, secondly, as a useful educational experience for a trainee assistant. The increasing use of research as a method of training, and its inherent value in adding to knowledge, has been noted by Harrell (1962) and an example of its use within the traineeship scheme is reported here.

What is immediately apparent on studying the published writing on the use of hypnotics, is the vast amount which have come from specialized sources, compared with that from the generalists who do most of the prescribing; and that anxiety emanates predominatly from specialist writing. This anxiety appears justified by specialist observations, and generalist studies over a broader field reveal a need for caution in the prescribing of hypnotics. Whether this need is great enough to justify inclusion of barbiturates and other hypnotics in the Misuse of Drugs Bill is debatable. Sir Edward Wayne's subcommittee, 1970, recommends this and has reported an unknown number of middle-aged patients who have become dependent on the drugs, apart from a number of young people who misued them.

Method

For a descriptive study to be useful it should permit easy comparison and this requires that it be compatible with normal practice organization. Our method of study takes account of this.

The practice numbered about 2,600, of whom patients on regular long-term treatment had been issued with cards of the pattern reported by Stevenson (1967) which allowed them to collect repeat prescriptions without the necessity of an appointment and a further consultation. A method similar to that of Adams and his colleagues (1966) was adopted and the names of all seeking repeat prescriptions for hypnotics in a period of two months were listed. A few further names were extracted from a review of consultations in the preceding six months and yet others, which had been overlooked by these methods, were added in the following two months. In this way, a list of 78 patients was compiled, these being all in the practice who have regular resort to the use of hypnotics.

These patients were then circularized with a simple questionnaire and this was followed by a consultation exploring matters in greater depth. Complete co-operation

was achieved and consistency of observation was ensured by using a standard structured interview, and by having only one interviewer. (P.S.)

Results

The 78 patients (13 men and 65 women) represented 3·o per cent of the executive council list at the start of the survey. The only study we have found which can fairly be compared came from a larger industrial practice where 1·3 per cent of the patients received hypnotics in this way (Johnson and Clift 1968) and speculations have been made on the extent to which local habits determine the prescribing of hypnotics. (*British Medical Journal* 1970b). The preponderance of women agreed with other studies.

Figure 1 shows strikingly the steady rise with age of the percentage of the practice population who were taking hypnotics.

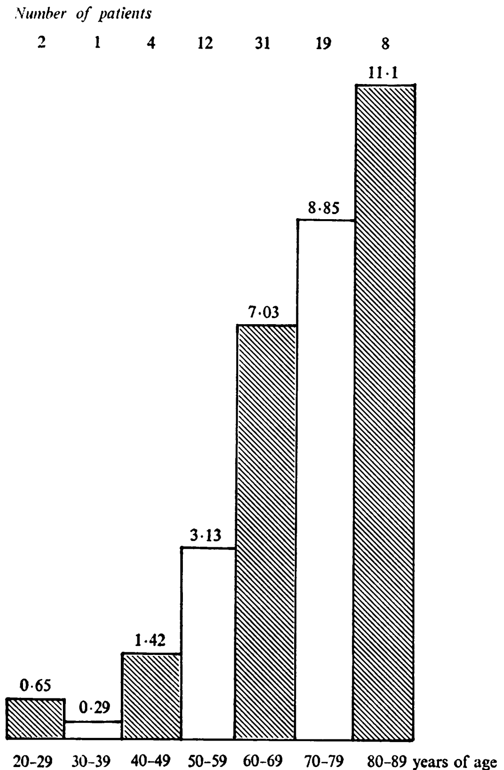

Figure 1. Percentage of each decade of practice taking hypnotics regularly

In respect of civil state, 14 were single, 38 married (six of these socially separated), 25 widowed and one divorced. If civil state is related to sex, the proportion of widows is much higher—(24 out of 65) (37 per cent) than among widowers (one out of 13 men, 8 per cent).

A wide range of drugs was being used and figure 2 shows the number of patients taking each. Forty-one patients had used only one hypnotic, 30 had used two at different times and seven had used more than two.

The numbers who have taken hypnotics for different periods of time is shown in figure 3. No relationship is to be found between age and duration of drug taking. Seventy-three patients had taken hypnotics regularly and five intermittently. The clinical record sometimes contradicted the patient's recollection of events. Elderly patients, in particular, were less likely to date their drug-taking from a specific event and more likely to underestimate the length of time they had been taking hypnotics.

Allowing for possible subjective error, the patients' expression of their experience in trying to give up taking hypnotics is still arresting, particularly in the light of present advocacy that they should do so. Eleven patients had made no attempt to stop using hypnotics, although nine of the 11 had been taking tablets for more than five years. Ten patients had made one attempt, eight had made two attempts and no fewer than 49 claimed to have made more than two attempts to stop their sleeping tablets. Of these 67 patients, four had attempted graduated withdrawal and 63 immediate total withdrawal.

Adams and others (1966), in a study of patients receiving barbiturates, gave the reasons for prescribing within a classification offered by Kessel and Shepherd (1962), part of this amplified by a diagnostic scheme from the College of General Practitioners (1963). Adoption of this method proved useful for descriptive purposes and no better

classification can be suggested. It should be realized, at the same time, that the interrelationship of the physical and psychological, when seen by the patient retrospectively over variable periods, is too indeterminate to allow diagnostic accuracy. The figures quoted to illustrate reasons for prescribing these cannot be used either as a reliable basis for calculation or for outside comparison.

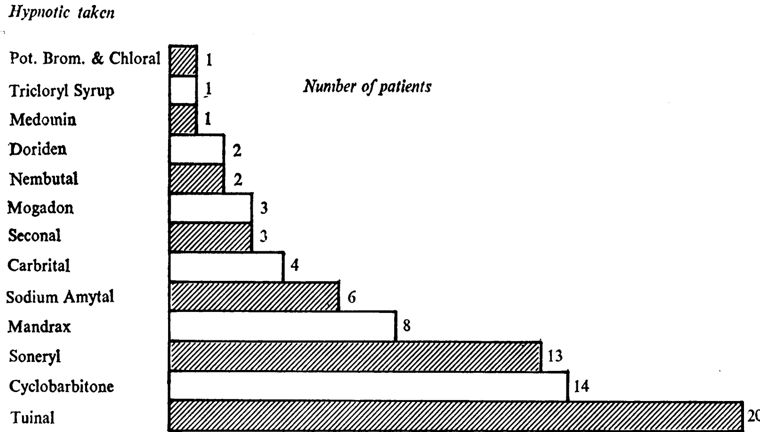

Figure 2. Number of patients taking different hypnotics

Using this classification, 15 patients were thought to have begun to take sleeping tablets because of physical disease. Fourteen required hypnotics now for physical disease and nine ascribed failure to stop the tablets to this cause. The assumption is

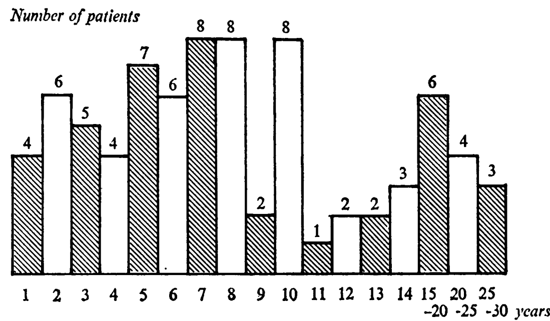

Figure 3. Numbers of patients taking hypnotics over varying periods of time

that sleeping tablets were required in about 20 per cent of patients because of physical disease. Of the 15 patients, however, who started tablets for this reason, only nine still took them for the same reason and, for the six others, the reason for still taking tablets was psychosomatic.

The reasons for starting tablets, using Kessel and Shepherd's classification, were—

Physical only	10
Physical, elaborated or protracted	16
Psychosomatic	17
Psychological	30

As with the first group of these, so with the others the clinical indication changed with time and no statistically useful conclusions can be drawn.

Seventy patients thought they enjoyed a better sleep pattern on their hypnotics, three thought they slept about the same and five thought they slept more poorly since

starting drugs. Malpas (1970) has, however, shown the unreliability of patients' opinions in this connection.

In addition to holding unreliable opinions, patients can be unreliable in their behaviour in ways which lead to dependency on or addition to hypnotics. When the practice of repeat prescribing as described was begun, entry on each occasion in the patient's notes gave the doctor confirmation of the rate of consumption of the drugs. A period of absence of the doctor due to ill-health followed by a move of surgery premises broke this pattern and subsequsnt sharing of the work of writing up presecriptions and entries reduced the effectiveness of this in-built safeguard. The consequence—only nine months later—was the finding of three patients who had personality disorders of which this development of addiction is simply one facet.

Considering the vulnerability of patients to the hypnotics they were using, 70 had had no thought of overdosage, but two had had such thoughts and six had taken an overdosage at some time.

Discussion

These results—neither happy nor re-assuring—fully justify the survey undertaken and require a review of prescribing of hypnotics in the practice. But where at present are the guide-lines for such prescribing? We have indicated how little help for general practice the literature appeared at first sight to offer. It seems rational, however, to attempt some practical clinical classification and, applying recent research advice to this, a more justifiable pattern has emerged for the initiation and maintainance of prescribing of hypnotics.

One group of patients clearly have had their first experience of hypnotics in hospital and the drugs have been continued on their discharge to a point at which dependency had been induced. We strongly support the plea of Bond (1970) for the cessation of hypnotics some time before the patient's discharge and—aware as never before of the hazards of continuing these—we hope not to prescribe even where their use is recommended in discharge letters.

Where prescribing of hypnotics has been started in the practice, the indications appear to have been:

1. Reaction to some form of stress—e.g. grief, anxiety
2. Insomnia due to physical disease
3. Primary insomnia.

(1) Where the indication is reaction to stress, the greatest importance attaches to the assessment of the patient's pre-existing personality.

(a) If this is healthy, then it may be possible to help the patient whether a crisis of grief or anxiety without having recourse to drugs but, if they are indicated, the duration of their use will be limited and the choice of drug is less important.

(b) The reaction to stress requiring medical help is *per se* the more likely to indicate a dependent or neurotic personality in whom the two risks of dependency or overdose are high. In general, antidepressants and mild tranquillizers appear safer and should be considered first without adding hypnotics. If the latter are required, nitrazepam (Mogadon) is the drug of choice by reason of its safety (Mathew 1970) even though it is thought to have a greater hangover effect (Malpas 1970). Safety in face of overdosage seems, in the present state of our knowledge, to deserve priority over risk of addiction about which there is less certainty. In therapeutic doses, all drugs of addiction appear to disturb sleep but drugs such as Mandrax and Welldorm which would appear safe in this regard (Evans 1970) carry greater risk than Mogadon when the question of overdosage is considered.

The clinical impression of dependency shading into addiction as a simple consequence of continued use of hypnotics was very strong in this group and these patients may well fit the picture described by Balint (1970) in which the repeating of prescriptions represents the appropriate therapy. If these patients are identified thus, then their dependent need for repeated prescribing should not be met using hypnotics but by use of non-addictive drugs.

(2) Those suffering from insomnia due to proven physical disease seemed less likely to be vulnerable in their personalities and the risks of dependency and overdosage have not been as prominent as in the previous group.

Where physical disease is the indication, then, the drug indicated is the one which which will ensure sleep with least hangover effect and simple analgesics should be used, if necessary in combination with drugs such as Mandrax or Welldorm.

(3) Insomnia for which no cause can be found may also require a hypnotic in order to maintain daily function. The patients in our study who fell into this category were of stable personality so that, again, Mandrax and Welldorm—with less hangover effect—become the drugs of choice.

It remains to be seen whether this simple diagnostic classification and the consequent guide-lines for selection of drugs will alter the future prescribing hypnotics in the practice.

With regard to diagnosis, it may be anticipated that more than half of the widowed women who were found to be in this group (1b) would not now be started on hypnotics. With regard to prescribing, since barbiturates will not now be used when hypnotics are required, it is obvious that figure 2 will change completely.

Advantages to trainee

The trainee felt that this study was a maturing experience and taught lessons in general practice that could not easily have been learnt otherwise.

(1) It was encouraging to find that a practical problem of management of wide occurrence could be investigated within the resources of a single practice.

(2) The framework of a scientific paper was a useful aid to such a piece of research. 'Why did you start, what did you do, what answer did you get, and what does it all mean anyway?' (Hill 1965).

(3) The setting up of an investigation, reading the literature, examining the patients and working on the results until a logical presentation was achieved, developed clearer thinking and assurance.

(4) The value of a certain amount of structure in each consultation was discovered. During the interviewing the planned format was helpful in building trainee confidence in relationships with patients, and in providing information from a framework within which patients felt secure and from which they were more prepared to confide their troubles.

(5) The application of scientific method—by description, comparison, drawing of conclusion, hypothesis and verification by experiment—was beset by certain difficulties in general practice. A behavioural science less susceptible to statistical analysis than many specialized branches of medicine requires more accurate description so that the work of different observers can fairly be compared.

Summary

A review of repeat prescribing of hypnotics in an urban practice is reported. This revealed a position which was unsatisfactory in the light of recommendations based

on recent research into the effects of these drugs. A diagnostic classification is suggested, adoption of which would improve clinical management of patients in whom hypnotics might seem to be indicated.

This small research study was treated as an educational exercise within the traineeship scheme and advantages of such an approach are outlined.

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The Village Doctor

What a different sort of man is the village doctor of the present day from the one we can remember fifty years ago. Of course there are degrees—some able, some incompetent; some skilful, others butchers; some well-read, others with only an elementary smattering of knowledge of the healing art, and of drugs. Now, as then, there are differences and degrees, but they are not so marked as formerly. The very able gravitate to the towns, and there can be none utterly incompetent . . .

Formerly exact uniformity in the way of thinking, speaking, dressing, acting, was not insisted upon, and the village doctor was not infrequently an oddity. He affected the oddity—to be a little rough and domineering, he put on an acerbity of manner that belied his real sweetness of temper, assumed a roughness at variance with his real gentleness of heart. . . .

They could generally tell a good story. They were inveterate gossips—knew all the ins and outs of all the families in every grade of life within their beat, and though they kept professional secrecy, were nothing loth to tell a tale, where not within the line of professional responsibility. And they were such delightful humbugs, also, veiling their ignorance so skilfully, with much explanation in grandiose terms that meant nothing.

S. BARING-GOULD.
An Old English Home, 1898. P. 244