

1 **Handwritten to Electronic Prescriptions: Emerging Views and Practices,** 2 **Saudi Arabia**

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4

5 **Abstract**

6 **Background:** There has been little research on electronic prescribing (EP) in Middle Eastern
7 countries. This is in part due to the slow implementation of electronic health records integrated
8 with electronic prescribing. Electronic prescribing is associated with a considerable reduction in
9 medication errors compared to handwritten prescriptions. **Objective:** This paper reviews the
10 research literature on handwritten and electronic prescribing in the Kingdom of Saudi Arabia
11 (KSA). **Search Strategy:** Computer searches of PubMed and Google Scholar were conducted
12 using the keywords “electronic prescribing”, “handwritten prescribing,” and “medication errors.”
13 A total of 101 studies were included in this work. **Results:** Observations indicated more articles
14 on handwritten prescriptions than on electronic prescribing due to a lack of research and slow
15 implementation of electronic prescribing systems in this part of the world. Electronic prescribing
16 that was supported by well-defined standards and careful implementation was associated with a
17 reduction in serious medication errors, morbidity, mortality, and service cost, as well as an
18 increase in work flow efficiency, a higher quality of healthcare service delivery, and greater
19 satisfaction of both healthcare providers and consumers. Electronic prescribing is now being
20 practiced in many major medical centers and specialist hospitals in KSA. However, there
21 remains a need to implement electronic prescribing systems in other hospitals, primary care
22 outpatient settings, and throughout the private health sector. **Conclusion:** It is time for the
23 widespread adoption of electronic prescribing, electronic health record, and health informatics
24 systems across Middle Eastern countries including KSA, as well as for systematic research to
25 evaluate their effectiveness.

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27 **Keywords:** Handwritten prescription, electronic prescribing, electronic prescribing systems,
28 electronic health records, medication errors, Saudi Arabia

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34 Introduction

35 Medication errors are unintentional errors that tend to occur during prescribing, dispensing and
36 administration phases of a medication while under the control of a healthcare provider or a
37 consumer. Most of medication errors are preventable. However, medication errors associated
38 with serious adverse events contribute significantly to morbidity and mortality, poor quality of
39 care, huge medical costs and poor outcomes [1]. Medications errors are caused both by
40 handwritten and electronic prescriptions, although the former leads to a higher prevalence of
41 medication errors and adverse events, due especially to the illegible handwriting of the prescriber
42 [2]. This paper reviews this topic in order to address a number of interconnected issues related to
43 both methods of prescribing: 1) problems in current medication prescribing practices, especially
44 handwritten prescribing; 2) the role of electronic prescribing in mitigating these problems; 3) the
45 functions of the electronic health record system with electronic prescribing imbedded within it;
46 and 4) mechanisms of implementing electronic prescribing system in Saudi Arabia with a further
47 focus on identifying potential barriers and challenges.

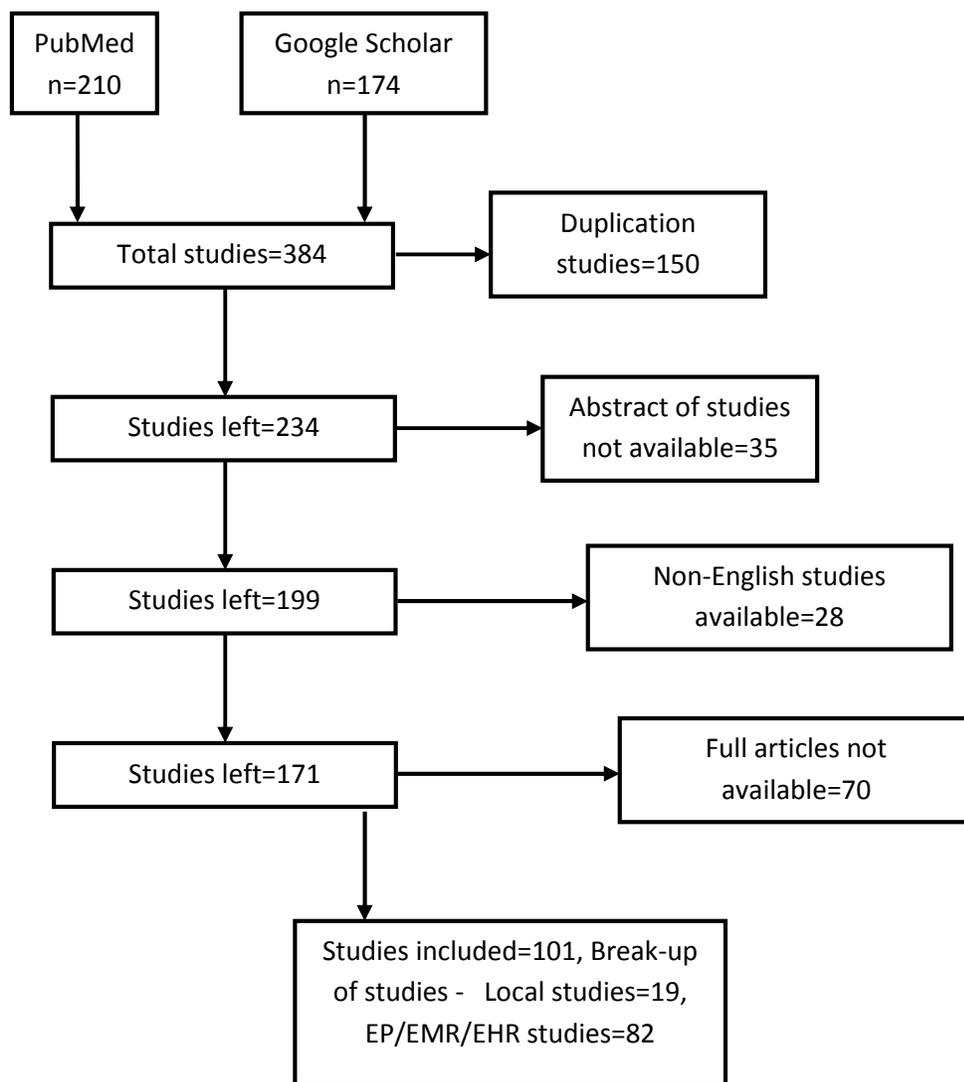
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49 Search Method

50 Computer searches of PubMed and Google Scholar (1980-2013) were conducted using the
51 keywords “handwritten prescription,” “pen and pencil prescription,” “medication prescribing,”
52 “medication errors,” “electronic prescribing,” and “electronic medical records.” We also used a
53 strategy in which two words were combined to retrieve the peer-reviewed articles published in
54 English language journals. The words combined with key words included mechanisms,
55 standards, advantages, disadvantages, challenges, plan, and opportunities. In addition, we
56 carried out hand search of English journals to identify handwritten and electronic prescribing
57 studies. We identified a total of 19 studies on handwritten and electronic prescribing (n=19) in
58 Middle Eastern countries. In addition, peer-reviewed articles that mainly focus on the
59 mechanisms, standards, principles, advantages, disadvantages, benefits, costs and pitfalls of
60 electronic prescribing and published in English journals were retained. We also excluded studies
61 published in non-English journals (n=98). We did not consider studies whose abstracts or full
62 texts that were not readily accessible (n=99). We retained only those papers that focused on

63 local handwritten prescriptions and e-prescribing (n=19) and mechanisms, principles, and
 64 standards of e-prescribing systems embedded with electronic health record (n=82). We focused
 65 on meta-analytic studies, systematic qualitative and quantitative reviews, randomized clinical
 66 trials, cross-sectional studies, and a few detailed case studies. Thus, a total of 101 studies were
 67 included in this work [Figure 1]. Two of us (NAQ & AMB) reviewed these studies and any
 68 arising disagreement about the inclusion of a study was resolved by three of us (NAQ, AMB &
 69 HGK).

70 **Figure 1 Flow chart of selected studies**



91 **Handwritten Prescribing**

92 Writing prescriptions by hand is the predominant method of prescribing drugs in healthcare
 93 systems of Middle Eastern countries. A number of studies have explored the different aspects of

94 handwritten prescriptions in three healthcare settings in the Kingdom of Saudi Arabia (KSA) [3-
95 12]. These studies offer a historical background on handwritten drug prescribing as it relates to
96 both non-psychiatric [3-12] and psychotropic medications [13-14]. In a primary health care
97 (PHC) study, Khoja et al focused on four types of prescribing errors, finding that prescribing to
98 relieve symptoms was the major reason for prescribing medications [6]. The number of drugs
99 written for per prescription was 3.2, which differed from other studies [4-5, 10] and was
100 attributed to study sample size and other methodological issues. In contrast to these studies [5-6,
101 10], Al-Nasser reported a higher number of drugs per prescription written to the clients in Al-
102 Baha city [4]. In Bahrain, Al Khaja and colleagues explored three types of prescribing
103 medication errors and offered recommendations including training to improve the prescribing
104 skills of health professionals [15]. Researchers in Iran found that general practitioners often
105 overprescribed medications [16], and in Jordan, Otoom and colleagues reported that physicians
106 overprescribed antibiotics and under-prescribed generic drugs [17]. Furthermore, all of these
107 studies provided recommendations to further improve the overall quality of prescribing in PHC.
108 In a study of informed self-medication that substantiated earlier findings [9,18], Bawazir
109 reported that analgesics/antipyretics and dermatological drugs were the most commonly
110 dispensed over-the-counter (OTC) drugs, while antibiotics were the most common drugs
111 dispensed through handwritten prescriptions [7]. In addition, physicians often engaged in
112 polypharmacy, and this prescribing pattern was similar in hospital outpatient clinics and in PHC.
113 Bawazir recommended that regulations related to the sale of drugs be enforced and that a list of
114 medications sold OTC be developed. In the KSA, Al-Faris and Al-Taweel found that the most
115 frequently handwritten prescribed drugs were antihistamines (25%), paracetamol (20.3%), and
116 antibiotics (14.7%) [19]. In more than 50% of prescriptions, the diagnosis was upper respiratory
117 infection for which antibiotics (26%) and antihistamines (28%) are the usual treatments. This
118 study recommended the training of both patients and doctors regarding the benefits of treatment
119 and the importance of adherence.

120 In summary, the key findings of these studies [3-19] were that: 1) there is inadequate
121 documentation in prescribing (omission errors); 2) the prescription of drugs is one of the most
122 important factors in the rising cost of health care services; 3) most patient visits in healthcare
123 settings end up with a drug being prescribed (often involving overprescribing); 4) doctors and
124 pharmacists need continuing education in the area of appropriate drug prescribing drugs

125 (prescribers not well trained); 5) informed self-medication could be appropriate and cost-
126 effective; 6) there is need for patient education on the benefits of drug treatments especially in
127 the management of chronic diseases (patient health literacy low); 6) more audits of the
128 prescribing habits of professionals are needed (the findings of these audits should be fed back to
129 the professionals to improve the quality of prescribing); 7) brief intensive courses on mental
130 health disorders are necessary for enhancing physicians' skills both in terms of identifying
131 disorders and prescribing appropriate psychotropic medications ; and 8) there is a need for
132 future studies assessing different aspects of prescribing errors, clinical as well as non-clinical.
133 None of these reports recommended the implementation of electronic prescribing (EP) in the
134 KSA healthcare system, although handwritten prescriptions are associated with more than twice
135 the medication errors, higher morbidity and mortality, decreased workflow efficiency and quality
136 of care, poorer medical outcomes, decreased patient and health providers satisfaction, and
137 increased costs as compared to electronic prescriptions [20-22]. Although these problems of
138 handwritten prescriptions have not been discussed extensively in KSA, research in the Western
139 world on handwritten prescriptions largely supports our observations here. There is now a large
140 volume of literature on physicians' prescribing and handwritten prescriptions in the western
141 world [23-25] where currently electronic prescriptions are nearly uniform with a significant
142 decrease in the problems related to non-electronic prescribing.

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144 **Local e-Prescribing Scenario**

145 Few studies have explored EP in the KSA and only indirectly. One study has reviewed the
146 implementation of electronic health records (EHRs) [26]. Another study has qualitatively
147 explored clinicians' perceptions of computerized physician order entry (CPOE) system in the
148 intensive care unit of a leading health care organization [27]. In the latter study, researchers
149 surveyed 43 clinicians to assess perceptions regarding 32 factors collected from the literature
150 related to the successful implementation of the CPOE system [27]. The factors most critical for
151 success were as follows; 1) the provision of training prior to system implementation, 2) adequate
152 clinical resources during implementation and 3) allowing sufficient time for ordering.
153 Researchers concluded that the benefits expected were much higher than the risks and that CPOE
154 reduced medication errors (MEs) and improved quality of care. Two recent surveys about the
155 hospital pharmacy practices in Saudi Arabia found that about one-third (34.5%) of hospitals have

156 CPOE systems with clinical decision-support systems (CDSSs) and over half (51.9%) have
157 EMR/EHR system in place [28]. For medication dispensing, 21% of hospitals routinely use bar
158 coding technology with automated dispensing cabinets, and for medication administration, 33%
159 use electronic medication administration records (eMARs), 7.4% have bar-code-assisted
160 medication administration (BCMA), and 12% have smart infusion pumps [29]. According to
161 this research, hospital pharmacy practices including prescribing, transcribing, dispensing, and
162 administration are all well developed. Among recommendations made was the use of health
163 informatics including robotic drug dispensing [30]. Both e-prescribing and robotic dispensing of
164 drugs has been shown to substantially reduce medication errors [30, 31].

165 **Scope of this review**

166 The present review focuses on EP in Middle Eastern countries including Saudi Arabia.
167 Electronic prescribing is now beginning to be practiced in many major medical centers and
168 specialist hospitals in KSA. However, further impetus is needed to expand the implementing
169 EHR and electronic prescribing systems in other major hospitals, primary healthcare centers, and
170 private clinics and hospitals. As has occurred in the European Union [32], we hope that EHR
171 systems with EP will be implemented over time in Middle Eastern countries. This paper seeks to
172 inform healthcare policy makers, which we hope will lead to further implementation of EPS
173 either as a standalone system or embedded within EHR [33].

174 **E-Prescribing System – a troubleshooting tool**

175 In contrast to the problems associated with handwritten prescriptions, electronic prescribing (EP)
176 has brought significant changes to how drugs are efficiently prescribed and monitored [34].
177 Electronic prescribing systems (EPSs) have been subject to clinical trials and then implemented
178 in high income countries, which has resulted in improved clinician prescribing practices,
179 increased patient safety, and improved monitoring of patients with multiple illnesses taking large
180 numbers of medications [35,36,37]. Health information technology (HIT) has opened up an
181 exciting frontier that has the potential to tremendously improve the care and safety of patients,
182 substantially reduce medication errors (MEs) and adverse drug events, decrease morbidity and
183 mortality, and decrease long- and short-term health care costs [38-42]. Computerized physician
184 order entry, for example, is a powerful method that has been used to advance and refine the
185 process of prescribing medications across all levels of healthcare in high income countries and
186 upper middle income countries [34,43]. Standalone EPSs or those embedded in EHR systems

187 have the potential to empower prescribers, patients, and pharmacists to reform the quality of
 188 pharmaceutical care and improve workflow efficiency [34,44,45]. EPSs help to prevent MEs,
 189 lower the incidence of MEs, lower morbidity and mortality, lower re-admission rates; reduce the
 190 number of ME-related claims; and increase the prescription of more affordable medications
 191 (generics), EPSs also improve communication about medications, support of clinical activity
 192 through interaction with knowledge sources, improve clinical decisions at the point of
 193 prescribing and administration, enhance patient safety, and most importantly, improve the cost
 194 and quality of services provided to patients. When EPSs are implemented, health providers and
 195 managers tend to experience higher job satisfaction and there is improvement in work
 196 performance. Furthermore, the work atmosphere is less stressful and there is more cooperation
 197 and communication between professionals, technical staff, and patients [33, 44, 46]. There have
 198 also been reports, however, that EPSs increase the rate of some MEs [33]. As a result,
 199 recommendations have been made to improve EPSs with even better systems [33, 46].
 200 Commonly used terminology in relation to MEs, including electronic prescribing, are
 201 summarized in Table 1.

202 **Table 1** Definitions of medication errors (MEs) and electronic prescribing (EP)

Terms	Definition
Adverse drug event (ADE)	Any injury due to medication, including known and expected injuries of medications; unavoidable but preventable. Such as drowsiness from diphenhydramine and an anaphylactic reaction to penicillin
Adverse drug reaction (ADR)	Harmful, unintended reactions to medicines that occur at doses normally used for treatment are called adverse drug reactions. ADRs are preventable and classified as Type A to Type G . Type A predictable and dose-dependent whereas Type B unknown and need to be identified and communicated quickly. Type B usually idiosyncratic and unpredictable. Other types of ADR include Type C (chronic effects), Type D (delayed effects), Type E (end-of-treatment effects), Type F (failure of therapy) and Type G (genetic reactions). Examples include respiratory depression with opiates and liver toxicity with troglitazone
Electronic Prescribing	Includes two-way transmissions between point of care and dispenser; a prescriber’s ability to electronically send a prescription directly to a pharmacy from point of care; and transmission of prescription and/or related information between prescriber, dispenser, pharmacy benefit manager, and health plan, either directly or through an intermediary using an electronic system. These functions can be performed using single-purpose software or EP functionality imbedded in EHRs.
Error	The failure of a planned action to be completed as intended or the use of an incorrect plan to achieve an aim. An error may be an act of commission, an act of omission, or both

Prescription fill status	Indicates whether prescription is filled, not filled, or partially filled; includes providers, patient, and drug aspects of SCRIPT message. Not yet generally used
Medication Error	Any error occurring during the prescribing, dispensing, or administration of medication. Preventable and inappropriate use of medication or any preventable event – potential or actual – that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional or patient. “Potential errors” not considered ADRs or ADEs – they are reports of possible medication errors (Near misses or close calls). “Actual errors” may or may not reach the patient. MEs that reach the patient either cause harm or no harm.

203

204 **Electronic prescribing: standards and principles**

205 Electronic prescribing (EP) is defined as the transmission of prescription or prescription-related
 206 information by electronic means between a prescriber, dispenser, pharmacy benefit manager, or
 207 health plan, either directly or through an intermediary such as an EP network. EP includes two-
 208 way transmissions between the point of care and the dispenser [47]. In the U.S., the Medicare
 209 Modernization Act of 2003 advocated for EP standards and supported the electronic transmission
 210 of prescriptions and the electronic transmission of information on eligibility and benefits in terms
 211 of drug formulary, prior authorization messages, and patient instructions [48-49]. Moreover, A
 212 Clinician’s Guide to Electronic Prescribing (2008) noted that a qualified EPS must be capable of
 213 performing all of the following functions: 1) generating a complete active medication list
 214 incorporating electronic data received from applicable pharmacy drug plans if available; 2)
 215 selecting medications, printing prescriptions, electronically transmitting prescriptions and
 216 conducting all safety checks including automated prompts that offer information on the drug
 217 being prescribed, potential inappropriate dose or route of administration, drug–drug interactions
 218 (DDIs), allergy concerns, and/or warnings or cautions; 3) providing information related to the
 219 availability of lower cost alternative medications; and 4) providing information on formulary or
 220 tiered formulary medications, patient eligibility, and authorization requirements received
 221 electronically from the patient’s drug plan [50]. If these functions are performed accurately by an
 222 EPS, this will result in a considerable reduction of MEs, improving patient safety and quality of
 223 healthcare [51]. Furthermore, EPSs have immediate benefits in terms of improved quality and
 224 safety of prescribing, as well as providing more cost-effective medication options for patients
 225 and improving ambulatory care workflow [49-50, 52]. EPSs have standards (Table 2) and
 226 principles (Table 3) that guide ethical, technical, policy, and financial developments in this field.

227 Stakeholders often utilize these fundamentals of EPSs as they develop strategic and tactical
 228 initiatives on EP [52-54]. One study found that physicians who used EP endorsed EP as
 229 improving patient safety but did not perceive benefits from using standardized Medication
 230 History (RxH) transaction or formulary and benefit information [55]. Therefore, researchers
 231 called for more studies of these standards in application to determine how to maximize the
 232 benefits of such systems [55].

233 **Table 2** Electronic prescribing standards.

Standard	Remarks
Medication history*	Provides a uniform information about drugs used by the patient for healthcare providers that is useful in preventing medication errors as well as understanding medication management adherence
Formulary and benefits*	Provides prescribers with information about a patient’s drug coverage at the point of care, which may include drugs on formulary, alternative drugs not on formulary, rules for prior authorization (PA), and step therapy, and the cost to the patient for one drug option versus another. Prescription of generic drugs is encouraged because of cost issues.
Prescription fill-status notification*	Intends to notify the prescriber about whether a patient has collected a prescribed medication at the pharmacy, thus following-up patients with poor drug adherence
Prior Authorization**	Insurers require patients in consultation with physicians to receive approval from the latter before certain drugs will be covered, hence streamlining process to communicate the need for PA directly to the prescribers and allow prescribers to send the necessary information along with the prescription
Structured and codified signature**	Seeks to ensure that patient instructions for taking medications (called “signatura”) – such as “by mouth three times a day” – are placed at the end of a prescription
RxNorm	Provides standards for the name, dose and form of available drugs that need further refinement and evaluation before being deployed in a live setting
SCRIPT (v 8.1)	Intends to improve prescribing workflow and prescriptions that need revision and modification updates without needing to create a new order; allows for a refill to be sent from the facility to the pharmacy without the physician’s intervention; and allows patient information to be updated outside the context of a prescription
Ref: 52-54,58, Notes: *Standard recommended by evaluation team; **Standard not recommended by evaluation team.	

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236 Policymakers have divergent views about EP, including that it merely involves e-prescriptions
 237 sent and received electronically, that it is associated with higher quality of healthcare, and that it
 238 promises healthcare at lower cost [56]. EPSs use several measures for increasing the safety and
 239 convenience of prescribing: electronic prescribing, e-refilling (the electronic transmission of
 240 refill requests and authorizations), making prescription history available across multiple
 241 providers , providing information about eligibility, availability of drugs on the formulary, and
 242 vendor’s commitment to customer support, and bidirectional data transmission between
 243 physicians, pharmacies, insurers, and other stakeholders [56].

244 **Table 3** Electronic prescribing (EP) principles.

It is believed that widespread adoption of EP can provide many benefits; for example: improved medication safety, enhanced practice efficiency, cost savings, more effective medication management, increased patient adherence, and improved integrity of the prescribing process
All health care stakeholders should collaborate to encourage widespread adoption and optimal use of standards-based EP through: appropriately aligned incentives to support effective use of the technology in diverse practice settings; collaborative development and delivery of innovative programs, education resources, training, and support; efficiencies in workflow for the physician and pharmacist in diverse practice settings; and connectivity and tools to facilitate medication reconciliation, formulary and medication history information, and transmission
EP system design and/or the implementation of EP should: enhance the patient–clinician relationship by providing more comprehensive clinical information at the point of care; preserve the patient’s choice of pharmacy; facilitate the clinician’s informed choice of medication; and be part of an integrated plan toward full implementation of an electronic health record (EHR) system
Both EHRs and stand-alone EP may be utilized to realize the functionality and benefits of EP. Overall quality of care can be enhanced by implementation of EP that is integrated within an HER
Consumer organizations, providers, pharmacists, payers, and educators should help patients understand and experience the benefits of EP. Informed patients will play an important role in encouraging providers and pharmacists to use EP
Ref: 52-54

245

246 E-prescribing and EPS programs are associated with improved health care to patients [34]. These
 247 systems provide electronic health records (EHRs) for health organizations that establish links
 248 from primary to tertiary care [52, 56-57]. EPSs also allow access to health information about the
 249 relevant healthcare activities for each individual patient. Accordingly, EPSs have a major role in
 250 supporting a patient’s treatment with the correct medications wherever they may be treated. EP
 251 provides information about treatment to any health professionals who need that information and

252 whenever they need it, provided they have the legitimate right to access that information. EPSs
253 also offer online access, at the point of need, to relevant knowledge and clinical decision support
254 systems (CDSSs). Thus, important features of EPSs include provision of access to prescriptions
255 in multiple locations by multiple system users; automatic or semiautomatic stock control; legible
256 prescription production; provision of access to medication records; reminders and alerts,
257 including those relating to formulary choice, to support prescribers at the time of prescribing;
258 support for medicine administration; and note-making abilities to support communication
259 between all health care workers caring for a patient [56-57]. Researchers have identified several
260 mechanisms involved in EP [58].

261 **Advantages of e-Prescribing**

262 According to the Institute of Medicine, preventable MEs result in at least 1.5 million adverse
263 drug events (ADEs) and 7,000 deaths each year in the USA [49-50]. EP reduces MEs and
264 improves patient safety by eliminating illegible prescriptions and providing virtual real-time
265 checking for drug-drug interactions (DDIs), drug allergies, dosing errors, and therapeutic
266 duplications [52]. In addition, real-time checking of drug formularies can reduce cost and
267 improve work efficiency by minimizing pharmacy telephone callbacks [52]. According to one
268 study, the average reduction in pharmacist labor costs from EP was about \$0.97 USD for each
269 new prescription and \$0.37USD for each renewed prescription [53]. Hence, the Institute of
270 Medicine recommended that EP should be used globally by all prescribers and pharmacies by
271 2010 [49-50]. The benefits of EP were further confirmed when up to 86% of serious MEs were
272 eliminated across the Western world following incorporation of CPOE into health care systems
273 [59]. EP also facilitates formulary compliance and supplies medicines much faster and more
274 cost-efficiently to hospital wards at 36% of the price of traditional methods [60-61]. Electronic
275 transfer of information on admission allows drug histories to be imported directly into EPSs.
276 Another advantage of EP is that it allows dispensing records to become available through a
277 national care records service as has been implemented in the USA. Likewise, information from
278 electronic community pharmacy systems can be made available through EPSs that increase
279 patient safety, effectiveness and efficiency of drug administration [62]. Further, the electronic
280 capture of drug administration by scanning of pack barcodes facilitates automatic bedside stock
281 control. EP also improves workflow and increases the involvement of pharmacists in clinical
282 care [57, 61]. A systematic review of the impact of health information technology (HIT) on the

283 quality of medical care revealed that HIT interventions – primarily EHRs – improve quality by
284 improving medication safety, increasing adherence to guidelines, and providing tools to enhance
285 disease surveillance [54]. However, most studies documenting benefits of EP were not conducted
286 in the ambulatory setting, where volumes are greater and complexity increases [54]. Many
287 potential advantages of EP have been emphasized throughout the published literature worldwide
288 [54,63].

289

290 **Disadvantages of EP**

291 E-prescribing is reported to cause a new generation of unintended MEs [64]. Accidental selection
292 of the wrong drug, dose, or dosage form from computer dropdown list is associated with
293 increased medication errors [65]. In a way, this replaces MEs due to illegible handwritten
294 prescriptions. Another disadvantage is the selection of the wrong patient profile [66]. Moreover,
295 sometimes a dosage or dosage form listed on the computer is only the dose the drug formulary
296 allows or pharmacy stocks and does not reflect the dose range. This can lead to inappropriate
297 dosing. Prescription duplication can also occur if the prescriber tries to change a dose and forgets
298 to discontinue the old prescription. In addition, prescribers may ignore alerts for allergies, drug-
299 drug interactions (DDIs), and therapeutic duplication when too many alerts flash on the screen
300 [67]. Though not applicable to the Saudi health care setting, a transmission fee is charged in the
301 USA for receiving prescriptions or refill approvals electronically. The average cost is about
302 \$0.25 USD per transmission. The cost of receiving an e-prescription by fax is less than receiving
303 the prescription electronically [48].

304 There are other drawbacks of EP [54]. First, there are concerns about how to electronically
305 prescribe controlled substances, which are typically used to treat severe pain or anxiety.
306 Prescriptions for these medications may be written using an EPS but cannot be transmitted
307 electronically to pharmacies. Typically, the physician will print such prescriptions, which may
308 require his/her signature. In one study prescribers were optimistic about the potential for e-
309 prescriptions for controlled substances to improve practice, but viewed the necessary security
310 measures as a burden and a potential barrier to use [68]. Currently, prescription drug abuse is a
311 major problem that is increasing worldwide. This trend could be reduced by prescription drug
312 monitoring programs (PDMP), which have multiple areas of focus that include prescribing
313 practices. These electronic databases collect data on controlled substances so that health care

314 providers can decrease abuse, doctor shopping, and diversion [69]. Further research is needed on
315 e-prescribing controlled substances so that action can be taken [69].

316 Second, patients, physicians, and pharmacists should not think that the use of EPSs eliminates all
317 potential for MEs to occur. Patients need to be aware of their medication history and current
318 treatment and make sure that physicians are aware of any conditions they have, including
319 allergies. EPSs supplement the expertise of physicians and normal medical diligence but do not
320 eliminate the need for awareness. Third, EPSs may not have information on all the medications
321 that a patient is taking, such as over-the-counter (OTC) drugs, which can cause allergic reactions
322 or other problems that a physician should know about. Thus, patients must provide all relevant
323 information about any OTC and/or complementary and alternative medicine (CAM) drugs to
324 physicians. This is an integral component in prescribing error (PE) prevention strategies [54].
325 Finally, the typical data collected by an EPS might not be useful in identifying doctors at higher
326 risk for making serious prescribing errors [70].

327

328 **Legal Perspectives**

329 There are several legal issues involved in electronic prescribing including accountability, criteria
330 for access to electronically stored patient data, risks of unauthorized access to patient data, and
331 misuse of electronically stored patient data. In USA, state prescribing laws applicable to other
332 countries provide solutions for e-prescribing data collected on controlled and un-controlled
333 medications and how to share datasets with other stakeholders including health consumers,
334 health providers, sponsors and researchers [71]. For example, the prescription drug monitoring
335 program (PDMP) collects designated data on substances including controlled medications
336 dispensed in the state. The PDMP is housed by a specified statewide regulatory, administrative
337 or law enforcement agency. The housing agency distributes data from the database only to
338 individuals who are authorized under state law to receive the information [56,72].

339

340 **Opportunities, challenges and e-Prescribing**

341 There are many opportunities and challenges to electronic prescribing. EPSs facilitate the
342 patient-centered role of pharmacists in medication review and treatment plans, review of patient
343 response, identification of optimum dosage forms, patient education and counseling, improving
344 accuracy of medication dispensing on hospital discharge, and communication of ongoing

345 pharmaceutical care needs [56, 73-74]. Thus, EPSs help to improve pharmacists' contributions to
346 the clinical care of patients. As a result, pharmacists are able to spend more time serving patients
347 in inpatient and outpatient settings [48-50].

348 Challenges and weaknesses of EPSs need to be addressed. For instance, those first beginning to
349 use EPSs tend to experience difficulties with formulary checks and RxH documentation, which
350 are associated with prescriber distrust and unwillingness to rely on EP-based information [75].
351 Greater data accuracy and completeness must be assured if EPSs are to meet their objective of
352 improving the efficiency and safety of EP in PHCs and other settings [75]. Another example
353 concerns faxed e-prescriptions. If computer software such as SureScripts sends prescription faxes
354 to community pharmacies [56], those pharmacies may not accept these prescriptions because
355 they have not seen a computer-faxed prescription with an electronic signature before. This
356 problem, however, can be easily addressed through widespread education programs.

357 The importance of staff training and increasing public awareness of EPSs cannot be
358 overemphasized. The public and patients need continuing awareness campaigns about EPSs.
359 Initially, the country that adopts EPS needs to make a huge investment not only for the purchase
360 of a comprehensive, qualified and fully functional EPS software but also for the continued
361 training of health staff and the mounting of public-awareness campaigns [56]. Returning to the
362 pharmacists handling of prescriptions, rather than searching through faxes and voicemails,
363 pharmacy staff could check e-prescriptions directly sent to their computers and dispense
364 medications to the patient. Another challenge for EPSs concerns medical errors. MEs have
365 detailed taxonomies [49-50, 76-77], multiple etiologies [78-79], and relevant pre- and post-EP
366 era issues. The development of EPSs to capture all forms of MEs, then, is a daunting task.
367 However, continuing advancements in information technology offer strategies that can help to
368 implement clinical practice guidelines [80]. Furthermore, an interesting tool has been built to
369 develop collaboration between patients and physicians that allows the physician to make well-
370 informed and safe EP decisions based on personal medication records contributed by the patient
371 [81].

372 The field of mental health is not yet on par with physical health around the world and this
373 extends to EPS integration into mental health care settings. This, however, is slowly changing,
374 and in the USA researchers have recommended implementing EPSs in the public mental health
375 system [82]. Hopefully, other nations will follow this important development [83].

376

377 **E-prescribing Needs in KSA**

378 Although Saudis accept the need for EP, its implementation across all health care delivery
379 systems including the private sector has been minimal and slow, with only a few hospitals now
380 having an EPS [26-27]. The problems associated with handwritten prescriptions need to be
381 addressed globally. Major medical centers such as King Saud Medical City, King Fahad Medical
382 City, King Abdulaziz Medical City, and major hospitals such King Fahd Hospital Dammam, and
383 National Guard Hospitals have already implemented EHR that include electronic prescribing
384 systems. The pace of implementing EHR with EPS has increased recently and at least 70
385 hospitals across the country now have fully functioning e-prescribing systems [28-29]. The
386 present authors argue that the time is right for the Saudi Ministry of Health to develop a
387 comprehensive plan for EPS implementation in all current and future hospitals in all 13 regions
388 and urban primary health care (PHC) centers in KSA. EPSs will need to be implemented in rural
389 PHC centers in phases. The private health sector should also be encouraged to implement EPS.
390 Such an agenda would be in line with the recent rapid implementation of e-prescribing in Canada
391 [84].

392

393 **Limitations**

394 This overview has several limitations. There is a large literature on handwritten and e-prescribing
395 in the Western world. This study does not include all related papers, thus raising the possibility
396 of selection bias. Publication bias is also a possibility since unpublished research was not
397 included in our review. We have also stepped beyond a simple objective review of the literature
398 by advocating the implementation of EPSs despite its limitations and challenges. However, the
399 strength of this review is the consistency of the research findings by others and the widespread
400 recommendations made in support of electronic prescribing. Another limitation of this review is
401 that it did not evaluate the quality of the studies cited, although this was not our objective. There
402 is extensive literature on studies regarding health information technology and informatics related
403 to the use in EHR and EPS in the Western world and there is insufficient space to
404 comprehensively review the quality of these studies here. Nevertheless, we have
405 comprehensively reviewed the most cited studies on e-prescribing and have addressed some of
406 the ethical and legal issues involved in this practice. We reviewed research conducted both

407 locally in Saudi Arabia and around the world to make our case for implementing electronic
408 prescribing systems, either those that are standalone or embedded within EHR, here in Saudi
409 Arabia.

410 **Discussion and Conclusions**

411 Handwritten prescribing of medications is a common practice in the Middle Eastern countries.
412 This practice has many disadvantages including increased minor and serious medication errors
413 (15%) related to illegible prescriptions and failure to identify drug-drug interactions, increasing
414 morbidity and mortality, decreasing work flow efficiency, increasing the costs of care, and
415 decreasing the quality of healthcare services and patient safety [20-22]. Most of these medication
416 errors could be overcome by adopting an electronic prescribing system [85-86]. In addition,
417 omission and commission/documentation errors are frequent problems in handwritten
418 prescriptions both among outpatients and inpatients [87-88].

419 Electronic prescribing systems, however, are not without problems. Surprisingly, omission errors
420 (61% of all errors) are most frequently reported in computer-generated prescriptions in outpatient
421 settings [66]. Electronic-prescribing may also take more time than handwritten prescriptions
422 [89], although this finding needs to be replicated. E-prescribing may also lead to medication
423 errors of a different type, such as overwhelming prescribers with alerts or increasing the
424 likelihood of selecting a wrong dose from the dropdown list of medications [33, 90].

425 Educational programs focused on e-prescribing that target prescribers are reported to decrease
426 handwritten prescription errors including errors related to route of administration, illegible
427 handwriting, and inaccurate dosages. In addition acute adverse events may also be minimized
428 [20]. There are educational programs that target multiple healthcare providers to reduce
429 prescribing medication errors. Medication errors have multiple determinants which educational
430 programs need to address [91].

431 Electronic prescribing has considerable benefits including decreased medication errors (8%),
432 increased workflow efficiency, enhanced satisfaction of patients and care providers, and
433 increased attention to medication error alerts, all resulting in decreased morbidity and mortality,
434 better patient outcomes, improved quality of care, and decreased cost [21, 92-93]. In addition, e-
435 prescribing increases the likelihood that pharmacists' recommendations will be implemented
436 more so than is seen with hand-written prescriptions [94]. The computerized alert systems
437 associated with e-prescribing can significantly impact physician behavior in terms of avoiding

438 the use of abbreviations as commonly occurs with hand-written prescriptions [95]. There are
439 challenges, however, in the implementation of e-prescribing. These challenges include
440 physicians' resistance, the need for a substantial initial financial investment, the need for
441 provider training, and the increased likelihood of new types of medication errors [21, 96-98].
442 Financial incentives to providers for implementing EPS in USA have the use of e-prescribing,
443 which has also increased the likelihood of prescribing generic medications that has considerably
444 decreased medication costs [99].

445 Only a few studies have examined the use of EHR and EP in Saudi Arabia, and the perceptions
446 of health providers with regard to EP [26-29]. However, based on the electronic prescribing
447 literature in the West, EP has many advantages that make for a strong case for also implementing
448 EPS in Middle Eastern countries such as KSA. Further studies, however, are needed to explore
449 different aspects of EPSs in order to develop a research base for developing strategies to prevent
450 and reduce medication errors, make clinical and policy decisions regarding implementing EPSs,
451 and updating EPSs that are now in place, with the goal of improving the quality of healthcare
452 services and reducing the costs of healthcare.

453

454 **Recommendations**

455 Our recommendations focus primarily on the prescribing of medications in the Kingdom of
456 Saudi Arabia. The prescribing trend in this country is slowly changing and electronic prescribing
457 is beginning to be adopted in major medical centers and specialist hospitals across the country.
458 Electronic prescribing is now well defined and there exist standards for implementing EPSs.
459 While there are many advantages to EP, there are also challenges such as the training of
460 healthcare providers in the use of e-prescribing and the resistance of physicians in adopting this
461 new practice. To maximize the benefit of e-prescribing, electronic prescribing systems with full
462 functionalities should be implemented in all current and future hospitals and primary healthcare
463 centers throughout KSA. Private sector hospitals and clinics should also adopt such systems.
464 Other countries in the Middle East region may benefit from and follow this trend. Finally, there
465 is need for longitudinal pre- and post evaluations of newly implemented electronic health record
466 systems that contain EPSs following the procedures that have been recommended by others
467 [100-101].

468 **Ethical Consideration:** Not applicable

469 **Conflicts of Interest:** The authors have no conflict of interest in this work.

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