TP29

CANCELLED

TP30 ABOUT THE GOOD USE OF ANTIBIOTICS : ZOOM ON PRESCRIPTIONS OF PIPERACILLIN-TAZOBACTAM AND TIENAMYCIN

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The frequency and the severity of multiresistant bacteria infections have become one of the most preoccupation in hospital. The aim of this study is to evaluate Piperacillin-Tazobactam and Tienamycin's prescriptions of a 400-beds university-Hospital. This study was carried over a period of 4 months, on behalf of the Committee of the Good Practice in Antiinfectious and the Infections Control Committee.

Nominal prescriptions of these two antibiotics were collected and analysed on the one hand on their form (conformity of the decree of 9 August 1991 which make rules for drug's prescription, dispensation and administration), and on the other hand, on their content (infected site, germs in cause, administered doses, total treatment duration).

Our first results concern, for a period of 2 months, 23 patients, and 72 prescriptions. For both drugs, 92,8 % of prescriptions are properly written.

15 patients (65.2%) received Piperacillin-Tazobactam and 8 (34.8%) received Tienamycin.

Out of 17 more careful study showed 12 documented curative treatment with Piperacillin-Tazobactam and 5 no documented treatment with Tienamycin. Average treatment duration was respectively of 8 days (at the mean dosage of 146 mg/kg/day) for Piperacillin-Tazobactam and 16 days (at the mean dosage of 23mg/kg/day) for Tienamycin.

The detail of indications showed that Tienamycin was most frequently prescribed in mediastinitis due to Enterobacter (40 %) as usually described in literature. On the other side, the highest use of first line therapy with Piperacillin-Tazobactam (25%) in Pseudomonas sp infection (detected in broncho-alveolar lavage), is not in adequation with the spectrum of this antibiotic.

This work shows that it is essential to follow recommendations in order to rationalise the antibiotics prescriptions and thus to limit the emergence of the multiresistant bacteria infections. Further investigations will be necessary to evaluate the efficiency of recommendations.

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TP31 COMPUTERISED PHYSICIAN PRESCRIBING IN A PRIVATE GENERAL HOSPITAL

Roure C (1), Lacasa C (1), Martinez J (1), Bachpol L (2), Humet C (3), Alguersuari N (4)*

INTRODUCTION. Computerised order entry directly by physicians has advantages over traditional manual systems: transcription is eliminated, illegible or ambiguous orders are avoided, it allows real-time order-checking and decision support and offers new opportunities for quality improvement and cost containment. However, it is remarkably difficult to implement, especially because it represents a major process change in physicians' daily practice.

AIM. The purpose of this study is to show our experience with a physician-based computerised prescriptions-entry system and particularly the effectiveness of different strategies used to gain physicians' endorsement of the system.

METHODS. Hospital de Barcelona is a private 340-bed acute-care general hospital with an integrated information system based on computerised medical records. Activity (13,547 surgical procedures and 19,471 patients discharged in 1996) is performed by more than 1,000 different physicians. Computerised prescribing has been available since August 1992. Strategies for increasing physicians participation in order entry were: A: periodic reporting to staff physicians of their own computerised prescription-entry rate and general ranking (October 92); B: computerisation of non-staff specialists consulting, with payment for services dependant on report entry (October 93); C: ancillary test ordering and reporting (October 95); D: development of easy-to-use menus for most commonly prescribed orders in surgical or obstetric patients (September 96). Five different study periods were established in order to measure the effectiveness of each of the above-mentioned strategies.

RESULTS.

	Orders entered by physicians %(n)			Physicians who used the system	
strategy / study period	intial	final	(%)	n	(%)
A / August 1992 - July 1993	8(511)	19 (1,667)	137	36	
B / August 1993 - July 1994	19	29 (3,283)	52	77	114
August 1994 - July 1995	29	27 (3,3317)	-7	88	14
C / August 1995 - July 1996	27	36 (4,798)	33	132	50
D / August 1996 - April 1997	36	54 (8,524)	50	586	344

CONCLUSIONS. Each strategy developed has led to meaningful increases in computerised physician prescribing. When no special interventions were implemented, further diffusion of the system was interrupted. Staff physicians' initial endorsement of the system led to a major increase in the number of computerised prescriptions. The Hospital Manager's support of the system, especially during the first two study periods, was an important key to success. Especially designed menus focusing on user needs and process simplification have proven extremely useful in order to gain non-staff physicians' acceptance.

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TP32 ETHICAL AND OTHER CONSIDERATIONS ABOUT CLINICAL PHARMACIST'S ROLE IN FUTURE THERAPY ACCORDING TO EXPERIENCE WITH HUMANITARIAN AID IN ONE HOSPITAL IN YUGOSLAVIA

*R.Velickovic**

Sudden interruption of regular Health Organisation, Drug production, Drug Marketing and Financial Support in ex Yugoslavia opened questions that could be ignored before 1991.Authorities in Health, Law, Merchant, Economy and others react slowly and obeying higher principles. In practise, appeared numerous problems:

1.To find out information about factories and countries in which already registrated drugs could be found (Pharmacoinformatics; over 50 books, journals, documents researched)

2.To calculate needs for uncertain period and epidemiologic development and unknown economic possibilities of potential donor (Pharmacoepidemiology, Pharmacoeconomics; Daily, monthly, yearly drug utilisation, real and supposed; over 100 reports)

3.To make contact with Humanitarian, Professional, Governmental and non-Governmental Organisations over the world (over 300 letters, phone calls and faxes)

4.To accept, store, assure about quality and distribute with adequate information everything that came(Logistic)

5.To introduce with known and new products(over 1500 drugs supplementary drugs,disinfectants;47% internistic, 34% psychiatric and neurologic,8% antibiotics,3% hormones,6% nutritions and vitamins,2% others; manufactured by 143 factories from 23 countries with explanations in 10 languages; Pharma- cology, Pharmacotherapy, Pharmacokinetics, Languages)

6.MAIN PROBLEM: To make decision what to do with new drugs, unknown producers, products with short shelf life or even out of it; those with no quality control declarations. What are knowledge ,skills and responsibilities that give right to put such products in therapy or not, to speak about or to keep silent,to inform patient or not?Over three hundred of patients waited for therapy every day. Was it more ethical to hit responsibility ball to clinicians and Health Authorities ? After last six years it is obvious that: Clinical pharmacist has to be well and multidisciplinary educated to have ability of professional criticism to computer and marketing pressure and to overcome ethical dilemmas. He/she has to be trained to adopt changes in practise and ma- ke own decisions including responsibilities for them. There should be formed "intelligent computer systems" in the area of pharmacotherapy but the last word stays human. It is not probable that temporary competition between Doctors and Pharmacists brings an improvement on any side. Public Health is Public thing and has to be seriously discus- sed in media by the Pharmacists too.

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July 23th 1997

Cristina ROURE

Dear Colleague,

Your abstract : **"Physician order entry in a private general hospital"** has been accepted with or without modification (see Georges HAZEBROUCQ's letter).
We are now preparing the proceedings of the congress.

Can you send your text **before October 1st** on diskette or by e-mail (Word 5 or 6 or Excel 5 or 6 for graphs) to :

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The text (3 or 4 pages) should be arranged as follows:
Title
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Methods
Results
Discussion, conclusion
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Thank you for your cooperation. See you in Tours.
Very sincerely.

Marie-Caroline HUSSON