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The Art of Writing Prescription

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Abstract

Introduction: The prescription is our single most important communication. It reflects our personality, ability to communicate, sensitivity, and knowledge. Unfortunately, most psychiatric training programs do not pay much emphasis on it. There are a few studies on the appropriate use of drugs, proper use of guidelines as well on prescription errors.

Aims and objects: This paper discusses the strengths and deficiencies of individual prescriptions by trained psychiatrists on the following parameters. Is the drug use rational? Is the prescription economical? Has the prescription been individualized? Should fixed drug combinations used? Does the prescription reflect the psychosocial needs of the patient?

Material and methods: This subjective study is based on the author's experience of practicing psychiatry for over 50 years. Many patients in psychiatry shift from one clinician to another as the illnesses are usually chronic and relapsing.

Observations: Treat the individual with the disease-the focus of treatment is often on the disease and not the patient. We plan to treat schizophrenia or depression and lose sight of each patient's specific need. Each patient suffering from an illness receives a similar prescription. The prescription must be individualized. Does the patient need an injectable medicine or an orally administrable medicine? The quality of life-treatment goals should be clear. Often, the goal is to treat the illness and reduce the chances of recurrence. We often do not consider the effect of the medicines on the patient's quality of life. Sometimes we may have to reduce medicines or use medicines that help patients' quality of life despite having symptoms. A hallucinating patient who is working is a better choice than a non-hallucinating, dull person living at home and doing nothing.

Conclusion: This paper has highlighted some of the issues related to prescription writing in India. Unfortunately, there has not been any study that analyses prescription errors in this country. There seems to be an urgent need to start prescription audits in some form to improve practice in our country.

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Introduction

The prescription is our single most important communication. It reflects our personality, ability to communicate, sensitivity, and knowledge. Unfortunately, most psychiatric training programs do not pay much emphasis on it. Prescription writing is learned from the prescriptions of their teachers and seniors. The errors the seniors made are perpetuated. Many prescriptions are illegible, leading to the wrong drug administration. Most doctors follow the formula of writing the specific drugs, a tonic, and an antacid and throw in a few

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more nonspecific drugs to make the prescription impressive. There is a tendency to write medicines in TDS, BD, OD, and HS doses. The medicines that have a half-life of 24 hours tend to be prescribed twice or thrice daily. There is a worldwide drive to reduce the number of times drugs are given to make drug administration easy. This aspect of prescription writing has not been studied. There are a few studies on the appropriate use of drugs, proper use of guidelines as well on prescription errors.[1-5]

Aims and Objects

This paper discusses the strengths and deficiencies of individual prescriptions by trained psychiatrists on the following parameters.

- Is the drug use rational?
- Is the prescription economical?
- Has the prescription been individualized?
- Should fixed drug combinations used?
- Does the prescription reflect the psychosocial needs of the patient?

Material and methods

This subjective study is based on the author's experience of practicing psychiatry for over 50 years. Many patients in psychiatry shift from one clinician to another as the illnesses are usually chronic and relapsing. Many prescriptions of different psychiatrists were seen over a period and the impressions developed are the subject matter of this presentation. Few prescriptions have been presented to demonstrate certain issues. The names of the clinicians are not disclosed. This author does not profess that he knows more than the others. This presentation aims to communicate certain observations about prescriptions that may start a dialogue on improving the quality of prescriptions in India. This author has committed all the mistakes that he is referring to and may be committing many even now. The aim is to go on learning and improving.

Observations

Treat the Individual with the Disease

The focus of treatment is often on the disease and not the patient. We plan to treat schizophrenia or depression and lose sight of each patient's specific need. Each patient suffering from an illness receives a similar prescription. The prescription must be individualized. Does the patient need an injectable medicine or an orally administrable medicine?

The Quality of Life

Treatment goals should be clear. Often the goal is to treat the illness and reduce the chances of recurrence. We often do not consider the effect of the medicines on the patient's quality of life. Sometimes we may have to reduce medicines or use medicines that help patients' quality of life despite having symptoms. A hallucinating patient who is working is a better choice than a non-hallucinating dull person living at home and doing nothing.

Steps of Prescription Writing

Select a diagnosis if that is not possible, choose the second-best possibility of treating symptoms, and decide the order in which they are to be treated. Many clinicians use the umbrella approach and use a mixture of antipsychotics, mood stabilizers, antidepressants, and tranquilizers, hoping something will work. It may reduce florid symptoms but is usually counterproductive.

Choosing the medicine

While choosing medication, the following factors must be kept in mind. Choose the most effective drug. What is the side effect profile of the drug? Will the patient be able to tolerate it? The clinicians should keep a drug interaction chart handy and choose appropriately. If there are any drug sensitivities, they should be recorded. Many times, patients tend to overemphasize their drug sensitivities and one should specifically seek evidence for them. Many drugs are available for each diagnosis. Treatment guidelines supply a list of drugs to be used as the first line of treatment. Second- and third-line treatment strategies can be used if the frontline drug fails. The clinicians often select a drug with which he is familiar. The side effect profile is suitable for the patient. He selects drugs to control side effects. Separate drugs may be needed for controlling sleep and agitation. Most clinicians add vitamins, tonics and antacids for general healthcare. Antacids are often prescribed as most patients complain of gas as the basic problem. These extra medicines unnec-

essarily increase the cost of treatment and do not provide any benefit. The practice of prescribing such drugs should be stopped at once. These medicines should be prescribed when specifically indicated.

The next question that arises is whether he should use a single drug or a combination. Most guidelines recommend a single antipsychotic for the treatment of schizophrenia, though there are circumstances where combinations could be used. Yet in clinical practice, most patients with schizophrenia are being treated with a combination of antipsychotics. What are the reasons for this practice? Schizophrenia is a condition with a poor prognosis. The clinician, out of anxiety, uses multiple drugs.[6] Research all over the world has shown that multiple antipsychotics do not increase response, but the side effects are increased. Another question that needs to be answered is whether one should use an added antiparkinsonian drug and for how long. The dosage of the antipsychotic drug has also to be carefully considered. The antipsychotic drug dose should be enough to occupy dopamine receptors. If that is achieved, higher doses are counterproductive. The agitation and excitement need to be controlled by benzodiazepines. These must be stopped as soon as agitation and anxiety are controlled. On the contrary, while treating depression, a single drug is effective in around 50% of patients. The remaining will require the addition of other antidepressants or other drugs that are called treatment facilitators. Many clinicians start multiple antidepressants initially to induce quick relief. Such activity reflects the clinician's anxiety and is often counterproductive. Many clinicians start using first-line drugs along with a second or third-line alternative to achieve a quick response.

Use of fixed drug combinations

Drug combinations are available in the Indian market and many of them are extensively used. A common combination is that of escitalopram and clonazepam in different strengths, which is extensively used. This combination provides easy acceptability of escitalopram as its undesirable side effects are masked by clonazepam. The downside is that the drug leads to habituation and many patients feel that the drug is making them drowsy. This combination should not be used. Both drugs may be used initially, and clonazepam can be tapered off as the patient's anxiety is reduced.

A combination of antipsychotics with antiparkinsonian drugs is also commonly used. This combination leads to an increase in antiparkinsonian drugs whenever you increase the antipsychotics. The antiparkinsonian drug needs to be given only during the day. If you are giving a combination, then you are unnecessarily giving this drug at night. However, I still use this combination for patients who are poor and less informed. These patients often try to reduce the number of drugs. I have seen that they drop antipsychotics as they cause discomfort but continue taking antiparkinsonian drugs. This is an example of need-based deviation from pure science.

Voluntary or involuntary treatment

Does the patient accept the disease, and is he ready for treatment or does he deny illness and refuse treatment? Such patients need to be given prescriptions for more patient-friendly drugs that do not produce many undesirable side effects. We often use Haloperidol in patients with mania, which causes severe side effects. These patients often refuse to take treatment after such experiences. This also raises the ethical question of treating patients against their wishes. The consent of close relatives and the immediate good of the patient can justify such practice. Prescription of soluble, tasteless medicines is often given in such situations. This could be given for an abbreviated time. The patient should be informed of drug usage as soon as he can appreciate it.

Monetary status

The issues of the monetary status of the patient are not often emphasized. Most of our patients must buy medicines from their pockets, a very few are covered by insurance or by the state or central government. Many psychiatric illnesses require long-term treatment and if the cost is too high, most patients will stop medications. The clinicians should discuss the issue of cost with the patient and the supporting caregiver. Many patients would say that cost does not matter, but one needs to explain that the treatment is like to continue for a long time. It is better to select an affordable medicine. One must choose the most effective and cheap medicine.

Where cheap generic medicines are available, they must be used.

Distance from the clinic

Distance from the clinic is also a crucial parameter while planning the prescription. The travel costs are exceedingly high and if prescriptions are given for short periods, the patients will either stop the treatment or get the prescription repeated without consulting the clinician. Both conditions are detrimental to proper treatment. The clinician should supply a prescription for a period that is practical for the patient. Conditions where quick review is needed must lead to early revisits.

Duration of prescription

Prescriptions given for the long term pose a different ethical dilemma. Benzodiazepines should be prescribed for as short a period as possible. If we give prescriptions for one month or more, then we will need to prescribe these drugs for a long time which is scientifically incorrect. I usually ask them to taper off benzodiazepines after 15 days, but most continue taking the same dose. One would have to decide between practicability and correct practices.

Psychological needs

Patients' and families' expectations and responses must be respected while writing a prescription. The patient and family often request the doctor to give a mild medicine, non-sedative/sedating medicine. Some may ask that pills should be smaller others may not want injections. Many patients complain that psychiatrists give sleeping pills, which keeps them lying down the entire day. The patient's earlier experiences with drugs must be considered. These requests are usually not based on facts but are real for the patient. The clinician should try to accommodate as much as possible. The unavoidable requirements should be clearly explained.

Many patients request tonics, herbal preparations, and medicines for gas in the abdomen, constipation, and weakness. All these requests should be carefully heard and scientifically explained. Unnecessary prescriptions of tonics and antacids should be avoided.

Non-pharmaceutical advice many prescriptions carry psychological advice like doing yoga, relaxing, not getting angry, and stopping smoking and drinking. This advice often leads to increased anxiety in the patients and conflict between patients and caregivers. They may be communicated verbally, where one can discuss the practical aspects.

Illustrations

Case one

This is a prescription for a patient with schizophrenia.

- Olanzapine 7.5 mg BD and 2 HS
- Trihexyphenidyl 2 mg TDS
- Clonazepam HS dose not specified.

The clinician has selected the most patient-friendly medicine. He has given it in as 7.5 mg BD and two tablets at bedtime. The same can be given twice daily or even in a single dose. Trihexyphenidyl three tablets are unnecessary. This could be given once daily. The habit of writing BD or TDS gives rise to such anomalies. Clonazepam could be avoided, as olanzapine in such a dose would induce sleep.

Case two

- Psychosis (NOS)
- Monocefo 200 BD
- Olean RT 10 mg BD
- Fostera 10 mg HS
- Shelcal 500 mg BD
- Tab Sizopin 50 mg HS
- Dicorate 750 mg HS
- Lithosun SR 400 mg BD
- Tab Sumo sos
- Pantocid DSR OD

In the second prescription, the prescriber has put the diagnosis as psychosis (NOS). The patient seems to have a fever for which antibiotics and antipyretics are prescribed. Two preparations of olanzapine are used. Clozapine 50 mg has been added at bedtime. This must have been done to induce sleep. Lithium and divalproex sodium have been given. The clinician must be considering manic illness, which led to the prescription of mood stabilizers. The second prescription shows the anxiety of the prescriber. It would have been useful to prescribe olanzapine 20 mg and excitement could be controlled by benzodiazepine. The use of lithium and divalproex at this stage appears unnecessary. There is an antacid and calcium preparation added, why?

Case three

This is a patient with depression:

- Escitalopram 10 mg BD and 1 HS
- Clonazepam 0.25 mg TDS
- Primox 1 BD 2 HS
- Lorazepam 2 mg HS
- Migrabeta 20 mg BD
- Pantodac DSR morning
- Zerograin+ 5 mg HS

Recommend doing yoga and keeping busy.

This patient had depression with a headache. He was given two antidepressants at the largest dose and two tranquilizers. The pattern of writing TDS and BD affects the time interval of different drugs. Antacid has been routinely added. The patient was drowsy and was extremely uncomfortable. Reduction to one antidepressant and reduction of tranquilizer made the patient feel better.

Conclusion

This paper has highlighted some of the issues related to prescription writing in India. Unfortunately, there has not been any study that analyses prescription errors in this country. There seems to be an urgent need to start prescription audits in some form to improve practice in our country. If we do not do it ourselves, some regulatory authority will do it, and the clinicians will feel offended. Most postgraduate training programs do not teach prescription writing and the prescriptions are not checked regularly. Every clinical department should develop a prescription writing protocol that also needs to be evolved at the national level.

Common Errors Seen are

Poor handwriting. We should encourage computerized prescriptions that will take care of handwriting as well as unclear instructions.

All medicines should have a pharmacological name along with the trade name.

Only specific medicines should be written and avoid the use of tonics and antacids.

The psychosocial needs of the patient and the family should be kept in mind. A working person should not get medicine that affects his work.

The cost of medicines and travel should be kept in mind.

Combinations should be rationally used.

Every clinician should continue improving his prescription by studying the responses of his patients as well as discussing with a colleague.

The question of writing a diagnosis should also be considered carefully. Will the mention of diagnosis increase stigma or reduce stigma? There is often a change of diagnosis during treatment. How will it reflect on the ability of the clinician?

Medical practice is lifetime learning. This presentation raises some questions on prescribing practices in India and we need to discuss them with an open mind.

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