

Patient-centred prescribing

SUMMARY

Patients' requests and expectations, and prescribers' perceptions of these, are strong influences on prescribing behaviour.

Prescribers often overestimate patients' expectation of a prescription and so may overprescribe. Exploring patient expectations may reduce this.

Strategies for improving the quality of prescribing include clarifying the patient's concerns, goals and expectations of treatment, discussing management options, and the explicit use of evidence to inform shared decision making.

Introduction

Patients influence the behaviour of prescribers. What do we know about the complex interaction between patients and prescribers, and how can we use this knowledge to make us better prescribers in practice?

One of the goals of a consultation with a patient is to reach a shared understanding of their illness, and the underlying disease process and its effect on their lives. The treatment options need to be discussed, including their pros and cons. From this, a treatment plan can be negotiated taking into account the patient's goals and expectations of treatment.

Patient expectations

Patients may declare their preference for a medication. Sometimes this is through a direct request or it may be by mentioning a particular disease. Occasionally patients may present a set of symptoms typical of a condition which they believe should result in a prescription.

Persistence of symptoms ('Can't seem to shake this one, doctor') and life circumstances ('I am going overseas next week') may be offered as a reason for a prescription. Previous experience with a particular drug may also be used to influence a prescriber's decision.^{1,2} Many patients present with information gained from internet searches informing their requests. This is to be welcomed as evidence of an engaged patient and is an opportunity to discuss sources of quality information such as NPS MedicineWise.

Patient requests and expectations influence a prescriber's behaviour. An expectation of a prescription increases the likelihood that a drug will be prescribed.³⁻⁷ A request may contribute to overprescribing but can be beneficial by alerting a doctor to a problem and increasing the attention paid to it. For example, in one study patients asking for antidepressants increased and improved history-taking for depression.⁸

Patients may be dissatisfied if they expect a prescription and do not receive one. This experience has been found to double the likelihood that a patient will consult another doctor for the same problem.⁹ Consumers' expectations are not, however, fixed. The doctor should explore the reasons why the patient wants a particular medicine and a mutually agreed decision can be made based on the benefits or otherwise of a prescription.

Direct-to-consumer advertising, common in the USA, influences patients to request medication. This in turn strongly increases the likelihood of prescription.⁶

Prescriber perceptions

The perception that a patient expects a prescription is a strong driver to prescribe, increasing the likelihood by 10 times in one study.⁷ In other studies, it was identified as the strongest factor affecting prescribing behaviour.^{3,7,9,10} Prescribers may perceive the patient's expectation as 'pressure' to prescribe.⁵ Doctors report concerns that failing to prescribe may damage the doctor-patient relationship and decrease the likelihood of an effective therapeutic alliance.^{2,11}

About two thirds of the time, prescribers correctly identify a patient's expectation of a prescription.^{10,12} If a prescriber responds to this expectation by providing a prescription, the patient's belief that a prescription is the appropriate response is reinforced. In this way the doctor's behaviour may influence the patient's future expectations, increasing the likelihood of future prescriptions.² Doctors tend, however, to overestimate these expectations and many studies have shown a tendency to overprescribe because of this.^{2,5,12-14} On the other hand, a perception that a patient does not want a medicine may lead to under-prescribing.

Other patient factors that influence prescribing

A study of insulin prescribing for older patients found that doctors may adjust their prescribing depending

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on many factors including the perceived health literacy of the patient, their social supports as well as their socio-economic status.¹⁵ There is evidence that patients with lower socio-economic status receive poorer quality prescribing with more drugs, increased polypharmacy and decreased prescription of preventive drugs such as statins for lowering cholesterol.¹⁶ Older patients may experience similar problems.¹⁷ An Australian study found location to be an important factor with less statin prescribing in remote and rural populations compared with urban patients.¹⁸

Models

Understanding and discussing a patient's concerns, goals and expectations helps to optimise prescribing.⁵ A number of influential models of the doctor-patient interaction have emerged which incorporate the patient's influence on medical decision making including the decision to prescribe.

The content: evidence-based medicine

Perhaps the most influential model for treatment decision making has been evidence-based medicine, defined in Box 1.¹⁹ Patient values are often forgotten in the discussion of evidence, but were rightly included as a core component of the original model. Understanding a patient's ideas about their medicines and what has or has not worked in the past is invaluable for making effective future prescribing decisions. It is also important to explain the evidence base for treatment options.

A person is unlikely to take a prescribed drug, even under the best guideline, if they expect no benefit, or even harm, from it. Similarly a patient's goals and expectations may mean that treating to a guideline-based target is not appropriate. Clinical expertise enables the prescriber to explore the common ground

between the best evidence and the patient's values and sometimes to select other treatments or influence the patient if required. Evidence-based practice acknowledges and incorporates the influence of the patient in decisions about treatment.¹⁹

The consultation: the Patient-Centred Clinical Method

Evidence of factors which improve outcomes in the patient-doctor interaction led to the description of the Patient-Centred Clinical Method model, summarised in Box 2.²⁰ A clinician should seek to fully understand the disease and the illness including the patient's ideas, concerns and expectations about their illness. They should also aim to understand the patient as a person and their life context. Preventive care and being realistic about what is achievable are important. Try to find common ground with the patient, clarify and agree goals and share decision making about investigations and treatment. Finally, effective interactions involve attention to improving the doctor-patient relationship. This model provides an evidence-based approach to making the best use of patient influence within the consultation to maximise outcomes.

Conclusion

Clinicians seeking to base their decisions on best evidence will take into account patients' values and goals. In consultations, a prescriber will be aware of a tendency to overestimate patient expectation of a prescription. By asking and understanding a patient's concerns and expectations, common ground is more likely to be found allowing shared decision making and maximising the effectiveness of medicine use. <

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Box 1 Evidence-based practice¹⁹

Evidence-based practice is the integration of clinical expertise, patient values, and the best research evidence into the decision-making process for patient care.

Clinical expertise refers to the clinician's cumulated experience, education and clinical skills.

The patient brings to the encounter his or her own personal and unique concerns, expectations and values.

The best evidence is usually found in clinically relevant research that has been conducted using sound methodology.

Box 2 The six interactive components of the Patient-Centred Clinical Method²⁰**Exploring both the disease and the illness experience**

Patient history, physical examination, investigations

Dimensions of illness (feelings about being ill, ideas about the illness, effects of the illness on their function, and their expectations of the doctor)

Understanding the whole person

The person (e.g. their life history, personal and developmental issues)

The proximal context (e.g. family, employment, social support)

The distal context (e.g. culture, community, ecosystem)

Finding common ground

Defining the problems and priorities

Establishing goals of treatment/management

Identifying the roles of patient and doctor

Incorporating prevention and health promotion

Health enhancement, risk avoidance/reduction, early identification, complication reduction

Enhancing the patient-doctor relationship

Including compassion and trust, sharing power and healing. Building self-awareness in patient and doctor, and being aware of unconscious aspects of relationship such as transference and counter transference.

Being realistic

Clinicians need to be realistic about their own time and about building the capacity of the practice team. Wise stewardship of resources is important.

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