The prescription pad in the 20th Century

by Dr Paul Davis

Prescriptions have been around from antique times. Sumarian doctors scribed their instructions to apothecaries on stone and clay tablets. The present prescription has its origins from the thirteenth century.

The form has hardly changed in the last 700 years. It is still an instruction to a pharmacist on the medication his patient should receive.

The new prescription described, is an attempt to bring the humble prescription into the twentieth century. It has been motivated and designed to cope with the extra pressures the modern doctor is faced with. The most important of which are discussed below:

Litigation

Gone are the halcyon days when the doctor's "I know my patients", is a sufficient record system. Society and patients demand more. A doctor has to account for his actions, and this perforce means the keeping of some form of clinical record.

The rise of the number of malpractice suits and the increase in medical defence insurance rates is positive proof of this. Stolen, or worse, the altered prescription is becoming more prevalent practice in Western society.

Rising costs

In 1980, in RSA alone, practice costs rose by 18%. From 1973, practice costs were related to 25 - 33% of the tarrif fee, in 1981 no less than 67% of the tariff fee for GP's is devoted to practice costs. This is further aggravated by the fixed statutory tariff.

This does not take into account the increasing cost of living and increasing difficulty in just maintaining living standards.

Time

This is the biggest single factor in Private Practice today. The modern doctor has to fulfil three roles, those of doctor, husband and father.

He has an increased workload, is expected to read journals, keep up to date, attend conferences and seminars. This is in addition to the time that this family now demands.

The pad I am now going to describe will go some way to relieve some of the problems. The focus on the prescription pad, to resolve some of these issues, is for the following reasons;

(1) The prescription is part of Western medicine. It's almost more ubiquitous than the stethoscope. Most consultations end in a prescription of some sort.

(2) It is the one piece of paper on a doctors desk or bag, that he is most likely to write upon.

(3) The prescription comes at a critical time in a consultation — at the end. By the time a doctor writes a prescription, the diagnosis is made, and a decision relating to management has been taken.

On the other hand experience has shown, that once this is completed, his mind is moving onto the next patient, and he is most likely not to write anything further in his clinical notes.

(4) The Law related to prescriptions insist that it contain at least: The date; the patients name and address; the drugs prescribed with dosage and quantity.

These are the bases of a rudimentary record system, the first two being an administrative record and the third a clinical record form.

For these reasons I am convinced that this prescription pad with the modifications and additions can be the pivot of practice management.

Description of the pad

There are three essential modifications, they are: duplicate pad; the extra data cues; addition of a detachable administrative tab.

A duplicate prescription is becoming a central issue in South Africa, our teachers and the law are convinced that a duplicate script should be kept as a formal part of a patients record. It is incontravertible evidence of what the doctor has prescribed. A duplicate prescription form will become a practice essential.

The extra cues: age — the age is important to minimise adult/child dosage errors. It should be filled in for all children under 12 years of age; time — the time the prescription was written is of particular importance in certain medico-legal situations. It also provides your accountant with the time a call was made to ensure correct recording and billing; telephone numbers — this is particularly useful information about patients seen after hours, and it makes it simple to enquire about the patient the next morning.

The perforated administrative tab at the bottom of the prescription has the following cues; Notes — space for short notes related to the consultation; Number — the prescription and the duplicate are sequentially numbered, which ensures an accurate administration record process, and reduces the fraud risk; Diagnosis — symptoms may be more than one, eg. cough and hypertension; Treatment — procedures done at this consultation, eg. ECG, Bloods, Urinalysis etc, used as a record for billing patients; Action — essentially instructions for your nurse. eg. book for Ba Meal, do blood test, refer to

Continued on page 26

Continued from page 24

DR. JOHN SMITH

Telephones:
Rooms 243-5791
Res.: 796-8312
Emerg.: 12-3456

Consulting Rooms:
5631 Medical Hill
Cor. Kotze & Claim Streets
Hillbrow

19

AGE TIME

TEL.:

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NOTES

N°

M	F
A	C
I	R

Systemforms

△	PX	AX

specialist, etc.

The importance of this tab is enhanced as the doctor does not have to leave his desk to instruct the nurse. Also the details are all filled in, in his own handwriting.

The duplicate contains all the information on the prescription form, and the duplicate has the same number as the original and form part of that patient's clinical record system.

Any confidential information which should not appear on the administration tab may be recorded at the back of the duplicate copy.

The whole issue is that all this extra information takes an extra 30 seconds to record and you only record it once i.e. a single entry system.

The system will save the busy Doctor time and it will go a long way to provide the basis for a clinical record system.

It will accurately and irrefutably capture the data for practice administration, and is amenable to support by the pharmaceutical industry.

The prescription can be used effectively by day-clinics, poly-clinics, the dispensing doctor, military medical faculties, and is compatible with data processing computers i.e. the entire primary care spectrum.

Van bladsy 22

33, 144) konstateer:

"In producing long-term medical care students are expected by their patients to deal with many emotional and social problems. When a student's perception of the physician's role excludes these issues, anxiety and frustration result."

In Desember 1977 blyk dit uit 'n vraelys wat deur interns van die Universiteit van die Witwatersrand voltooi is dat hulle beter vir die uitvoering van sekere motoriese vaardighede (bv. venepunksie, opstel van I.V. infuus) as vir die verkryging van sekere interpersoonlike vaardighede voorberei is. (Schreier, A., Shapiro, C., Beaton, G.R., en Shapiro D. 1979. S.A. med. J. 56, 805).

My pleidooi is dus dat hoe belangrik kennis en vaardigheid ookal is, die huisarts steeds daardie gesindhede wat vir die pasiënt van belang is, moet openbaar. ,,Belangstelling" lyk of dit die één effektiewe eienskap is wat bo al die ander uittroon.

Die mens bestaan uit 'n liggaam, gees en siel. Hierdie drie elemente is onafskeidbaar aan mekaar verbonde en kan nie afsonderlik beskou word nie — dit is 'n werklikheid wat nie ontsnap kan word nie.

Hantering van probleme van die liggaam (kliniese geneeskunde) en sommige probleme van die gees (psigiatrie) word in die mediese skool aangeleer. Die huisarts se taak lê egter baie dieper as dit.

Luister na wat een van ons kollegas alreeds tweeduisend jaar gelede gesê het toe hy die opdrag van die Meester aanhaal (Luk. 10:9): ,,En maak die siekes gesond wat daarin is, en sê vir hulle: Die Koninkryk van God het naby julle gekom".

Die opdrag is dus duidelik tweeledig van aard — moet nie net alleen die siek liggaam en gees gesond maak nie, maar gee ook aandag aan die siel.

Sekere affektiewe eienskappe is dus absoluut noodsaaklike in die mondering van die volwaardige huisarts. Hierdie eienskappe is hoofsaaklik aangebore, maar kan ook verworwe wees deur **opvoeding** — nie deur **opleiding** nie.

My slotgedagte: Hier is dit waar een van die groot taakgebiede van 'n Department van Huisartskunde in die opset van 'n mediese skool lê die **opvoeding** van die geneesheer van die toekoms!