Prescribing in general practice

Doctors who treat the symptom tend to give a prescription; doctors who treat the patient are more likely to offer guidance.

Apley (1978)

A CYNIC is reported to have said that it was not until the first ten years of the twentieth century that the average patient stood to gain from the average prescription from the average doctor. Hence the history of effective therapeutics is only 70 years old and the unusual scientific, ethical, and practical problems of prescribing are relatively recent.

General practitioners' prescriptions are a fascinating topic for research because they are easily measured, costed, and analysed. Since they are issued in about two thirds of consultations they offer a good starting-point for understanding consultations in general practice.

Scientia and caritas

The traditional view of the medical prescription is that it is a scientific process in which a scientist selects a chemical on rational grounds to achieve a scientific solution to a pathological problem. Whilst the ever increasing range of pharmaceuticals and the never ending complexity of their interactions and variations will remain a permanent challenge to each generation of clinicians in general practice, the conventional view of prescribing as a purely scientific process can no longer be sustained.

On the contrary, the equally complex threads of what can be called the sociological or symbolic use of drugs—the *caritas* of prescribing—need also to be understood. Since time immemorial the doctor's medicine has had a significance far beyond its chemical composition, as witnessed by the almost universal placebo effect. Balint and his colleagues (1970) analysed repeat prescriptions and showed that these as often reflected the doctor-patient relationship as the pathology of the condition being treated. In understanding prescribing in general practice it is necessary not only to establish scientific therapeutic criteria but to establish the behavioural significance of the use of drugs in the medical interaction.

Expectations

The cost of drugs prescribed in general practice has continued to rise ever since the introduction of the National Health Service and it now exceeds the cost of the doctor's own income and professional expenses combined. The interests of governments, which foot the bill, and pharmaceutical companies, which depend on general practitioners for much of their profits, thus combine to bombard the 25,000 prescribers with ever increasing pressures to conform to one policy or another. The literature is growing. Parish's (1971) supplement, followed by the report of the symposium on the medical use of psychotropic drugs (*Journal of the Royal College of General Practitioners,* 1973), and *Prescribing in General Practice* (Medical Sociology Research Centre, Swansea, 1976) form a trio of publications which have illuminated this scene.

Simultaneously Illich's (1974) challenge to the medical profession, and the concern felt in society about doctors' use of drugs, means that increasingly the general practitioner is asked to decide not merely which drug to choose but whether it is necessary to prescribe at all.

Furthermore, the significance of the use of drugs in relation to patient and doctor expectations is also becoming better understood. The classic doctor's defence that "patients expect prescriptions" appears to have little evidence to support it (Stimson, 1976) and practitioners are becoming increasingly aware that using drugs, especially for minor ailments, may breed dependency on doctors and expectations of further use of prescriptions when similar problems recur. Especially in child care and in life problems, practitioners are listening more and prescribing less. Indeed, another cynic has said that the main purpose of the prescription is to close a consultation! Certainly the use of tranquillizers has been questioned increasingly and it is possible that a prescription for tranquillizers can be regarded as something of a therapeutic failure. A prescription for diazepam ('Valium') is beginning to look like the doctor's excuse for not listening to the spouse or family.

Future trends

Future trends in general-practitioner prescribing are gradually becoming clearer. The first is an increasing emphasis on the quality rather than quantity of prescribing. General practitioners have never been so interested in what they are prescribing and why. More and more local groups of practitioners are choosing to

analyse their prescribing habits, particularly in partnerships, trainer groups, College groups, and symposia, and reasons for taking prescribing decisions are increasingly discussed.

The Department of General Practice at the University of Aberdeen has an outstanding reputation for carrying out important studies on general-practitioner prescribing and it was Howie in 1972 who first showed that general practitioners' prescribing decisions are related more to the medical history and physical signs than to conventional, pathologically based diagnostic labels. Later (1976) he showed that prescribing decisions in the treatment of sore throat reflect information about personal and social factors regardless of the objective appearance of the throat. Now Taylor, in this issue today (p.531) has begun to develop an index of quality and to tease out a logical system for analysing prescriptions.

Another recent trend is the growing involvement of the patient, in terms of his knowledge and understanding, his choice, and his criticism. It is certain that topics of public concern today, such as the writing of prescriptions by receptionists, which is studied by Jones in this issue (p.543), or problems about patients driving whilst under sedation, will snowball during the years ahead.

It is likely that the scientific precision with which many drugs are prescribed in general practice will increase through biochemical monitoring of blood levels, just as anticoagulants may be titrated against serum prothrombin times and anticonvulsants adapted in the light of their blood levels, so that many more drugs are likely to become susceptible to more specific monitoring in general practice.

Two further principles stand out. First is the growing concern of Government, public, and profession with adverse reactions to drugs. Whether it be oral contraceptives on the one hand, or the most potent new chemical on the other, the public is becoming increasingly aware that a price has to be paid for all major chemical revolutions and that the absolutely safe drug never has, and probably never will, exist.

Secondly, an immediate challenge to general practice is to improve the quality of its records and in particular the quality of the recording system for drugs prescribed. Many practices are introducing drug record cards or systematizing the information about drugs prescribed. With medicine increasingly fragmenting and ever more complicated drugs affecting ever more systems of the body, the need for the generalist to co-ordinate and control all prescriptions becomes clearer. Here indeed lies one of the great and growing responsibilities of general medical practice and one which will require increasing study in the years ahead.

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Safeguarding personal information

BURIED among the mass of press releases supplied by various government departments in recent months is one from the Department of Health and Social Security (DHSS) of fundamental importance to the future of medicine in Britain. On 27 April 1978 the DHSS issued a press release from the Child Health Computing Committee enunciating a policy which has subsequently been confirmed by Mr Roland Moyle, Minister of State for Health, in the House of Commons (Moyle, 1978).

This one-page announcement summarizes the results of an important battle that has been raging behind closed doors in various professional associations and government departments in this country. It is interesting and instructive to trace the origins, analyse the principles, and describe the resolution of these conflicts.

Fragmentation of the specialties

The first general trend was the growing tendency for medicine to fragment into numerous sub-specialties, each of which busily engaged in extending the frontiers of knowledge within its own field. Many of these separate specialties, and especially neonatology, were increasingly concerned with factors affecting their patients' health outside the immediate technical problems of the disease. Each of these specialties in turn has gradually come to appreciate the importance of the