PRESCRIBING IN GENERAL PRACTICE

PRESCRIBING in general practice is remarkably difficult and has not been adequately studied. Its origins are rooted in medical history, and the apothecaries' right to give medical advice at all depended on their supply of drugs, as was established in the test case in the House of Lords in 1703.

Osler noted that the desire to take drugs distinguished man from animals and this effect is compounded by the doctor's own desire to prescribe. These two pressures produce a prescription at about two thirds of all consultations in general practice.

Two of the great failures of British Medicine have been the delay in establishing departments of clinical pharmacology in the regions, and the failure to realise that the findings of clinical pharmacology cannot readily be translated into the social pharmacology of general practice.

Unlike hospital practice, domiciliary doctors can never be sure that their patients are taking the treatment at all. Patients have been known to change the dose, change the drug, change the bottle, hoard the drug, and, perhaps most dangerous of all—to give it to their friends.

The Department of General Practice at Aberdeen has pioneered research on prescribing, and Howie (1972) in a paper of major importance has shown that the prescribing decision in general practice is more related to the practitioner's findings on examination than to the diagnostic label.

Prescribing in general practice is much more influenced by the doctor's knowledge of his patient and the predicted pattern of behaviour. Similarly the result is greatly influenced by the patient's expectations and trust in the doctor—the placebo effect occurs maximally and can be harnessed by a skilled prescriber for the patient's good. Paradoxically, at a time when science has produced more potent chemotherapeutic agents than ever before, the importance of the doctor–patient relationship is coming into its own. This is partly because Balint (1967) showed that whatever the agent used, the most important drug in general practice is the doctor himself.

National Health Service prescriptions provide a running commentary on general practice, revealing both triumphs and failures—sometimes simultaneously. The dramatic reduction in prescribing chloramphenicol and the elimination of amphetamine prescribing in Ipswich can be contrasted with the thousands of prescriptions for both drugs which still occur in other areas.

Psychotropic drugs

One in three of all prescriptions written by general practitioners is now for a drug countering anxiety. Parish (1971) in his classic study in this *Journal* gives some frightening graphs and reports a 50 per cent increase in the past decade. Are 3,000,000,000 doses a year all really necessary?

Repeat prescriptions

Any therapeutic intervention may be more significant in general practice than in hospital because the prescription may have to be repeated. All doctors providing con-

tinuing care learn to their cost that drugs that were so easy to start sometimes prove singularly hard to stop. One of the new principles emerging is the art of avoiding habituation to hypnotics.

The book *Treatment or Diagnosis*? (1970) suggests that the pattern of regular repeat prescriptions may constitute a diagnostic syndrome in itself.

One of the new problems not shared by the hospital service, is the way patients can now collect repeat prescriptions *without having seen the doctor*. The average doctor may now allow this as often as ten times a day. Is this desirable? Is it safe? What alternative would help the patient more?

Mass medication

The idea that the entire population might eventually take a drug is no longer ridiculous. One in five of all British women of child-bearing age is now taking oral-contraceptive steroids. One in six of the whole population is using a psychotropic drug, and diseases like diabetes, schizophrenia, hypothyroidism, epilepsy and pernicious anaemia all have a prevalence of about one per cent of the population, all are increasingly being diagnosed in general practice, and all require long-term medication.

Patients today more readily seek a drug solution to the everyday problems of life and a growing number now ask for drugs to make their children sleep or to prepare themselves for obstacles like driving tests.

General practitioners are themselves partly responsible for these trends and partly prisoners of them. Accessibility has been one of the great triumphs of British general practice but once the doctor is involved, the expectations of the patient and the training and traditions of the doctor favour the giving of a prescription. As Parish states, "it is easier to give a prescription than to give advice".

Improving the standard of prescribing

Much can now be done to improve the standard of prescribing. First, it is necessary to recognise the size of the problem and the extent of the challenge. Why is the subject of general-practitioner therapeutics so rarely tackled at postgraduate medical centres? Practitioners are still reticent at reporting what drugs they use and why (Wilson, 1971; Patterson, 1972).

Doctors can learn a lot from reviewing periodically all their own prescriptions and discussing these with partners and colleagues. Much can be done with carbon copies and Wells shows today what can be achieved in the hypnotic field alone.

There are few publications giving an unbiased view of drugs, but *Prescribers' Journal* is supplied free in the National Health Service and *Drug and Therapeutics Bulletin* published fortnightly by the Consumers' Association is short, useful and worthy of support.

Reporting side-effects and drug interactions is critically important since as many as one in ten of all hospital admissions to medical beds are caused by drug use. General practice generates about 100 reports a week to the committee on the safety of drugs, but far more are needed: completing these forms is the hallmark of prescribers who take a pride in their work.

Packaging is important. Why is strip packaging not used more often? How many lives would be saved if child-proof containers were always used?

Finally, the fragmentation of the specialties means that there is a growing responsibility for the generalist to co-ordinate his patient's medication. Hospitals should only prescribe in emergencies and it is in the patient's interest to receive all prescriptions from one doctor.

The future

The future in therapeutics is relatively bright although the price of new and effective drugs will probably include unexpected side-effects. A new precision in prescribing will become possible with the advent of biochemical measurement of drugs in the blood. A fixed dose of imipramine may produce a thirty-fold variation in plasma levels in different patients, so the 'slow responders' of today may prove to be the 'fast metabolisers' of tomorrow.

With drugs like steroids, anticoagulants, beta-blockers, mono-amine oxidase inhibitors and cholesterol-lowering agents already being used in general practice, it is clear that at the stroke of a pen a patient's whole metabolism can be fundamentally altered. Indeed the decision as whether or not to start an apparently fit and symptom-free patient on cholesterol-lowering drugs because of persistent elevation of the plasma lipids obviously requires both knowledge and judgment.

Prescribing in general practice is both a privilege and a responsibility.

REFERENCES

Balint, M. (1967). *The Doctor, His Patient and the Illness.* London: Pitman.
Balint, M. *et al.* (1970). *Treatment or Diagnosis.* London: Tavistock Publications.
Howie, J. G. R. (1972). *Journal of the Royal College of General Practitioners*, **22**, 310–315.
Parish, P. A. (1971). *Journal of the Royal College of General Practitioners*, **21**, Supplement No. 4.
Patterson, J. S. (1972). *Journal of the Royal College of General Practitioners*, **22**, 191–194.
Wilson, D. J. (1971). *Journal of the Royal College of General Practitioners*, **21**, 558.

PRESENT STATE AND FUTURE NEEDS OF GENERAL PRACTICE

THE third edition of *Present State and Future Needs of General Practice* is published today and copies are being distributed with this issue of the *Journal*. This is number 16 in the *Reports from General Practice* series which consists of papers written, commissioned, or approved by the College.

Of this series, the previous editions of *Present State and Future Needs of General Practice* have been among the most popular and thousands of copies have been sold. Several now appear on the required reading lists of universities all over the world including the Johns Hopkins University of the United States.

This edition will prove equally popular and Dr John Fry, who has done much of the work, can be congratulated on the result. Not only have many of the important facts and figures been brought up to date but the setting of general practice in society in different countries is considered.

One of the recurring themes throughout this volume is the need for more data and, by identifying some of the key subjects, this edition may promote further research on and in general practice in the future (*see Book reviews*).

Dr W. A. R. THOMSON

DR W. A. R. THOMSON has been editor of *The Practitioner* for nearly 30 years. He has now resigned, and we would like to thank him for all the help he has given the College since its earliest days—ever since the Steering Committee was called together.

His journal published the Steering Committee's report and also the College's first 19 *Annual Reports*, so that these have been available for reference in all the more