Dear Sir,

Guidelines on Prescription of Sedatives

I refer to the recent newspaper report in The Straits Times on 26 August 1997. It concerns a deregistration of a doctor for over-prescription of sedatives.

I think many of my GP colleagues, as well as myself, are very concerned about the matter. We feel that there is no proper guidelines for the above. We seek to understand the SMA's stand on the matter.

I have the following queries:

1) What is 'over-prescription'? Is prescribing sedative once a day over-prescribing? Or, is the concern more related to the duration of supply at each consultation? (E.g. one-month supply)
2) Can a GP treat an insomniac regularly? That is, can a GP follow-up an insomniac over a long-term but with the intention of cutting down the dependence of the sedative? I personally do it by giving the patient a decreasing dosage over weekly-blocks. E.g. five pills a week; four pills a week; and so on. I feel that to simply refuse treating them is to push them to other less scrupulous 'suppliers'.
3) Is there any medico-legal implication in the choice of sedative one prescribes? E.g. Valium versus Dormicum/Erimin.
4) Can a doctor prescribe sedatives to self-confessed or suspected opiate addicts? I personally feel that there should be no discrimination in treatment. I feel that to help them to sleep well while they are struggling to overcome their opiate withdrawal effect is only humane. Of course one should not create a new dependence. The sedative is only meant to be a short-term measure.

Please throw some light to the above issues as I think many primary healthcare doctors would be faced with them regularly.

Thank you in anticipation.

Dr Ng Tsorng Chinn
General Practitioner

Reply to author

Dear Sir,

I hope to offer some advice on the judicious prescription of sedatives. The views expressed here are my own.

1. Over prescription

   Prescribing sedatives once a day is not over prescribing. In view of the practical problem of doctor hopping, it would be prudent not to prescribe beyond one month supply. The diagnosis of primary insomnia would need to be reviewed at the next consultation before giving another repeat prescription.

   The rationale is that the general practitioner would be dealing mainly with short term insomnia which should ameliorate within a month's time.

2. Treatment of chronic insomnia

   Although a general practitioner is able to treat chronic insomnia and decrease the benzodiazepine dosage gradually over several months, there is a likelihood that unscrupulous patients can abuse the system. Although there is merit in the argument that not treating such patients would push them to other less scrupulous 'suppliers'; there is nothing to stop such patients from seeking alternative supplies even while undergoing a general practitioner supervised gradual withdrawal regime. A three-month limit would be sufficient to deal with most cases of insomnia. Referral to a specialist would be indicated if the patient requires medication beyond three months. At our insomnia clinic at the National University Hospital, a review of the mental state would be initiated to elicit any concomitant substance abuse, anxiety or mood disorder. Judicious switching to longer-acting benzodiazepines with the addition of other medication is usually advocated. This requires assessment of the side-effects as well as the close monitoring of the mental state.

3. Medico-legal implications in choice of sedatives

   Whether a benzodiazepine is controlled or otherwise depends on the previous record of the drug usage in the community and not on the pharmacokinetics of the drug. Thus, Erimin, a long-acting benzodiazepine, is a controlled drug, whereas a short-acting benzodiazepine, like Dormicum or Alprazolam, is not on the controlled list; although it can be argued that these short-acting benzodiazepines are equally, if not more, addictive.

4. Prescription of sedatives to self-confessed or suspected opiate addicts.

   According to the law, all cases of suspected or confirmed opiate abuse have to be reported to the Central Narcotics Bureau. Hence, even if the doctor only suspects that the patient is on sedatives to overcome heroin withdrawal, he must still report the case. Otherwise, he cannot plead ignorance, as the amount of sedatives required in detoxification of opiates would require high dosages of benzodiazepines, much more than the amounts commonly used to treat insomnia. Detoxification of opiates would usually require in-patient treatment with additional medication like clonidine, anti-histamines, anti-emetics, anti-diarrhoea medication and tranquilizers. In Singapore, if the opiate addicts are not wanted by the Central Narcotics Bureau, they can avail themselves to such voluntary drug treatment programmes at the New Changi Hospital (for patients with no past drug abuse record only) or the National University Hospital (for all cases). Once detoxification is over, we would revert the patient back to the referring general practitioner for the Naltrexone maintenance programme.

Dr BrianYeo
Senior Lecturer & Consultant Psychiatrist
Department of Psychological Medicine
National University Hospital