

Appropriate medications: prescription and use in primary care

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This issue focuses on medication use, particularly in older people. Our lead paper by Lee et al. reports on a study of patients aged 75 years and older with depressive symptoms, whose median number of medications was six (range 1–21). Nearly half of these patients had been prescribed at least one potentially inappropriate medication (although clinical correlation would be needed to determine whether all these were truly inappropriate).¹ As our guest editorial from Professor Carmel Hughes points out, poly-prescribing is not inherently wrong, but a balance needs to be found between ‘many drugs’ and ‘too many drugs’.² Research by Bagge and colleagues of patients in this same age group found that, while elderly patients disliked taking their prescription drugs, they generally believed that these were necessary, trusted their doctors’ expertise regarding their medications, were unconcerned about side effects, and considered it important that they took their medicines regularly, even if sometimes they did forget them.³

With the move towards prescribing rights for other health professionals, Hatah et al. have looked at how general practitioners (GPs) perceive the contribution that pharmacists might make.⁴ Generally GPs thought their own strengths lay in their skills, training and understanding of clinical conditions, but they often had heavy workloads and time constraints. They felt that while pharmacist prescribing might confuse patients, they supported pharmacists conducting in-depth medication reviews, again to see whether patients were taking appropriate and necessary medications.

Once patients are on medications, it can be difficult to discontinue them. This issue’s *Nuggets of Knowledge* outlines sensible guidance on how to stop medications in the elderly.⁵

Ensuring that patients receive the most effective medications and understand how to use them can be challenging. Te Karu et al. studied Maori patients with gout, and found that they often only received acute treatment for many years prior to being started on allopurinol, and had little awareness of the role this drug could play in preventing their attacks.⁶ Sometimes allopurinol use was unsuccessful because patients did not understand how to take it. Other research by Bryant et al. found nearly half of patients receiving inhalers for asthma or chronic obstructive pulmonary disease had poor inhaler technique and did not recall ever having their technique rechecked after their initial instruction.⁷

Self-medicating options may also not be appropriate. A review by Dr Shane Scahill in the *Potion or Poison?* column concludes that magnesium is unlikely to be effective in preventing muscle cramps, and Dr Megan Arroll in the *Cochrane Corner* determines that cranberries are no better at preventing urinary tract infections than prophylactic antibiotics and only slightly better than no treatment.

In other research in this issue, one qualitative study gives examples from large-bodied women of negative messages pertaining to their body size that they had received from health care providers in general practice.⁸ Another qualitative study explores the perspective of palliative care patients and their families on services provided by a hospice, particularly with regard to cultural appropriateness for an ethnically diverse population.⁹ A short report describes the experience of postgraduate medical training in rural general practice from both the trainee and the practice staff’s points of view.¹⁰ The *Vaikoloa* column addresses an initiative aimed at building clinical research capacity in the Pacific Islands.¹¹

J PRIM HEALTH CARE
2013;5(3):178–179.

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Finally, there is a move to the more theoretical and philosophical. In *Back to Back* this month, Dr Kate Baddock contends that altruism requires that GPs 'put patients above self-interest in return for autonomy and self-regulation'. Traditional professionalism involves the right of the profession to judge the quality of its own work, and the loss of this through 'new professionalism' means that medicine is viewed as a job rather than a vocation, with a corresponding loss in altruism.¹² Law Professor Ron Paterson, former Health and Disability Commissioner, argues that the profession needs external regulation, but altruism will survive if 'supported by the collective morality of physicians'.¹³ Read and decide for yourself.

The development of pharmacogenetics and personalised medicine requires identification of a patient's genome. This raises important issues of security of their personal genetic data. In our *Ethics* column, Richman Wee addresses the increasingly complicated issue of patient consent in this context.¹⁴ He introduces the concept of dynamic informed consent, whereby a person's DNA information can only be accessed or used for circumstances for which he or she has given specific consent.

While increasing technology allows us to do many things never dreamed possible only one or two decades ago, it does come at the cost of ever-increasing complexity, and the requirement of new systems through which both doctors and patients must navigate. Dissemination of new knowledge competes with privacy concerns. Our collections of health and medical datasets continue to grow exponentially. The world is awash with big data. As with any innovation, this comes with the potential for both good and harm.

References

1. Lee D, Martini N, Moyes S, Hayman K, Zolessi M, Kerse N. Potentially inappropriate medication use: the Beers' Criteria used among older adults with depressive symptoms. *J Prim Health Care*. 2013;5(3):182–190.
2. Hughes C. Potentially inappropriate prescribing—moving from process to outcome. *J Prim Health Care*. 2013;5(3):180–181.
3. Bagge M, Tordoff J, Norris P, Heydon S. Older people's attitudes towards their regular medicines. *J Prim Health Care*. 2013;5(3):234–242.
4. Hatah E, Braund R, Duffull SB, Tordoff J. General practitioners' views of pharmacists' current and potential contributions to medication review and prescribing in New Zealand. *J Prim Health Care*. 2013;5(3):223–233.
5. Bryant L. Discontinuing medicines in the older person. *J Prim Health Care*. 2013;5(3):255–256.
6. Te Karu L, Bryant L, Elley CR. Maori experiences and perceptions of gout and its treatment: a kaupapa Maori qualitative study. *J Prim Health Care*. 2013;5(3):214–222.
7. Bryant L, Bang C, Chew C, Baik SH, Wiseman D. Adequacy of inhaler technique used by people with asthma or chronic obstructive pulmonary disease. *J Prim Health Care*. 2013;5(3):191–198.
8. Russell N, Carryer J. Living large: the experiences of large-bodied women when accessing general practice services. *J Prim Health Care*. 2013;5(3):199–205.
9. Bray Y, Goodyear-Smith F. Patient and family perceptions of hospice services: 'I knew they weren't like hospitals'. *J Prim Health Care*. 2013;5(3):206–213.
10. Scott-Jones J, Lucas S. Rural general practice training: experience of a rural general practice team and a postgraduate year two registrar. *J Prim Health Care*. 2013;5(3):243–248.
11. Ekeroma A, Vaikoloa: Building clinical research capacity in the Pacific Islands. *J Prim Health Care*. 2013;5(3):257–258.
12. Baddock K. Altruism will survive the new professionalism in general practice—the 'no' case. *J Prim Health Care*. 2013;5(3):251–252.
13. Paterson R. Altruism will survive the new professionalism in general practice—the 'yes' case. *J Prim Health Care*. 2013;5(3):249–250.
14. Wee R. Dynamic consent in the digital age of biology. *J Prim Health Care*. 2013;5(3):259–261.