working to protocols devised and agreed jointly with GPs, so that both perspectives are recognized.

There is a dearth of research relating to skill-mix in primary care. It is essential that this issue is addressed urgently to produce high-quality, reproducible information and to establish whether, for example, increased teamwork and delegation are changing the context of consultations, or are the most effective ways in which we can achieve the benefits of delegation without exposing patients to undue risk. Great care has to be exercised when designating the combination of skills that provide, at the least cost, both high-quality care and the desired outcomes for patients.[15]

The nurse practitioner role has now been systematically evaluated in the United Kingdom through the South East Thames Regional Health Authority (SETRHA) project;[16] it was found to be most effective and efficient when associated with a general practice setting. Studies have found nurses who felt they were already practising within the nurse practitioner role,[17] but what marks nurse practitioners apart from other nurses in the GP setting is their specific educational basis for practice.

It could be argued that by the time doctors have undergone professional training their vies are so entrenched that they are unwilling to develop a true appreciation of each other's roles, which hampers a 'team' approach to the care of patients. Perhaps doctors and nurses receiving education together (at the undergraduate level and while training as community nurses and GP registrars) will allow some of these barriers to be removed through improved communication, for the benefit of patients.

General practitioner now have a massive workload. In reviewing this issue it is essential that we do not simply discuss our professional territories but instead take the opportunity to look at our tasks and redefine our roles, to enable us to work together for the best for those we serve — our patients.

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References

1. Reith B. *Statement on a primary care led NHS.* London: RCGP, 1996.
2. Wilson M, Ball J, Barnett R, *et al. Medical workforce.* Report of the Task Group of the General Medical Services Committee. London: BMA, 1995.
3. Department of Health. *General practice in the National Health Service. The 1990 contract.* London: HMSO, 1989.
4. Kitwan M, Armstrong D. Investigation of burnout in a sample of British general practitioners. *Br J Gen Pract* 1995; **45:** 259-260.
5. Lenehan C, Watts A. Nurse practitioners in primary care: here to stay? [editorial]. *Br J Gen Pract* 1994; **44:** 291-292.
6. UKCC. *The scope of professional practice.* London: UKCC, 1992.
7. Stilwell B, Greenfield S, Drury M, Hull FM. A nurse practitioner in general practice: working style and pattern of consultations. *J R Coll Gen Pract* 1987; **37:** 154-157.
8. Salisbury C, Tettersell M. Comparison of the work of a nurse practitioner with that of a general practitioner. *J R Coll Gen Pract* 1988; **38:** 314-316.
9. Maynard A, Walker A. *Planning the medical workforce. Struggling out of the time warp.* Discussion paper 105. York: Centre for Health Economics, 1993.
10. Marsh GN, Dawes ML. *Establishing a minor illness nurse in a busy general practice.* BMJ 1995; **310:** 778-780.
11. Lilley E. What lies ahead for the NHS gatekeeper? *BMA News Review* 1996; **22:** 38.
12. Buchan J. Nursing shortages: a reality, and likely to get worse without national and local intervention. *BMJ* 1996; **312:** 134-135.
13. British National Formulary. *Nurse Prescribers Formulary.* London: Royal Pharmaceutical Society of Great Britain, 1995. pp. 642-644.
14. Heath I. Skill mix in primary care [editorial]. *BMJ* 1994; **308:** 993-994.
15. Buchan J. Nurse manpower planning: Role, rationale and relevance. In: Robinson J, Gray A, Elkan R (eds). *Policy issues in nursing.* Buckinghamshire: Oxford University Press, 1992.
16. South East Thames Regional Health Authority. A new insight into primary health care: evaluating nurse practitioners. London: SETRHA/NHS Executive, 1994.
17. Greenfield S. Nurse practitioners and the changing face of general practice. In: Loveridge R, Starkey K (eds) *Continuity and crisis in the NHS.* Buckinghamshire: Oxford University Press, 1992.

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Repeat prescribing — still our Achilles' heel?

GIVEN the considerable clinical and economic importance of repeat prescribing, it is surprising that there has been so little recent study of the subject. We correct this in the current issue of the *Journal* by publishing two complementary studies.

Harris and Dajda[1,2] give the grand picture, analysing what literature there is about the subject and providing the best data currently available on repeat prescribing in England in 1993, derived from data on over three-quarters of a million patients in the MediPlus database. The headline figures are that repeat prescribing accounted for 75% of items and 81% of the cost of all prescribing, and that 48.4% of all patients (and practically all patients over 75 years) were receiving a repeat prescription.

Zermansky's study[2] fills in the detail. Although he studied only 427 patients taking a total of 556 drugs, his data are drawn from randomly selected samples from a total of 50 general practices in Leeds; these themselves had volunteered from a randomly selected sampling frame. It is likely that his findings have relevance for UK general practice as a whole, and it is therefore worrying that his report is quite critical of the quality of repeat prescribing.

There is no longer any dispute that repeat prescribing is a necessary and entirely justifiable part of general medical practice. The desirable intervals for prescribing and for clinical review do not often coincide. It is usually undesirable to give a patient much more than a month's supply of a drug at any one time, but someone with mild and stable hypertension does not need clinical review at such frequent intervals. As Zermansky states, however, 'Periodic review and tight control are necessary to ensure effective treatment, minimize therapeutic misadventure and limit waste.' He examines the process of repeat prescribing according to a very useful model, which covers three tasks:

- Production: usually the responsibility of a receptionist

- Management control: usually the responsibility of the practice manager, and
- Clinical control: entirely the responsibility of doctors.

In respect of clinical control in particular, Zermansky found a number of clear deficiencies, including no evidence of a clear authorization decision in more than half of prescriptions, and no evidence of a periodic review in the past 15 months for 72% of repeat prescriptions. The phrase 'no evidence' is important because it is more than likely that there were many instances in which these tasks were completed but not recorded. The practice of 'carrying information in our heads', formerly the hallmark of the archetypal family practitioner, is no longer acceptable. The process of care should be explicit and all decisions of importance should be recorded. Ideally, another doctor ought to be able to take over care without the patient 'seeing the join'. It is also in our professional interests to ensure good documentation because we do much more for the patient than is usually apparent from medical records; although it may never be possible to record all that we do, the more we do record, the more readily good quality of care will be apparent.

Harris and Dajda point out that, while practice computers have significantly increased the scale and ease of repeat prescribing, they can also be used to prevent some of the consequent dangers. The main lessons to be drawn are that the practice must control its system according to explicit rules, and that, at the very least, the standard should be that the medical authorizations for initiation and subsequent continuations after review are clearly documented for every repeat prescription.

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References

1. Harris CM, Dajda R. The scale of repeat prescribing. *Br J Gen Pract* 1996; **46:** 649-653.
2. Zermansky AG. Who controls repeats? *Br J Gen Pract* 1996; **46:** 643-647.

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