GMC consultation on Good Practice in Prescribing and Managing Medicines and Devices

1. I write with regard to the GMC consultation on Good Practice in Prescribing and Managing Medicines and Devices.

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, and we have provided answers to the individual questions below.

4. As a preliminary, we note the highly prescriptive nature of this document – the repeated use of ‘you should’ or ‘you must’ sets a standard of excellence that even our prescribing experts feel would be very unlikely to be reached by any doctor. Specific examples would be the difficulty for any doctor in keeping up with all the guidance produced by NICE, and the reality that at present only a tiny proportion of adverse drug reactions are reported. The language describes the ‘perfect prescriber’,
and we would be concerned that this might conceivably be misused in a court of law against otherwise entirely competent doctors.

5. It is suggested that an alternative approach might be to describe the attributes of a good prescriber, outlining a range of behaviours from good to poor with the implication that better performing doctors exhibit many of the good behaviours. The document might then be seen as aspirational rather than prescriptive.

**Answers to specific questions:**

**Q1. Do you think it would be helpful to define ‘prescribing’ in the guidance?**

The views of our respondents varied on this, but most felt that it was not necessary to provide a definition, but it might be useful to stress that the document covers not only the act of prescribing, but also a range of other activities involved in medicines and device management.

**Q2. Do you have any other comments on the About this guidance section?**

The section is broadly clear and appropriate. However, it is noted that more detailed advice would be welcomed around point 1.3j and the need to reconcile making ‘good use of the resources available to you’ with 1.3b and 1.3c requirements to use treatments that ‘serve the patient’s needs’ ‘based on the best available evidence’. Given current and future financial pressures, doctors may well be faced with local guidance that requires them to limit (i.e. ration) the resources they use and, particularly where evidence is limited or open to doubt, prescribe treatments that are not the best possible to serve the patient’s need. GPs are conscious of being increasingly vulnerable to complaints from dissatisfied patients, and more thorough guidance from the GMC here could be invaluable.

**Q3. Do you think it is reasonable, at paragraph 11, to expect those to whom doctors delegate responsibility for dispensing medicines to be registered with or trained to the standard that would be required by the General Pharmaceutical Council?**

This is clearly a source of some tension between the General Pharmaceutical Council and dispensing physicians. Most of our respondents do feel that this is reasonable, but one suggests that dispensing physicians might reasonably ask their staff to prescribe if the physician is satisfied that those staff are safe and competent and the physician takes full responsibility for his or her staff’s actions.
Q4. Do you have any other comments on the *Keeping up to date and prescribing safely* section?

With regards to the British National Formulary (BNF), to be ‘familiar’ with this is quite a challenge. Perhaps a better statement would be to say that prescribers should consult the most current edition of the BNF when appropriate.

Also, paragraph 10 implies that prescribers should take account of guidance from NICE and from Scotland, Wales and Northern Ireland, which is surely not what is meant. Perhaps this could be rephrased to ‘clinical guidelines published by the appropriate national body’.

Q5. Do you agree with the advice at paragraph 12 on prescribing to meet patients’ identified needs?

Our respondents have identified likely exceptions to this – where prescribers may adjust medication frequency to suit district nurses or carers, such as prescribing once a day antibiotics or dressings as this is more practical; or the carer may be disabled themselves and the prescriber will try to simplify treatments.

Q6. Do you think the guidance at paragraphs 13 to 16 on doctors prescribing for themselves and those close to them is appropriate?

There may need to be a distinction between treatment and prescribing here – ie basic first aid treatment, or paracetamol for a headache would be acceptable, but prescribing except in acute, one-off circumstances would not. Perhaps there should be a list here, akin to the nurses’ formulary, of which medicines might appropriately be prescribed in these circumstances.

Q7. Do you have any other comments on the *Need and objectivity* section?

No.

Q8. Do you think pharmacists and other healthcare professionals are well placed to provide patients with the information, advice and services suggested in paragraph 22?

On the whole we agree, and of course it makes sense to make use of all resources to support patients. However, there is an obvious danger here of patients receiving a wide range of advice. There is no mention here of information sharing, and what responsibility GPs have when others (e.g. pharmacists) have given patients advice. It needs to be clarified that GPs can only be expected to act on information that they have been given.
Q9. Do you have any other comments on the *Consent to prescribe* section?

We would note the constraints of the standard doctor-patient consultation – time pressures mean it may not be possible to achieve everything listed here, so that the guidance is effectively idealised rather than realistic.

Perhaps also the guidance should direct doctors to the mental capacity act – to note that, if a competent patient, fully informed about a medication, refuses to take it, their doctor must respect such a decision.

Q10. Does the guidance at paragraph 24 accurately describe the information that should be provided with referrals?

Yes.

Q11. Do you have any other comments on the *Sharing information with colleagues* section?

The sharing of information between consultants and GPs has been a longstanding source of difficulties, with GPs complaining of discharge summaries that only list the medication changes and not the full reasons for the prescription – diagnosis, investigations carried out, how long the medication should be taken for, dosage instructions etc.

Q12. Do you have any comments on the *Prescribing at the recommendation of a professional colleague section*?

The document should be explicit in criticising ‘budget-shifting’, where the onus to prescribe is shifted to the GP for purely financial reason.

Delegation of prescribing (e.g. from consultant to GP) can put the delegatee in a difficult position, under pressure from the patient but without possessing all the facts. It is essential that the recommending doctor must not delegate prescriptions for immediate use (e.g. antibiotics) as this puts unrealistic pressure on the prescriber. At the very least, the recommending doctor should provide contact details so that the delegatee can check the prescription if necessary.

Q13. Do you have any comments on the *Shared care prescribing* section?

In practice doctors will follow local protocols which they may not have had input to, and in which cost is quite likely to play a part – aspects of this section are therefore quite
unrealistic. Our respondents also felt that paragraph 35 is unclear and needs re-phrasing.

**Q14. In addition to those mentioned in paragraph 38, are there other organisations to which reports of medicines-related adverse incidents or near misses should be sent?**
The NPSA has had an important role in this area – they are to be disbanded, so which organisation will pick this up?

**Q15. Do you have any other comments on the Raising concerns and reporting adverse incidents section?**

It is noted that many health professionals are not aware of the National Reporting and Learning Service – the opportunity could be taken here to give professionals, particularly GPs, more information about this.

It is right that the GMC encourage doctors to inform patients about how they might report suspected adverse drug reactions (ADRs) to the MHRA. We query the use of ‘should’ here, as this is something which, in practice, is rarely done at present (see our opening remarks). If the GMC is giving this advice, it should also make it easy to fulfil by providing information such as the following:

*Members of the public wishing to know more about patient reporting to the Yellow Card Scheme, including how to make a report, can find out from the following website [http://yellowcard.mhra.gov.uk/](http://yellowcard.mhra.gov.uk/). Alternatively, Yellow Card report forms are available from many community pharmacies or by phoning the National Yellow Card Information Service 0808 100 3352 (10am to 2pm Monday-Friday).*

**Q16. Do you have any comments on the Repeat prescribing and prescribing with repeats section?**

This is a useful reiteration of guidance. It might be worth noting that, in particular, early requests for repeats may indicate overuse – a problem with hypnotics, opioids etc.

**Q17. Do you have any comments on the Reviewing medicines section?**

We would be interested to know if there is evidence to show that pharmacist medicine reviews ‘can help improve safety’ etc – since of course these reviews cost the NHS extra money.
In this section the GMC might also mention the need for blood test monitoring, where appropriate, at intervals recommended by authoritative sources such as the British National Formulary.

**Q18. Do you think the draft guidance on remote prescribing represents a reasonable balance between patients’ autonomy and safety?**
Our respondents expressed significant reservations about prescribing remotely, particularly online, with responses varying from calling for an outright ban (especially on overseas prescribing, which is seen as unjustifiable) to asserting that it can never be a replacement for standard monitoring and should therefore only be used in the short term.

**Q19. Do you think we should give advice on the remote prescription of Botox® and similar treatments?**
Yes. We have major reservations about the appropriateness of this practice – it avoids all the requirements for the clinician to directly assess a patient’s need.

**Q20. Do you have any other comments on the Remote prescribing via telephone, video-link or online section?**
In relation to paragraph 52, it should be noted that many care homes do not have nurses. Communication should therefore be with ‘care home staff responsible for the administration of medicines’.

We believe it is important to reiterate in this section that patients should always have the opportunity of a face to face consultation, and that video, online or telephone should never be seen as replacing (as opposed to supporting) this.

**Q21. Do you agree with the draft guidance at paragraph 58 that doctors can prescribe off-label or unlicensed medicines if satisfied, on the basis of authoritative clinical guidance, that it is as safe and effective as an appropriately licensed alternative’?**
Yes, we do – it may be useful, though, to specify what counts as ‘authoritative clinical guidance’ in paragraph 58a – such as NICE guidance or the BNF.

**Q22. Do you agree with the guidance at paragraph 60 that it may not be necessary to draw patients’ attention to the licensing status of medicines routinely used off-label and for which there is authoritative clinical guidance?**
Yes, we do agree.
Q23. Do you have any other comments on the Prescribing off-label and unlicensed medicines section?

No.

Q24. Do you think we have identified the main conflicts of interest relevant to doctors' prescribing?

Yes, though it may be worth reiterating here that dispensing is a legitimate part of many self-employed GPs' businesses.

Q25. Do you have any other comments on the Conflicts of interest section?

No.

Q26. Do you have any comments on the Sports medicine section?

No.

Q27. Do you think the draft guidance contains the right level of detail?

We agree that it is about right, though our respondents felt that it might benefit from some examples based on real world clinical scenarios. This links with the earlier point and the perceived idealism of some of the guidance.

Q28. Do you think the guidance is clear?

Yes, very clear – with the exception of the point already raised above at Q13 regarding paragraph 35.

Q29. Do you think the guidance accurately reflects the law that applies where you live or work (in the UK)?

Yes.

Q30. Can you point to any other guidance documents, information or resources that it would be useful for us to refer to in the published guidance?

As discussed above at Q9, the guidance could make mention of the Mental Capacity Act.

It would be worth mentioning the NPC guidance on appropriate management of controlled drugs - [http://www.npc.nhs.uk/controlled_drugs/](http://www.npc.nhs.uk/controlled_drugs/).
Also, the Department of Health ‘Green Book’ on immunisations, and the NHSBSA ‘Drug Tariff’, which has some prescribing guidance. The guidance could also mention the Summary of Product Characteristics as available through the emc website - [http://www.medicines.org.uk/emc/](http://www.medicines.org.uk/emc/).

**Q31.** Can you point to any important inconsistencies between the draft guidance and guidance published by other relevant organisations? These might include, for example, the health departments, the Medicines and Healthcare products Regulatory Agency or the National Prescribing Centre.

No.

**Q32.** Can you identify any changes to practice that would be needed in order to meet the standards set out in the guidance?

We would refer you to our answers to Q2, Q11, Q12, Q13 and Q15. We have already alluded to the sense that this guidance is somewhat idealised, and there may be practical situations in which entirely competent clinicians may struggle to meet its standards.

On the whole though, we welcome this guidance as helping clinicians to focus on essential standards in preparation for revalidation.

**Q33.** Do you think that applying the standards in this guidance will have an adverse impact on particular groups of people? For example, will there be an adverse impact on particular groups of patients in any of the equality strands (age, disability gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation)?

No.

**Q34.** Do you have any comments on the consultation documents?

No.

**Q35.** Do you have any comments on the consultation process?

No.

6. We gratefully acknowledge the contributions of the College’s prescribing experts in formulating this response.
Yours sincerely

Professor Amanda Howe MA Med MD FRCGP
Honorary Secretary of Council