

Why treatment plans must replace prescriptions in an electronic age

By Bob Gartside, a pharmacist from Caernarfon, Gwynedd

Another Nature, God or Darwinian evolution intended the span of human life to be three score years, give or take a decade, yet many people today are living to be 80, 90 or even 100 years old. This is partly because of improved nutrition, partly because of central heating, partly because of improved education and television, and partly because of improved medical management and drug treatments for the infirmities of old age.

Yet our process for delivering medicines to patients has not ostensibly changed since Lloyd George's National Insurance Act of 1911, which set the framework for the later development of the NHS. Indeed, until recently, GPs kept patient records in "Lloyd George envelopes" and prescription forms are still printed to roughly the 1911 dimensions and layout. Even the introduction of electronic prescriptions will make little difference because the system under development is little more than an attempt to computerise an essentially paper-based operation, with some added bells and jingles to "guide" prescribers in the writing of prescriptions and a facility for repeatable prescriptions, which does not yet appear to have been specified.

What is really needed is a fresh look at the whole ordering and delivery system for medicines, making the fullest possible use of the possibilities latent in modern systems. I will confess freely that I do not know what form such a system might take but there may be pointers in current practice (which may not necessarily comply with the strict letter of the law and professional ethics but, most assuredly, does comply fully in spirit).

Bearing in mind that patients are human, forgetful, prone to dropping and losing things, and generally do not behave as the book says they should, let us look first at common, present-day problems in medicines supply. Over the years a system has spontaneously evolved in which pharmacies store patients' repeat requests and submit them to surgeries on patients' behalf. This system is little documented (North Wales Local Pharmaceutical Committee conducted a pilot some years ago which was reported to the Welsh Office) but is almost universally

used. Similar systems are in place for the management of medicines in care homes but these are frowned on by the NHS for reasons that are difficult to discern and which do not stand up to analysis.

I would submit that one major problem is that it takes most GP surgeries from one to four days to produce a prescription for authorised repeat medicines, and perhaps even longer for a new medicine requested by a consultant or suggested by test results. There is no reason why matters should improve following the change to e-prescriptions. Unfortunately, our feckless patient, used to nipping round the corner shop for a box of matches and therefore only thinking of requesting a new supply when there are only two or three tablets remaining, can be expected to experience involuntary drug-free days despite the fact that all other therapeutic effort is concentrated on maximum con-

dance and compliance. A further problem is that few surgeries are now open on Saturdays so that even when a prescription is produced there is a fair chance that it will be locked up in a closed surgery. There is no point in saying that patients should be more organised; other aspects of their lives are probably fairly well disorganised and they are only human. And many of them are old.

Many surgeries will only issue prescriptions when they think they are due, and this may mean monthly on set dates. But 28 days' supply means that 13 supplies are needed in a 365-day year. It seems likely that e-prescribing systems will be even tighter in this area than present systems and this will create problems for those patients who lose their tablets, drop them down the toilet, leave them where the dog can find them, or simply forget where they have put them (it happens). In passing, it is a great pity that the UK decided to go with a 28-day month while the rest of the world works to a 30-day month.

There may be additional problems over non-availability of medicines when the production or distribution mechanisms suffer dislocations and there are even more problems when a surgery leaves some medicines off a requested prescription, whether by accident or by design.

For all these reasons, modern community pharmacy practice can include a style of pharmaceutical care that pushes the legal and ethical boundaries within which pharmacy operates. Confronted late on Friday by a distraught 80-year-old who has been convinced by his consultant that he will die if he has to go for three days without atenolol and bendroflumethiazide, what is a responsible pharmacist to do? A retail sale of an emergency supply is out of the question: the old age pension income leaves no room for such procedures.

In Scotland such dilemmas have been recognised by an ad hoc arrangement under which emergency supplies can be made by means of a patient group direction and the NHS pays the cost. Wales may follow suit. Pharmacists in England seem likely to be left to fend for themselves, yet this is such a simple problem for them to solve by the exercise of professional judgement. Sadly, our rulers appear to believe that trust must be replaced by accountability, despite the vast cost implied by the need to employ an army of checkers and accountants. Professional responsibility is actually cheaper than any other method of management.

Bearing all of the above in mind, what sort of system for the management of maintenance medication should we be considering? I would suggest that the prescription needs to be replaced by a treatment plan. Instead of the prescription saying "Give Mrs Jones 28 bendroflumethiazide 2.5mg every morning (as a single supply)" or even Give Mrs Jones 28 bendroflumethiazide 2.5mg every morning once a month for six months", the treatment plan would say "Mrs Jones is to have 2.5 mg of bendroflumethiazide every morning; supply at approximately monthly intervals provided that her blood pressure remains within a specified range and she has no other untoward effects or symptoms; she is to attend surgery annually for checks."

Such a treatment plan would preferably be used by one pharmacy for every dispensing of Mrs Jones's medicines but, with sufficiently efficient IT, could be used by any pharmacy in the country. The essential thing is that day-to-day management is to be transferred from the prescriber to the pharmacist who would be expected to help the patient in every way possible. I submit that the introduction of e-prescriptions calls for such a change from prescriptions to treatment plans for the management of maintenance medication and that the profession should take a lead in seeking it.

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