Drug prescribing: some patients' views

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As a result of publicity given to the adverse effects of certain drugs the general public has become increasingly aware of the potential hazards, as well as the advantages, of drug therapy. This awareness, together with the knowledge of some difficulties surrounding the provision of drugs, led the Patients' Liaison Group of the Royal College of General Practitioners to set up a working party charged with the task of identifying patient concerns in this area and if possible to make suggestions for improved practice.

This article outlines the main issues raised by patients when approached by the Patients' Liaison Group. The comments come from a variety of sources, but especially from questionnaires completed by community health councils in Wales.

Verbal information

A clear message from the enquiry was that many patients wanted more verbal information from their doctor, and where appropriate from their pharmacist, about:

1. The nature and cause(s) of their illness, and its natural history and prognosis.
2. The alternative therapies available, including possible non-drug therapy.
3. The nature of the drug(s) being prescribed and the predicted benefits of such therapy.
4. The method and frequency of taking medication, especially when less common preparations are prescribed, for example, inhalers, aerosols and transcutaneous drug delivery systems.

Written information

It was clear that patients welcomed written information to reinforce, or add to, information from their doctor. Patients wanted labels on drug containers and information sheets to be written in clear, unambiguous language, and to take account of the needs of ethnic minorities and people with poor or no literacy skills, and the use of pictorial symbols, for example, was suggested.

The inclusion of patient package inserts was appreciated although the style of existing inserts was criticized. The patients wanted leaflets which were easier to comprehend and which gave:

1. Details of active ingredients (including the generic name of proprietary products).
2. Details of 'inert' fillers, for example, coating materials, colouring additives and flavourings.
3. Brief information about possible adverse effects of the drug, perhaps divided into those side-effects which are common and trivial and should largely be ignored by the patient, and the more significant side-effects which indicate treatment should be stopped or the symptoms reported to the prescribing doctor (or pharmacist in the case of non-prescribed medication). It was also suggested that there might be a reminder that if any other symptoms occur during or shortly after completion of a course of treatment these should also be reported.
4. The restrictions which should be observed during the course of medication, including a wider range of information than at present, for example, restrictions on use with certain herbal preparations and traditional remedies.
5. The name of the manufacturer of the product, together with the registered United Kingdom address of the company.
6. Details of how further information about the drugs can be obtained.

The last point reflects the view that additional, detailed written information about pharmaceutical products should be available to those who want it, for example the type of information contained in the *British national formulary* or *Data sheet compendium.* It was suggested that patients could gain access to this information from suitable books in public libraries or by information sheets posted to them from a central source. It should be stressed, however, that it was not thought that the dissemination of such information should remove responsibility from the prescribing doctor for seeking out the possible existence of contraindications to a drug.

Patient participation

Another finding of the enquiry was that many patients wanted to be more actively involved in decisions about the course of treatment to be followed. It was a source of much dissatisfaction that far too frequently doctors chose a therapy without discussing available alternatives with the patient. A number of respondents, however, considered that some doctors prescribed drugs too readily when none were required or when non-drug therapies might be more beneficial and thought that doctors should comply less readily with certain patients' expectations of a prescription at every consultation.

Considerable dissatisfaction was expressed about the prescribing, and repeat prescribing without face-to-face consultation, of drugs which may produce dependence, for example tranquillizers and hypnotics. It was thought that greater efforts were needed to prevent the long-term use of such drugs, and to give greater assistance and support to patients who wish to withdraw from them.

In connection with these points respondents suggested that doctors might review their appointment systems to see if more time could be made available for discussion and counselling in appropriate situations.

It was also thought that some patients would benefit not only from advice from their general practitioner but also from contact with self-help groups and voluntary organizations. The suggestion was made that voluntary and professional organizations should be encouraged to give greater consideration to ways of getting prescribed medication to patients who have difficulty gaining access to a pharmacy.

Drug licensing

While most respondents were unfamiliar with details of the manufacture and control of pharmaceutical drugs a few suggested that further debate was desirable on the appropriateness of licensing new drugs for which no advantages over existing products in terms of efficacy, safety or cost could be shown, and the possibility of rescinding the licence of drugs whose efficacy or safety had been surpassed (subject to necessary pro-

tection for pharmaceutical companies undertaking fundamental research).

The suggestion was also made that a more clearly defined 'experimental' phase might be introduced where drugs are licensed but subject to continuing formal evaluation. During this stage it was thought both doctor and patient should be informed of this status of the drug and encouraged to be extra vigilant about its effects. A number of respondents suggested that patients should be more actively encouraged to report suspected adverse effects to their prescribing doctor or pharmacist, or possibly direct to the Committee on Safety of Medicines.

While only a few patients had firm suggestions on the way the supply of pharmaceutical drugs might best be regulated, a considerable number wanted to see patients' representatives actively involved in all major debates on drug control.

Conclusion

While there was satisfaction with much in the present methods of prescribing drugs, the Patients' Liaison Group's enquiry showed that many patients want more verbal and written information about drugs and to be more actively involved in choices of treatment.

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Digoxin therapy and mortality after myocardial infarction

Recent studies have led to controversy about whether long-term digoxin therapy after confirmed or suspected myocardial infarction increases mortality. The mortality experience in 903 patients enrolled in the Multicenter Investigation of Limitation of Infarct Size (MILIS) was analysed. As in previous studies, the decision to treat or not to treat with digoxin was made by the patient's personal physician on the basis of the usual clinical indications. Cumulative mortality was 28% for the 281 digoxin-treated patients as compared with 11% for the 622 patients who did not receive digoxin ($P<0.001$; follow-up interval, six days to 36 months; mean, 25.1 months). However, patients treated with digoxin had more base-line characteristics predictive of mortality than did their counterparts. Adjustment for these differences with two separate applications of the Cox method yielded P values of 0.14 and 0.34 for tests of difference in mortality, providing no evidence for a significant excess mortality associated with digoxin.

Thus, the findings in the MILIS population do not support the assertion that digoxin therapy is excessively hazardous after infarction, but the existence of an undetected harmful effect can only be excluded with a randomized study. Until the results of such a study are available, the authors recommend careful consideration of whether any treatment of ventricular dysfunction is actually needed, consideration of alternatives to digoxin therapy, and restriction of digoxin use to the subgroup of patients (with severe chronic congestive failure and a dilated left ventricle) previously shown to have a beneficial clinical response.

Source: Muller JE, Turi ZG, Stone RE, *et al.* Digoxin therapy and mortality after myocardial infarction. Experience in the MILIS study. *N Engl J Med* 1986; **314:** 265-271.

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