FACTSHEET

Overuse of prescription medicines: a GP view

There has been a lot in the press recently about GPs prescribing addictive medicines. We are all aware of this, but we face great pressure from patients, and the hospital pain clinics, to provide relief from anxiety, depression and chronic pain that often has a significant impact on patients' quality of life.

I'll summarise here the approach that I, and my colleagues at The Wilson Practice, take, and I'll explain some of the issues contributing to these somewhat alarming headlines.

Firstly, most of the anti-depressants that we use **(sertraline/citalopram/fluoxetine/ venlafaxine/mirtazapine/amitriptyline)** are ***not addictive*** although patients may have to come off them slowly to avoid withdrawal side effects. This is not the same as being addicted.

Secondly, we always aim to prescribe all appropriate ***non-addictive medicines*** before we try something that we know could be addictive. When we do issue these we warn patients of their addictive qualities and issue them only for short courses initially, starting at the very lowest strength indicated for that condition. We aim to review patients on a regular basis and place an emphasis on reducing dosages as soon as we can. **Patients are often not keen on this.** Some of these medicines, such as **gabapentin** and **pregabalin**, are also prescribed for controlling anxiety, so have a dual use.

Thirdly, GPs generally, and certainly those working in The Wilson Practice, have been **steering clear of prescribing opiate-based medications** wherever possible, particularly in younger patients with long-term conditions, because of concerns about addiction. ***However,*** some patients, and in particular patients at the end of their lives, absolutely need them to control their symptoms and assure them a quality of life. We would not want to limit the use of these drugs unnecessarily for these patients.

Fourthly, there have been manufacturing issues and shortages of some medicines, which means alternatives need to be prescribed; this has been adding to the confusion.

And finally, there are, in fact, ***few alternatives***. Which gives GPs a dilemma when a patient reports that they are continuing to struggle with pain or symptoms of depression.

So, in conclusion: we wish to reassure patients that at The Wilson Practice we assess each individual and their symptoms on their merits, discuss the benefits and risks of each specific therapy, and enter an agreement with the patient about dose, length of time to be prescribed, winding down etc. A 10-minute appointment does not always allow as comprehensive a consultation as we would like. General practice is under-staffed and under-resourced, which compounds the challenge we face in trying to do a comprehensive job. We are, however, hopeful that the investment in new staff across general practice over the next five years will make a difference. **We always strive to do our best for our patients**.

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September 2019