



Repeat prescribing = hassle

I did my GP trainee placement in 1989. When I started, we were using fountain pens on Lloyd George cards. By the time I left, there was a hard disc and printer on every consulting room desk and we were just discovering the model-reality gap between the structured data fields on the software and the messy reality of real-world illness and its treatment.¹

One particularly dramatic change was in repeat prescribing. In the pre-computer days, the doctors all gathered round a table in the conservatory after morning surgery for coffee and cake. In the middle of the table were several boxes of patient notes, each with a handwritten prescription affixed to it with a rubber band. We worked through them, initiating discussion about requests that surprised or concerned us.

Computerisation saw this daily communal ritual abolished as a paper-focused inefficiency that belonged in a bygone era. We signed our little piles of computer-generated repeats alone in our rooms. Most were completed quickly, but we produced a daily batch of 'pending' queries since we could no longer share our uncertainties or concerns with one another in real time. Receptionists spent less time writing out repeats by hand, although they seemed to spend a similar amount of time on the phone to the IT helpdesk.

The repeat prescribing system had become more 'efficient', but it had also become a chore and generated its own bureaucracy. Many years later, my research team studied the routines of repeat prescribing and showed that canny behaviour from receptionists to bridge the model-reality gap was the only thing that stopped the entire system grinding to a halt.²

Last month, a group of researchers published a qualitative study of the patient and carer experience of obtaining repeat medications.³ The findings can be distilled into a single word: hassle. Most patients interviewed were on 28-day repeats (a standard and 'evidence based' way of reducing practice prescribing costs). Many described how, because repeat dates came up asynchronously, they had to make two or three separate requests every month. Prescriptions often appeared with items missing that then had to be chased up.

Some participants spoke of being recalled for check-ups with the practice nurse, who told them 'one problem at a time' and restricted the consultation to the disease or body system for which that particular day's clinic was designated. One participant, who had a maths degree, described how his GP had miscalculated the number of tablets of L-DOPA for his Parkinson's disease; he now runs out every month and has to beg an extension. The sicker patients in this study spoke gratefully of community matrons who took over the hassle of obtaining repeat medication for them.

This is no way to run a 21st century health service. The fault here is not with computerised repeat prescribing but with practice-centred rather than patient-centred routines and procedures. Even the most basic GP prescribing system could be programmed and used in such a way that a patient's repeat medications all fall due on the same date. Those whose long-term conditions are stable should not be subjected to a power struggle every 28 days to renew their supplies. Medication review check-ups that fragment the patient into his or her component diseases or body systems should surely be outlawed.

The lesson I have learned from Wilson and colleagues' paper is that a medication check consultation should not end when the clinician has established that the disease markers are within expected parameters and side-effect profile acceptable. The consultation should end only when there is nothing further that can be done to reduce, for this patient, the *hassle* of obtaining repeat medication.

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