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General Medical Council consultation on Review of ‘Good Practice in Prescribing Medicines’

1. I write with regard to the GMC consultation on the review of ‘Good Practice in Prescribing Medicines’.

2. The Royal College of General Practitioners is the largest membership organisation in the United Kingdom solely for GPs. Founded in 1952, it has over 42,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. We are an independent professional body with enormous expertise in patient–centred generalist clinical care. Through our General Practice Foundation, established by the RCGP in 2009, we maintain close links with other professionals working in General Practice, such as practice managers, nurses and physician assistants.

3. The College welcomes the opportunity to respond to this consultation. The great majority of the content of Good Practice in Prescribing Medicines remains accurate, well-presented and up-to-date. However we hope that the comments below, produced in consultation with the RCGP Council and prescribing experts, will assist with the review process to make it even more useful.

General Comments
Prescribing to satisfy patients' expectations: The volume, quality and diversity of information available to patients today is far greater than previously. In many instances, patients, or their relatives, are able to ask more probing and incisive questions about a set of symptoms, and possible treatments than they have been able to in the past. This is also the case for contraindications, side-effects, dosage and duration of treatment. For acute conditions this is less of an issue, but for chronic or long-term conditions, the amount of information that needs to be exchanged has increased substantially. This increasing information transfer requires doctors to spend longer with individual patients, resulting in less time for their other patients. The GMC might usefully comment on this and suggest appropriate approaches for working with better-informed patients, as well as for avoiding or dealing with complaints when patients are not prescribed the medicines that they feel they ought to be.

This may be of particular importance in the likely context of future GP commissioning in England – there is concern that complaints from patients, made aware of alternative treatments that are available, may increase if GPs are seen to profit from prescribing decisions. It would be useful, in this context, to provide guidance on the individual prescriber's responsibilities with regards to locally agreed prescribing practice.

Prescribing at the recommendation of professional colleagues, including nurses and private doctors, and for overseas patients: This can be linked to the point at paragraph 26, that responsibility lies with the person signing the prescription. It is a common misunderstanding amongst community and acute sector clinicians that a consultant recommendation negates the responsibility of the primary care prescriber signing the prescription.

With regards to private clinicians, they should ensure that recommendations to NHS prescribers are consistent with current best practice / national guidance. If divergent from this, they should prescribe privately and not request continued prescribing on the NHS. Further elaboration may be helpful regarding 'episodes of care' for private patients.

Quality and timeliness of discharge summaries: This is a useful area to develop further, as these are recognised as a problem in some areas – discharge summaries should include the reasons for the discontinuation of any medications in hospital. See also the note on paragraph 27.

Sharing information to improve safety: There could be mention of GPs recording medications issued elsewhere on their clinical systems, so that they are considered by the decision support software that checks for contra-indications and drug interactions. The same applies for over-the-counter medication taken regularly by the patient.
It would be useful for the clinical indication to be added to dosage instructions, so that it is clear why a patient has been prescribed a particular medication.\(^1\)

**Comments by paragraph**

**Paragraph 5(c):** It might be worth inserting a line or paragraph here about any special procedure that may be necessary in prescribing for a patient with a learning disability or other disability.

Also, it may be useful to mention the need, where patients are expected to administer their own drug usage, to include pharmacists in prescribing plans, since they have an increasingly important role in supporting such patients in their community.

**Paragraph 12:** A reference to GMS guidance\(^2\) on excessive prescribing may be useful here.

**Paragraph 14:** As argued in the response you will have received from RCGP Scotland, there should be clearer guidance and more understanding here of the particular situation for prescribers in remote and island communities, for whom it may well be necessary to prescribe medication to members of family or other close associates in other than emergency situations.

**Paragraph 20(b):** It may be useful to be more specific about the ‘other sources’ of information for the evidence base on off-label prescribing. For example, this could read ‘should be on the advice of the BNF, cBNF or regional or national body who are independent and have reviewed the evidence.’

**Paragraph 25:** There may be a case for an additional clause here about shared care. This might read: ‘Where prescribing and patient care is shared between specialist and community via a shared care agreement (e.g. amiodarone, methotrexate), clinicians must ensure that they fulfil their relative responsibilities. This should include a systematic approach to checking adherence, reminding patients to report potential side effects, maintaining registers and audit to ensure safe prescribing, etc…’

**Paragraph 26:** As described in the response from RCGP Scotland, there are cases in which prescribers are placed under pressure by secondary care doctors to prescribe

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\(^1\) For a description of clinical indications, see [http://clinicalindications.com/](http://clinicalindications.com/)

medicines with which they may not themselves be fully familiar. Current practice is variable, and clarification of responsibilities in this area would be useful.

**Paragraph 27:** This section could have a brief note for hospital prescribers to advise the patient’s GP of the reason for prescribing as well as whether the medication is a short course or if it needs to be continued by the GP, and if so for how long. It is important that the information is provided to the GP in a timely manner and a copy given to the patient (often it can take weeks before the outpatient letter is received). When a patient is discharged from the hospital it is important for the GP to be advised of any changes in medication in a clear and consistent manner: i.e. *Medication started (clinical indication and if it's to continue and will need to be prescribed by the GP); medication stopped together with reason for stopping.*

**Paragraph 32:** This needs significantly more detail and emphasis on staff training to ensure safer prescribing. Each repeat prescription needs to be monitored and issued at the appropriate interval to ensure that the patient is complying with the dosage instruction and that the practice is monitoring frequency of issue of medication. The additional bit here could be for prescribers to ensure that each prescription item has an appropriate dose and quantity to ensure that the patient has sufficient medication before the next request interval. There could also be a section on which members of staff would be allowed to add and edit repeat medication and to ensure that any non-prescribing staff doing this work would have the appropriate training.

**Paragraph 33:** Another advantage of repeat dispensing, which may be worth mentioning here, is that it can help improve patient compliance.

**Paragraph 36:** This could also state that you should record the length of the repeat dispensing course and when the next prescription is due so that additional medication is not issued accidentally to the patient.

**Paragraph 39:** We suggest that the GMC may like to consider specific reference here to the Electronic Prescription Service and how good prescribing might apply in this area.

It may be worth noting here that it is highly likely that there will be an increasing number of remote consultations using the telephone or electronic communications, making this section one of increasing significance.

**Paragraph 40:** This could do with some additional detail for the situation where a doctor is remotely prescribing for a patient in nursing care, at a hospice or care home. It would specify that the doctor should speak with the patient or the registered nurse caring for the patient to establish the information required, and that the doctor should ensure that
his/her advice is understood by confirmation of any instructions by fax or email before any administration; or, in the event this is not possible, that a second nurse should be asked to repeat back the instructions - this may be the case if the drug is to be administered from a stock of drugs and does not require a separate FP10 before being given.

4. We gratefully acknowledge the contributions of the RCGP Council and our prescribing experts in formulating this response.

Yours sincerely

Professor Amanda Howe
Honorary Secretary of Council