opinion

Ethical and legal issues in Healthcare

In the first of a new series of articles exploring medico-legal and ethical issues in pharmacy, Cicely Roche asks 'what is a prescription?', and discusses the various roles the prescriber, the dispenser and the patient have in relation to this important document.

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What is a prescription?

When I first realised that this was a question for which I did not have an answer, I texted a number of friends (pharmacists and other healthcare professionals) seeking suggestions. The instinctive reply "it's an instruction" was quickly followed by "actually, we don't know what it is!" No surprise there.

Pharmacy and medicines legislation deal with how to write a prescription, who may write one and for what medication a prescription may be written. However none of the above legislation defines what a prescription actually is.

Medico-legal references show no apparent attempt to define the term either, except where general practitioner (GP) and barrister, Simon Mills expresses the view that "notes of consultations or prescriptions given to patients and transmitted subsequently to pharmacists may constitute the only permanent record of what has taken place between the clinician and the patient". He suggests that it is an indelible record of the practitioner-patient record which may prove invaluable as legal proof in any legal dispute that subsequently arises. His interpretation should be particularly relevant due to his first-hand insight into the GP's role. However, his interpretation assumes that the patient will always bring that prescription to a pharmacy, leave it with the pharmacy and that the GP will always have access to that file.

The Pharmaceutical Society of Ireland (PSI) has always advised pharmacists that a prescription belongs to the patient for whom it was legitimately written until it has been fully dispensed. The pharmacist must endorse the prescription at the time of dispensing, verifying the supply function inherent in the process of dispensing. It may be returned to the patient along with the dispensed medication. If and when a prescription has been dispensed in its entirety it must be retained at the pharmacy for a period of two years, after which it would be consistent with data protection legislation to shred retained prescriptions. The above suggests that the view expressed by Simon Mills is inconsistent with the reality of what happens to the physical prescription after it leaves the doctor's surgery. These are the different perspectives held by the two healthcare professionals generally involved in the prescribing/dispensing process in primary care, each appearing to be consistent with the 'duty of care' guidelines from their respective governing bodies. Differing perspectives such as these are the source of many professional dilemmas for practitioners.

Viewing prescriptions solely as potential evidence in a legal challenge, by either one's governing statutory body or as a result of an adverse event experienced by a patient, would be a most restricted view of their role in patient care. In order to ground our everyday practice in the principle of 'duty of care', each of us needs to develop a considered opinion of what a prescription actually is. I work from the basis that it is a communication from one healthcare professional to another, the conduit for which communication is the patient, who chooses, following the consultation with the prescriber, whether or not to bring the prescription to a second healthcare professional to have it dispensed. This right to choose respects the patient's autonomy to consent to or refuse a healthcare intervention as offered to him. The prescription, with the various communications between healthcare professionals written thereon, remains the property of the patient until it has been fully dispensed.

However, as the prescription continues to act as a means of communication between healthcare professionals, there is a responsibility on the dispensing pharmacist to:

1 Identify on the prescription identifying features of the product dispensed in order to assure clear communication with the next GP, pharmacist or other healthcare professional presented with the prescription. Of particular relevance would be clarification of the generic brand chosen or the quantity dispensed as a 'one month' supply. Needless to say, there are also times when clarification of the identity of the medication intended is required, and this would then be written alongside the script on the prescription.

2 Note on the prescription, verified with a signature and date, any relevant intervention made with or on behalf of the patient. This includes conversations with other healthcare professionals, significant advices given to the patient or results of any appropriate monitoring carried out.

Records retained on the patient medication record (PMR) in the pharmacy are a separate matter. Simon Mills' philosophy of the prescription always being part of that pharmacy-based record is inaccurate, as the patient might never 'fully dispense' a given prescription. The only prescriptions automatically retained by the pharmacy will be those with directions to dispense all items referred to on the prescription 'only once', such instructions inferred either by the scheduling of all items on the prescription or by those words being written on it by the prescriber.

Notations on a prescription do not replace the requirement to document all interventions on the PMR. The notations are a patient-centred approach to communicating with those healthcare professionals who subsequently use the prescription to provide further care for that patient. Comprehensive use of such written communication is an element of the 'duty of care' responsibility to the patient. If the 'communication' inherent in the notion of writing prescriptions is to be honoured, it is critical that all relevant information is recorded onto the physical prescription before it leaves the premises.

None of the above denies the risks inherent in ambiguously written prescriptions. Moves to ensure that all prescriptions are typed are well intentioned. The now infamous 'Migril' case highlights the potential for patient care to be adversely impacted by misinterpretation of sloppily written prescriptions. We have all had similar personal experiences, my own particular 'nightmare' being an artistically written 'Xanax' which was initially misread as 'Lanoxin'. However the 'typed prescription' mantra is not fool-proof either. This is especially so with the advent of computerised printouts of multi-item prescriptions which are then signed by GPs. I recently reviewed my dispensing of typed prescriptions over a one-hour period. I concluded that, if I were to interpret the prescription as an instruction to be literally followed, half of the patients under my 'care' would have not received their medication as intended.

Respect for patient autonomy is a core principle in healthcare today. The traditionally paternalistic approach to healthcare has made way for a relationship based more on a partnership approach to health than that of healthcare professionals 'telling' patients what to do. In this context, the trusting relationship between a patient and their healthcare practitioner(s) is fundamental to the assurance of positive patient outcomes. The last thing a patient needs is to unnecessarily doubt the efficacy of therapy, such as can happen when a different brand of medication is received without reassurance that there is good reason for a brand switch. This can be avoided by a simple notation on the prescription clarifying the brand dispensed at the first pharmacy, which would alert a subsequent pharmacist to endeavour to dispense the same brand, if possible, or else to reassure the patient as to the bioequivalence of the alternate brand.

The issuance of a prescription is the beginning of a process which has the objective of having a patient ultimately consume medicines appropriate to his care. If a patient's outcomes are likely to be optimised, the communication process that begins with that prescription must be meticulously continued right through to the final counselling of the patient prior to his consumption of the medicine. Prescribers and dispensers alike, we fail to add our input to that communication process at the patient's peril.

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References ~

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