Prescribing

"Doing prescribing": high hopes and unexplored beliefs

G Elwyn, J Braspenning

A novel approach to assessing prescribing behaviour involving the views of both patients and doctors, combined with an independent view of "appropriateness", provides a sophisticated approach to the act of prescribing.

Most consultations between doctors and patients involve transactions that pivot on exchanging a piece of paper on which is inscribed the name of a potion. The prescription is literally an "order" that should be followed by the patient, reified by a pharmaceutical intermediary who enacts the alchemy signified by this most symbolic of documents.

This description uses rather mystical terms perhaps, but it does so in order to point up the often forgotten ritualistic psychotherapeutic elements of this activity. "Doing prescribing" interactions are replete with decisions, many of which involve conflicts, ambivalences and reassurances. Patients will be asking: "is my problem worthy of attention?"; "will it resolve on its own?"; "will the doctor think I'm wasting time?"; "is it worth taking medicine given the opportunity cost, direct cost, possible side effects and interference with 'natural' defences?". On the professional side it is similarly complex: "how confident am I that this set of symptoms fits the presumed diagnosis?"; "is it worth intervening with a medication (similar cost issues)?"; "I don't want to 'disappoint' this patient by 'offering' nothing"; "will they be satisfied if I offer them reassurance without a prescription?". On the dark side of this equation is the use of prescriptions to terminate transactions—practitioners who use medication as the token to signal that their transaction is at an end: "take this three times a day and be gone". Two sets of preferences need to come together, yet the outcome can be evaluated along many dimensions including patient compliance, a professional's job satisfaction, and good clinical practice.

Studies on prescribing behaviour focus on counting volume, cost, type of drug, or adherence to guidelines,[1] but there have been few attempts to get under the surface of the prescribing process.[2 3] Few studies have tried to model the preferences of the negotiators and to make clear how they affect the outcome, although there are exceptions.[4 5] In this issue of *QSHC* a study by Britten and colleagues[6] makes an excellent contribution by combining the patient and prescriber perspectives and also adding a pharmacological dimension. Prescriptions were classified into any combination of the following three categories: unwanted (patient), unnecessary (doctor), and inappropriate (independent view based on analyses of medical record and drug prescribed). The authors have highlighted the study's weaknesses, yet the work stands out because of its preparedness to develop a more sophisticated approach to the act of prescribing. They reported many interesting findings, such as the confirmation (again) that patients declare lower expectations for prescribing than the rate that actually occurs (42% compared with 65%). Another interesting finding was the paradox that nearly a quarter of unnecessary prescribing (according to doctors' views) was "wanted" by the patient (patient expectations). Adherence to these prescriptions was problematic (not unexpectedly).

However, despite the novel approach, we would like to raise two issues: (1) the difficult concept of appropriateness and (2) the placing of the doctor in the position of being a judge of his or her own behaviour and the research method chosen for this. Appropriateness is a "slippery customer" and is dependent on differing viewpoints. Using carefully agreed criterion definitions can help but, if more than one criterion is selected or if different stakeholders judge the same criterion, a weighting problem is introduced. The drug prescribed can be appropriate according to the expectations of the patient but inappropriate according to a necessity defined by the doctor, or appropriate or otherwise according to an external judge using a pharmacological perspective. Britten *et al* address the issue by using the criterion of "appropriate prescribing" which they seem to value above the others and consider it to be more "objective". Maybe this is correct, and we should place patient or clinician views secondary to external judgements. However, this is debatable and the study makes it clear that we should set this weighting problem on our research agendas. More data will be needed to determine the contribution of each criterion to predict the degree of adherence, for instance.

Secondly, we were surprised to notice that the doctors questioned approximately one out of five of their decisions in terms of the prescribing necessity. We know that there is a temptation for window dressing when individuals are questioned about their own behaviour. It is therefore possible that unnecessary prescribing decisions are even more commonplace. Perhaps we should develop tools to support doctors at earlier points along the decision pathway. Decision support software might offer a way both to support and investigate these decisions, if ways were found of making such technologies fit into consulting and prescribing behaviours.

Parts of these prescribing interactions will remain difficult, if not impossible, to quantify. The theoretical field of decision making has suggested another qualitative method called "thinking aloud". This method has been applied to doctors,[7] but combining different perspectives will pose new challenges. As this study reveals, prescribing is as much about the negotiation by two people of emotionally coloured belief systems as it is about the use of rational pharmacological interventions. There is undoubtedly more room to investigate the quality of "doing prescribing".

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Authors' affiliations
G Elwyn, Primary Care Research Group, University of Wales Swansea Clinical School, Swansea SA2 8PP, UK
J Braspenning, Centre for Quality of Care Research, Universities of Nijmegen and Maastricht, 6500 HB Nijmegen, The Netherlands

Correspondence to: Professor G Elwyn, Primary Care Research Group, University of Wales Swansea Clinical School, Swansea SA2 8PP, UK; g.elwyn@swansea.ac.uk

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