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Delayed prescribing in primary care

Delayed prescribing (*AFP* September 2016)[1] has no place in general practice. Giving a mother a script for antibiotics and telling her to get the script filled if the child gets worse is a dangerous course of action. Asking the mother to be the doctor and make a serious clinical decision is not fair on the mother and unsafe for the child.

If the general practitioner (GP) is unsure if the patient needs antibiotics then, instead of giving a delayed script, the GP should plan to review the patient.

Dr Chris Clohesy, MBBS, DRANZCOG, FRACGP, FACRRM, MHA, MClinEd, Ngukurr, Northern Territory

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1. Sargent L, McCullough A, Del Mar C, Lowe J. Is Australia ready to implement delayed prescribing in primary care? A review of the evidence. Aust Fam Physician 2016;45(9): 688–90.

It is with mild amusement that I read the article on delayed prescription of antibiotics in primary care (*AFP* September 2016),[1] and wonder if this is a case of evidence catching up with clinical reality. Might delayed prescribing be used more widely in Australian general practice than Sargent et al credit?

In 1999, the GP who supervised my basic general practice training term taught me his strategy of the 'contingency script' when dealing with the challenges of diagnostic uncertainty and patient expectations in the clinical negotiation. I have used this strategy since, with all the elements described by Sargent et al:

- Reassurance and advice: 'I don't think antibiotics are warranted at present, but the situation may change', with acknowledgement that many GPs in similar circumstances would prescribe faster than you can say 'evidence-based medicine'.
- A brief account of the dangers of antibiotic overprescribing.
- Information on symptom management (eg zinc), which may help reduce the duration of the common cold;[2] and olive leaf extract (a known antimicrobial),[3,4] which anecdotally helps chesty respiratory tract infections
- Advice on use of the 'contingency script' (eg if not improving in a few days or worsening symptoms).
- Safety net – invitation for review or follow-up contact as appropriate.

What is the basis of these recommendations? Well, clinical experience and common sense. This then raises the question: 'Should GPs wait for evidence (in the narrow sense of randomised-controlled trials [RCTs], meta-analyses or expert committee guidelines) before recommending any intervention?'.

BMJ's clinical evidence project reports that about 50% of treatments they assessed were of 'unknown effectiveness';[5] however, such treatments are used anyway. If we waited for large RCTs or meta-analyses to inform the entirety of clinical practice, we would recommend few interventions to our patients. This might work to the benefit of patients, but almost certainly also to their, and our, frustration.

My answer to the above question is to broaden the definition of what counts as evidence, and to acknowledge the richness of all that informs clinical practice. I draw your attention to the concepts of 'medicine of meaning' and 'multiple pillars of evidence'.[6] If the purpose of medical practice is helping and healing, then we need not wait for either the recommendations of Sargent et al or the results of 'further research'. We can draw on common sense, clinical experience and the many pillars of evidence found in the broader scientific literature. This is what Sackett et al describe as 'clinical judgement'.[7]

One final observation: Sargent et al comment on the 'perception that it is quicker to prescribe than to educate'. I suggest that education and prescribing are not mutually exclusive. In my experience, prescribing should be a process of education. I suspect that the less I prescribe and the more I educate, the more meaningful my clinical practice.

Dr Liz Fraser
GP, Canberra

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Reply

We thank Dr Fraser for her comments. With no formal measures, nor any published data of delayed antibiotic prescribing in Australia, we have to rely on our own unpublished qualitative data, which indicate that GPs are aware of delayed prescribing, but rarely use it correctly. This piqued our interest in delayed prescribing for Australian general practice.[1]

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Employing treatment alternatives to antibiotics is a good idea. However, the effect size and inconsistency of zinc in treating and preventing the common cold[2] is disappointing enough for us to be hesitant about recommending it wholesale, although we hope that an updated review that looks at different subgroups of zinc salts, some of which may be more effective than others, will soon be available. The antioxidant effects of olive tree leaf quoted[3,4] are from laboratory-based studies that have not yet been tested in effectiveness trials.

We agree that evidence has to be used 'judiciously, explicitly and conscientiously'.[5] However, we disagree that 'clinical judgement' (if we interpret Dr Fraser's use properly) means 'clinical experience'. Sackett et al was referring to combining the best available external clinical evidence from systematic research, clinical expertise, and current patient health issues and expectations in making thoughtful and compassionate clinical decisions about patient care.[5]

Overall, we are heartened that Dr Fraser is already using delayed antibiotic prescribing, and hope that our article and the response it has generated will mean that those not currently using it might consider starting.

We also thank Dr Clohesy for his response, which supports our comments above, that delayed prescribing is not universally adopted as Dr Fraser indicates. In a Cochrane review,[6] it is clear that clinical outcomes of delayed prescribing are better than those of no prescribing, and not clinically significantly worse than prescribing; and safety-netting (of which delayed prescribing is an example) is well established in general practice.[7]

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Letters to the editor

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