NEW ZEALAND MEDICAL ASSOCIATION

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Dear Michael

Draft Statements for Doctors on the Subject of Prescribing

Thank you for providing us with the opportunity to comment on these draft statements.

In general the NZMA is very supportive of the statements which are well written and seem sensible. We note however that in regard to any statement there will always be some exceptions that need to be accommodated. We suggest that the statements acknowledge that there are likely to always be some cases where deviation from the rules is reasonable given the circumstances.

Good Prescribing Practice

Written versus Electronic Prescribing

Paragraph 2, bullet point two states that *"Prescriptions must be legibly and indelibly printed and personally signed by the prescriber with his or her usual signature (not a facsimile or other stamp). Therefore those issued only by email or other electronic means do not meet New Zealand legislative standards under sections 40-41 of the Medicines Regulations."*

While this statement may be appropriate today it is likely that electronic prescribing will become the norm soon and this statement will be out of date. Given that the change is likely to happen sooner rather than later we believe the statement should reflect this, even if only to say that "**until** legislative standards change, the following applies etc".

Face to Face Conversations

Paragraph 3 provides that *"for a patient to be "under his or her care", a doctor must have had a face to face consultation with the patient or have discussed the patient's treatment with another New Zealand-registered health practitioner who can verify physical data and identity."*

While we agree with the principle we note that when patients leave the district, it is not uncommon for patients to continue to contact their former general practitioner. For example a patient who has moved to a new town and who has not yet enrolled with another doctor may request a prescription from their former doctor. The patient is no longer under his/her former doctor's care and naturally the doctor directs them to urgently seek out a new doctor. In the interim however the provision of a prescription seems reasonable, provided that the former doctor is fully cognisant of the patient's health situation.

Patients to be Made Aware of Cost of Medicines Prescribed

The statement mentions several times the need to make patients aware of the costs of medicines prescribed. While we agree in principle we note that drug costs do change and it is often hard to keep up with the exact cost, particularly as pharmacists can and do vary in the mark-up they add to the wholesale price. We think that the statement should require a doctor to be able to either give a reasonable estimate of cost or make the patient aware that there is a charge for the drug (either part or full), and advise the patient to ask the pharmacist what the charge is for the particular medication.

Repeat Prescriptions for Colleague's patients

One matter not addressed by the statement however, which we think should be, is that of the doctor writing repeat prescriptions for his/her colleagues' patients. This situation often occurs in general practice, particularly when a colleague is away and there is no locum cover. This leaves an increased workload for the remaining doctors and, out of necessity, they are often required to write repeat prescriptions for patients they have rarely or never seen. This is usually done in response to a patient's itemised requests for more medication.

Generally, there is no problem; the patient correctly identifies all of the long term medications that are recorded in their notes. The medications seem entirely appropriate and there is no need for the patient to be seen on such an occasion. However on other occasions there are very real problems. For example, the HDC has previously criticised the actions of a medical centre for the GP's continued prescribing a 3rd generation OCP to a patient whose nominated "lead" GP did not inform her of the increased risks of venous thrombosis.

Other issues include

1. Disagreeing with the treatments the patient is on – should the doctor take issue and not prescribe or simply act as a proxy for the patient's own GP and repeat the script as requested?
2. It is very common for covering GPs to have to issue scripts that involve controlled drugs, or drugs of abuse. Patients on these drugs are getting

monthly scripts and inevitably some of these require renewal even if their GP is away for a short period. Unless good procedures are in place, these patients can quite easily exploit this situation.

3. The patient may have neglected to ask for all of their medication – this may be entirely appropriate, but it can be difficult to tell.

We believe the Medical Council should provide advice to doctors on what to do in all of the above situations. The NZMA would be happy to assist with this additional suggestion.

Drugs of Abuse

In the Drugs of Abuse paper we are unsure whether hypnosedatives constitute drugs of abuse. If they are, then according to the statement, they should not be prescribed for someone who is dependent. Simply cutting the patient off from the drug they are dependent on without first trying to wean the patient off the drug however may not be appropriate. We think the statement could be better worded to require Doctors to be alert for dependence and - where it is found to exist – to require doctors to attempt to wean the patient off the drug of dependence or to direct the patient to an agency that can do this. Finally, if all of these prove impossible, to require the doctor to exercise all care in ongoing prescribing.

We are happy to discuss any of the above matters further if you wish.

Yours faithfully

Dr Peter Foley
Chair