Editor's Briefing

DO NO HARM

Over 1 billion prescriptions are dispensed each year in England alone, at a total net ingredient cost of approaching £9 billion. This equates to an average cost per head of population of over £160: 90% of these prescriptions are free of charge. The most frequently prescribed group of drugs are those used for treating diabetes.[1] Almost 7% of hospital admissions are caused by adverse drug reactions, and approaching 10% of acute hospital prescriptions contain prescription errors. Adherence to medication prescribed for long-term medical conditions falls to about 70% at 10 days after initiating the prescription, and can be as high as 50%. Half of these patients realise that they are taking their medication incorrectly.[2] Antibiotic over-prescription and rising microbial resistance threatens a new dark age of uncontrollable sepsis … little wonder that patient safety, antibiotic stewardship and the quantification of the harms, as well as the benefits, of medical interventions are high on the educational and regulatory agendas.

This month's *BJGP* reflects on some of the dilemmas and uncertainties associated with prescribing, from an examination of the rate and appropriateness of antibiotic prescribing during office hours compared with out-of-hours prescribing, to the opportunities to improve specialist drug prescribing in primary care, and an exploration of why the self-management of chronic pain in primary care can be so challenging. An observational study from Hong Kong examines the medical and psychosocial factors associated with antibiotic prescribing, while a randomised controlled trial from the Netherlands fails to find therapeutic benefit of topical betamethasone in patients with chronic chilblains. An important comparative study from East London indicates the opportunities for substantial cost savings by reducing the number of liver function tests ordered in managing patients taking statins, while the place of vitamin B prescribing in patients who are alcoholics is the subject of a *Debate and Analysis* article.

At the core of this is the need to measure benefits and harms and to be able to quantitate, communicate, and minimise risks. Three thought-provoking articles deal directly with this. Juliet Usher-Smith and colleagues find support among primary care professionals for the incorporation of personalised estimates of cancer risk in the

general practice consultation, as the basis for lifestyle modification. In an interesting study of simulated general practice consultations, Olga Kostopoulou and colleagues report that a computerised decision support system, linked to the patient's electronic health record to generate a list of diagnostic possibilities early in the consultation, is associated with significantly increased diagnostic accuracy. And in a head to head debate, Terry Kemple, RCGP President, locks horns with Adrian Root and Liam Smeeth on the use of Numbers Needed to Treat (NNTs) and Numbers Needed to Harm (NNHs). Kemple sees them as the essential underpinning of informed and wise decision-making by patients, while Root and Smeeth question the strength of the evidence base underlying these measures, and both doctors' and patients' abilities to understand them.

In *Out of Hours* Ben Jackson describes his practice's Brexistential crisis, and Mary Lowth reflects on Donald Trump and whether torture works. James Sherifi reports on the intercultural differences he experienced in the care of a relative with a catastrophic brain stem infarction, and we review a new book about clinical reasoning. Please think about contributing to *Out of Hours* yourself.

Roger Jones,
Editor

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