MEDICAL PRACTICE

Personal Therapeutics

Better prescribing

FLEMMING FRØLUND

British Medical Journal, 1978, **2**, 741

Better prescribing implies that our present method of prescribing drugs is not good enough. Why is this, and can we make it any better? The more obvious and traditional reasons include lack of knowledge of medicine in general and clinical pharmacology in particular, the unnecessarily large assortment of drugs that are available, and the often unbalanced, overoptimistic, and persuasive information on drug treatment. There are, however, other aspects of prescribing that are rarely mentioned.

We have to distinguish between *rational* prescribing on a clinical-pharmacological basis and *realistic* prescribing for the individual patient. Rational drug treatment is a narrow concept that regards the patient as an object of therapeutic decisions, and is more concerned with, for example, the fate of a drug in the body than with the patient as a human being who has personal characteristics, problems, and feelings. Often a patient may not take the drug, in which case it does not help to know all about bioavailability and pharmacokinetics. This may be clever prescribing but it is not treatment.

Realistic therapeutics accepts that the patient may not take his medicine, and that prescribing is not the same as treatment. It appreciates the patient not as an object of therapeutic intentions but as a person who has to share the responsibilities of co-operation. It combines clinical and clinical-pharmacological knowledge and skill with insight into the social and psychological complexities of human beings. We doctors should think more of performing on the terms of our patients and of putting aside some of our customary reverence for our teachers and textbooks. Realistic therapeutics is an amalgam of science, experience, attitudes, and communication, and so there must be a continuous interaction between doctor, drug, and patient.

Obviously doctors must make repeated adjustments of their knowledge about disease and clinical pharmacology. They should be familiar with a reasonable number of drugs, and should appreciate that skilled use of a few alternatives may ensure that the patient takes the drug. Patients differ in their likes and dislikes, and superior bioavailability and other pharmacological properties may be of little avail if the particular preparation is unacceptable.

Careful information given in plain words that patients understand is more important than most doctors realise, and time spent in explanation may make all the difference between prescribing and treatment. Pharmacists could also help, as in Denmark, by writing on the label which disorder the drug is intended for, especially when patients are taking many different drugs.

Doctors must, of course, choose the right drug, but they must also think of the right pharmaceutical product for the individual. Some tablets are large and bitter, but there may be smaller, coated alternatives. Personal dislikes, proneness to nausea, sensitive gag reflexes may all play a part in patient compliance. Why don't we take more advantage of differences in tablet colours, shapes and sizes, dosage intervals, and packaging in co-operation with patients? Some packs, for instance, are bulky, others fit easily into the pocket. Some drugs are dispensed in containers with lids so small and fitting so tightly that arthritic fingers cannot remove them. Cost is obviously important but by always choosing the cheapest drug we may not be benefiting the individual.

A standardised patient exists only in textbooks. Different degrees of disease, intelligence, education and habits, and social relationships at home and at work vary within wide limits. Popular misconceptions and prejudices flourish, and even in this medicated age some people may still think it unnatural to take drugs. Patients need information about what *we* intend and what *they* may expect. "Defective compliance" may in practice mean defective information and faulty prescribing.

Good prescribing should therefore be an interaction in which doctor, drug, and patient are equally important. Like a stool with three legs, if one leg is broken—and it doesn't matter which—the stool is inevitably upset. If we do not realise this we are bound to continue with too much prescribing, resulting in too little treatment.

Roskilde, Laege, Denmark
FLEMMING FRØLUND, MD, general practitioner