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# Do we need to repeat prescribe?

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**SUMMARY.** In an attempt to rationalize repeat prescribing and patient review, the whole concept of repeat prescriptions was questioned and discarded as being unnecessary. The reason for the audit and some of the benefits and drawbacks are reported.

## Introduction

**I**N an age when we are becoming more accountable for the outcome of our actions, repeat prescribing must have exercised the minds of most doctors, and my impression is that no one has the ideal answer.

Eighteen months ago I decided to tackle the problem in our four-man, semi-rural, non-dispensing practice of 9,000 patients, and after some thought and discussion of the various methods available — for example, cards held by patients to be handed in when repeats are required, or post-dated carbon copies of prescriptions — I came to the conclusion that the concept of 'repeat prescribing' was unsatisfactory. My habit until February 1983 was to keep 'summary of treatment cards' in our Lloyd George envelopes, with regular drug treatment listed but not recorded when repeated. A note was handed in by the patient, the records pulled, the name and address was written by the receptionist on the prescription, and either I or one of my partners would write a variable quantity of the drug. I deceived myself that I knew my patients well enough to know what was going on and, what is more, believed that they should have some responsibility for their own illness and comply with my request to see me at regular intervals. I suspect the patients assumed the converse — that by repeating a prescription I was assuming responsibility and had applied some calculated professional thought to the further need for the drug (often far from the truth). The demand was controlled by the patient, the quantities prescribed often varied according to which doctor wrote the prescription, and the condition for which the drug was being prescribed was sometimes hard to identify (at this time we had just started sorting and summarizing our notes, which would make another story).

© *Journal of the Royal College of General Practitioners*, 1985, 35, 91-92.

## Aims

Intending to stop repeat prescribing altogether, I had the following objects in mind:

1. to assess the continuing need for the drug;
2. the appropriateness of the drug;
3. adjustment of dosage;
4. observation of side effects;
5. monitoring the condition for which it was prescribed;
6. providing sensible quantities.

It seemed logical that those patients on long-term medication should be given sufficient quantities to last them until their next check-up, thus saving excess prescription charges and providing a simple reminder as to when to make their next appointment — when their medication ran out.

## Method

A small recall slip stating 'would you please make an appointment with your doctor before this prescription runs out' was included with each repeat prescription for the pharmacist to attach to the container. The slip was purposefully not personalized to a doctor, as the repeat prescription was often written by the doctor who made the last entry in the notes, although he may not have been the regular choice of the patient. To allow for the initial increase in workload for consultation and discussion, I added six extra appointments per day to my normal consulting, time I hoped to save by not writing repeat prescriptions at the end of every surgery.

## Results

Because the method is used for review as well as to irradicate repeat prescribing, the outcome and benefits took several forms, some recurring and others, hopefully, non-recurring.

### *Points at random*

1. The recall slip caused occasional resentment and even panic, some patients assuming that I was intending to stop their drugs. Without exception, when I explained what

I was trying to do, it was agreed that it made sense, and many patients were glad that I was showing an interest.

2. Psychotropics and night sedatives — some patients have been weaned off these, but others seem unable to manage without them; nonetheless, I feel I know who is taking what and how much.

3. Two patients on long-term thyroxine and one patient on cyanobalamin turned out to have been put on medication for doubtful reasons, and have had it stopped.

4. Several asthmatics previously settling for repeats of oral bronchodilators and old-fashioned aerosols have benefited from newer therapies.

5. Topical steroid use has been discussed and rationalized.

6. The review of hypertension, ischaemic heart disease, etc. provided the opportunity to consider alternative drugs and once daily medications.

7. In the past I rarely saw diabetics and epileptics, other than in crisis. I now give such patients up to six months supply of their drug as appropriate to their state, then see them for review, thus generating an interest in their chronic care, checking blood levels and adjusting dosages.

8. Excessive and questionable use of analgesics proved to be a problem and in many cases the patients were given either more appropriate therapy or persuaded that their needs could be met at a domestic level rather than on prescription.

9. The administrative benefits to the receptionists have been on average 100 less records pulled and refiled every week for me alone, and the 'log jams' for repeats that occur before every public holiday have disappeared.

The main criticism of my method, particularly from pharmacists, is about the quantities of drugs I prescribe; and initially I was uneasy over that myself. But, logically, four months supply of an anticonvulsant or an anti-hypertensive is neither particularly risky to life nor wasteful, if the dosage has been well established and evaluated. After all, we give a year's supply of the oral contraceptive and large quantities of insulin without qualm, and in practice I have had no problems with the abuse of bulk prescriptions.

Before I undertook this audit I was writing 100 repeat prescriptions per week — now I write none; and I take much more care than I used to over those I do write during consultations. I make sure the dose and frequency of administration is recorded, and whenever possible use 'number of days treatment' box, leaving the pharmacist to work out quantities. Even with pro re nata medication, such as analgesics, most people have a rough idea of how many they use per day, or how long a tube of ointment lasts, and quantities can be prescribed accordingly. Most eye washes only have a shelf-life of only one month once opened but keep for a considerable time when sealed, and it is easy to judge the quantity required until review.

The only occasions when I am prepared to write prescriptions without seeing the patients is if they are going to run out of medication before they can get to see me, or for gluten-free flour, surgical appliances and dressings, and diagnostic reagents.

## Discussion

To insist upon seeing everyone for a repeat prescription is clear cut, and has an attractive simplicity, and it removes the weak links that are inherent in other methods whereby patients carry cards or keep post-dated prescriptions. To see patients at intervals determined by the longevity of their prescription may seem tiresome and theoretically wasteful, but all I can say is that I have not found it so. I am now professionally much more at ease with my prescribing and in firm control, I have spoken to the Family Practitioner Committee, the Pricing Bureau, and the Regional Medical Officer, with particular reference to the quantities on each prescription, and they have raised no objection.

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## CNS cancer in families

This study compared the occurrence of cancer in parents, siblings, and offspring of 643 patients who had central-nervous-system tumours in childhood (cases), as recorded in the Connecticut Tumor Registry, with the occurrence in parents, siblings, and offspring of 360 controls selected according to birth certificate and matched for sex, birth date, and birthplace. Overall cancer incidence was comparable in the two groups. However, 11 nervous-system tumours occurred in relatives of cases, whereas none occurred in relatives of controls ( $P = 0.0005$ ). Nine relatives of cases but no relatives of controls had cancer of the hematopoietic-lymphatic system ( $P = 0.003$ ). Nine siblings of cases but only one sibling of a control had cancer as children. Medulloblastoma and glioblastoma multiforme were overrepresented in the group of children whose relatives had central-nervous-system tumours. The actual number of cancers in the central nervous system or hematopoietic-lymphatic system in relatives of cases were compared with the number expected on the basis of known incidence rates and showed a fivefold excess.

It is concluded that the occurrence of a brain tumour in a child is a marker for an increased likelihood of central-nervous-system tumours, leukaemia, and childhood tumours in the family.

Source: Farwell J, Flannery JT. Cancer in relatives of children with central-nervous-system neoplasms. *N Engl J Med* 1984; **311**: 749-753.