The science and art of prescribing – Precious pearls from experienced clinicians

Interview with Dr. George Joseph, Professor, Department of Cardiology, Christian Medical College, Vellore.
Source: Reprinted from Pharmacy Bulletin, Feb 2016, a publication of the Pharmacy Service (DISH), CMC, Vellore.

Writing a good prescription is an art as much as it is a science. Traditional text books describe a disease and will tell us what drugs should be prescribed. But we will have to, of necessity, learn the art only from a senior who has accrued years of experience by treating patients. In this new series of interviews, we hope to garner some useful tips on developing good prescription writing skills from some of the senior clinicians in our institution and present it to our readers. We believe this will be a tremendously useful exercise that can challenge us to change our prescribing patterns to better ways. Read on and be challenged. Dr. George Joseph has been prescribing since 1982 when he was graduated as a physician in CMC. Today he is a senior consultant cardiologist in CMC and heads cardiology unit-1. He describes his principles, strategies and emphasis on prescribing apart from few advices for junior prescribers.

What principles do you follow to ensure that your patients get the best medications?

Many things, but the first is the use of generic names and avoidance of trade names. I always ensure that a drug is prescribed by its generic name. If brand name is required, I prefer writing it in brackets. Secondly, since many prescribers are unsure of the composition of combination products, I insist that when a combination product is prescribed, the generic composition be written alongside with the dose of each component drug. This will help other prescribers who peruse the patient’s notes to quickly understand what drugs the patient is on and in what dose. And moreover, since it is hard to remember all the combination products and since their composition also varies frequently, writing down the individual components becomes important both in the patient chart and prescription.

Sometimes, the combination product may not be available in CMC and in such cases, the individual drugs may be given separately if the dose of each component is written. Though I avoid combination products as far as possible, if the patient is already on a combination product and is doing well on it, I simply continue it. Secondly, as far as possible I simplify multiple-doses-a-day drug regimens. If the medications are spread throughout the day, like three or four times a day, the patient tends to be noncompliant. The availability of long acting forms can be used to simplify the regimen. Sometimes when patients come to me with a huge list of medicines, may be 10 or 15, I try to reduce the number of drugs to as few as possible and simplify the dosing schedule. This will improve adherence and the costs as well. Thirdly, I always consider the side-effects of drugs. For example, patients often complain of insomnia which physicians tend to ignore, but could sometimes be the side-effect of drugs such as the commonly-prescribed statins.

I frequently make use of the CMC intranet (Medclick/Online drug information) to check the side-effects of drugs and advise patients accordingly. Smartphones with web browsers also allow a quick check of the side-effects of drugs. Despite our busy schedule, an extra minute spent looking up drug side-effects can result in a huge relief for the patient. A patient who was on nitrate therapy came to me with intolerable headache which he had suffered for quite a while. Despite consulting many doctors in his town, including some specialists, nobody told him that nitrates can cause headache. Similarly, amiodipine commonly causes pedal edema and physicians often start such patients on diuretics thinking that this is a new unrelated problem. We should take time to check the side-effects of the drugs we prescribe and warn the patients about the common ones.

Apart from what you mentioned earlier, what other things do you emphasize to your patients when you prescribe drugs?

A very common error that occurs in prescribing drugs for patients with chronic conditions is when he or she is given a prescription, say for one month, and then he/she assumes that the medicines have to be taken for...
just for one month and then stopped. Because of this, very important medicines are stopped and the physician will not see the expected clinical outcome. To prevent this, the duration the drug has to be continued should be emphasized to all patients when they are prescribed a new drug. Tell them that they have to take this medication lifelong, though the prescription is only for one month. Another thing I emphasize when dealing with patients on multiple drugs is to avoid the common practice of writing CST (continue same treatment) on the chart. The problem with CST is that it tends to be repeated by the same or other physicians for many visits, and over time no one knows when these drugs were started and for what reason. Even the names and dosage of the drugs tends to go wrong. I think it is important to write the whole list of medications, if not every time, at least on alternative visits. In the midst of their busy schedules many physicians do not want to spend the time or take the extra effort to write down the whole list of drugs and their dosage. However, use of ‘CST’ tends to result in medication errors in the patient.

**How do you improve medication compliance in patients?**

We can suspect poor drug-compliance if the expected clinical outcome is not achieved, for example the blood pressure does not come down. To ensure compliance, the medicines prescribed should be affordable to the patient. So I discuss the anticipated monthly cost of the drug with the patient before prescribing it. The second thing is to check if the patient is noncompliant due to side-effects of prescribed drugs. So I ask patients about common drug side-effects, especially if I am not seeing the desired therapeutic effect. The third problem to overcome is poly-pharmacy and frequent dosing. Aim to simplify. Simple regimens like once or maximum twice daily dosing will improve patient compliance.

**How do you prescribe a new drug in the market to your patient?**

Usually new drugs are very expensive. They seldom come cheap. I go for new drugs when the old drugs are not sufficiently effective, have inconvenient dosing schedules or other problems (such as need to monitor INR periodically in patients on vitamin K antagonists) or are not tolerated by the patient, while simultaneously considering the affordability of the patient.

What can doctors do to avoid being negatively influenced by drug companies/representatives?

As far as drugs are concerned, I have stopped seeing medical representatives. I consider it poor use of my time having to hear about 10 different brands of a drug such as atorvastatin or clopidogrel. Whenever I need an update on new drugs I browse the web or read reviews. I have completely stopped seeing pharma representatives and have no pharma day or pharma time.

Which one do you prefer, electronic or paper prescription? Why?

I prefer paper prescribing mainly because I have a physician assistant. I spend quite some time writing the drugs, their dose and their schedule in the patient’s chart using generic names and do so legibly so that anyone can follow it without making errors. Then the physician assistant will transcribe the same to a paper prescription and after my verification and signature it goes to the patient. If it is electronic, I have to write it once in the chart and then again type it in an online prescription. This doubles the time required for a prescription for me. It is vital to write a very clear and detailed prescription in the chart so that everyone including the physician assistant and subsequent prescribers can read it correctly.

What advice would you give for younger doctors with regard to prescribing drugs?

I insist on drug names being spelt correctly. For example, the new antihypertensive drug cilnidipine is often misspelt clinidipine. Similarly metoprolol is often written as metaprolol. When I see such errors I bring this to the notice of the prescriber. More importantly, I insist on prescribing using generic names. Since the composition of combination products vary and is hard to remember, it is important to write down the generic names with doses of the individual drugs in combination products.