Logical process = smarter prescribing

Resist the sexy pill. Family doctors who heed this advice, unswayed by the marketing for the latest, "greatest" drug, are a step closer to more rational prescribing habits, delegates to the annual Family Medicine Forum were told Nov. 17.

"As humans we are naturally biased to think that newer is better, and because of that, we apply that to medicine. But it's not always the case," says Roland Halil, clinical pharmacist for the Bruyère Academic Family Health Team in Ottawa, Ontario, and an assistant professor in the department of family medicine at the University of Ottawa, who delivered a session on "rational prescribing in primary care" at the gathering in Toronto, Ontario.

A rational process for prescribing medication requires that doctors consider four factors, Halil says, while ranking those, in order of importance, as being: efficacy, toxicity, cost and convenience.

No surprise that whether a drug works tops the list. No one would disagree with that proposition. The issue, though, is finding information on efficacy from sources that don't have a motive besides helping patients — one such as, say, making oodles of money.

But good luck finding a clinical guideline on what to prescribe for any given condition that wasn't written by people with ties to the pharmaceutical industry, Halil says. Equally problematic is that much of the continuing medical education material regarding drugs that is available to physicians is often equally influenced by the same people who make and sell those drugs.

Little wonder, then, that the pharmaceutical industry was so well represented at the forum, which was cohosted by the College of Family Physicians of Canada (CFPC), the Ontario College of Family Physicians and the CFPC's Sections of Teachers and Researchers. Anyone interested in learning more about a drug needed only to follow the aroma of warm pretzels that was wafting out the doors of the facility's exhibition hall.

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Many factors come into play when physicians choose between drug A and drug B.

"The main challenge is finding unbiased information, because there is a generally accepted, but completely incorrect, assumption that the pharmaceutical industry has a role in medical education," says Halil. "And I don't think that's true. I wouldn't go to a Ford dealer to learn about cars."

Finding good data on the adverse effects and other risks of new drugs poses a different problem. Often, it's not so much about wading through oceans of biased information as it is waiting for data of any sort to arrive, Halil says. Randomized clinical trials tend to focus on efficacy, and it can take years, multiple trials and sometimes many deaths before there is a true understanding of a drug's risks. "Sometimes we forget to properly balance the efficacy against the toxicity — the benefit against the harm," he says.

And make no mistake, adds Halil, every drug has a downside. "Every single thing has a risk. I can give you too much oxygen and that can damage your lungs."

Cost and convenience carry less weight than the first two considerations in Halil's rational prescribing process, but they are still important. Everyone in health care should treat the limited resources of the system with greater care, he suggests. And if thought isn't given to making it easier for patients to afford, and adhere to their medication schedules, through such efforts as reducing their pill burden, then factors such as efficacy become somewhat irrelevant, says Halil. "If you are not taking it, it doesn't mean a thing."

But don't family doctors already follow some kind of rational decision-making process when prescribing drugs?

Not necessarily, says Halil. There are many factors that come into play when deciding between drug A and drug B, including a reliance on habit or tradition, instead of evidence-based sources; skewed perceptions of a drug's value because of industry influence; and pressure from patients, who

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have, in turn, been influenced by pharmaceutical marketing.

"They don't necessarily have a logical process for choosing one or the other," Halil says.

While it isn't easy for busy family doctors to keep abreast of the latest drug developments and the evidence that does or doesn't support use of a new drug, going through a logical process, step by step, should at least give physicians pause and make them aware of the holes in their knowledge, suggests Halil.

"I have the most respect for family doctors because they have to learn everything from cradle to grave — in a two-year residency. That's phenomenal. But every family doctor in the room has their strengths and weaknesses, the same way I do."

"There are some areas of therapeutics that they will be able to apply their knowledge to effortlessly and their patients will have fantastic outcomes, and there are other areas that they will have a little more trouble with, and they're going to need to find help or look for continuing education," Halil adds. "And where they find that information is kind of the kicker." — Roger Collier, *CMAJ*

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