



Original Article

Knowledge, Attitude, and Practice of Prescription Writing and Prescription Audit among Foreign Medical Graduates Working in Outpatient Departments of a Tertiary Care Hospital in North Bengaluru: A Cross-Sectional Study

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ABSTRACT

Background: Prescription writing is a core clinical skill, and prescribing errors are a leading cause of preventable adverse drug events, particularly in outpatient departments where continuous monitoring is limited. Foreign Medical Graduates (FMGs) form a growing part of the Indian medical workforce, yet differences in undergraduate training and exposure to national prescribing regulations may influence their prescribing practices. Evidence on their knowledge, attitude, and practice (KAP) of prescription writing and prescription audit in Indian outpatient settings is limited.

Aim and Objectives: To assess the knowledge, attitude, and practice of prescription writing and prescription audit among FMGs working in outpatient departments of a tertiary care teaching hospital, and to analyse whether KAP differ by gender and age.

Materials and Methods: An analytical cross-sectional study was conducted among 78 FMGs at a tertiary care teaching hospital in North Bengaluru after ethical clearance and informed written consent. A pre-tested, structured questionnaire assessed knowledge (10 items) and attitude (11 items). Prescribing practice was assessed by auditing outpatient prescriptions against a checklist based on the WHO prescribing indicators and the National Medical Commission (NMC) prescription format. Data were analysed in SPSS v26 using descriptive statistics, the chi-square test, and one-way analysis of variance (ANOVA); $P < 0.05$ was considered significant.

Results: A total of 78 FMGs (42 females, 36 males) participated, of whom 59.0% were aged 25 years or younger. The mean knowledge score was 6.83 ± 2.11 out of 10 (median 7; interquartile range 5–8) and the mean attitude score was 10.33 ± 1.29 out of 11 (median 11; interquartile range 10–11). Item-wise correct responses in the knowledge domain ranged from 28.2% to 92.3%, and attitude was highly favourable, with at least 89.7% agreement on every item. On prescription audit, 47.4% of FMGs demonstrated adequate prescribing practice. One-way ANOVA showed no statistically significant differences between males and females in knowledge ($F = 0.739$, $P = 0.393$), attitude ($F = 1.539$, $P = 0.219$), or practice ($F = 0.235$, $P = 0.630$), nor across age groups (all $P > 0.05$).

Conclusion: FMGs held a positive attitude toward rational prescribing but showed gaps in knowledge and practice, with fewer than half writing adequate prescriptions on audit. Structured orientation on the NMC prescription format and periodic prescription audit are recommended before independent outpatient prescribing.

INTRODUCTION

Writing a prescription may appear routine, but it is in fact one of the most critical clinical responsibilities a physician performs. A single error — a wrong dose, an unclear instruction, or an omitted detail — can directly compromise patient safety. Studies across health-care systems have consistently shown that prescribing errors are a major cause of preventable adverse drug events, particularly in outpatient departments where the opportunity for continuous monitoring is limited [1-4].

Prescription audit is a structured method of reviewing prescriptions to assess whether medicines are being prescribed rationally, safely, and in line with standard treatment guidelines. The World Health Organization strongly recommends prescription audit as an effective quality-improvement strategy to promote the rational use of medicines and to reduce medication errors [5-8]. Regular audits not only identify common prescribing problems but also create opportunities for feedback and education, ultimately improving patient care [9,10].

In India, Foreign Medical Graduates play an increasingly important role in delivering health-care services, particularly in tertiary-care hospitals and teaching institutions. However, differences in undergraduate medical training, exposure to national treatment guidelines, and prescribing regulations across countries may influence their prescribing practices [11,12]. Despite their growing contribution to the health-care system, there is limited evidence evaluating their knowledge, attitude, and actual practices related to prescription writing and prescription audit in Indian outpatient settings [13-15].

Understanding these aspects is essential to identify existing gaps, design focused training programmes, and strengthen patient-safety initiatives. This study was therefore conducted to assess the knowledge, attitude, and practice of prescription writing and prescription audit among FMGs working in outpatient departments, to identify the gap between knowledge, attitude, and real-world prescribing, and to examine whether these domains differ by gender and age, so as to support the better integration of FMGs into the Indian health-care system through improved prescribing practices [7,8,10].

MATERIALS AND METHODS

Study Design, Setting and Population: This was an analytical, descriptive cross-sectional study conducted in the outpatient departments of a tertiary-care teaching hospital in North Bengaluru (BGS Medical College and Hospital), Karnataka, India, over a defined study period. The study population comprised Foreign Medical Graduates currently working in the outpatient departments of the hospital.

Ethical Committee Approval: Ethical clearance was obtained from the Institutional Ethics Committee, BGS Medical College and Hospital, Bengaluru, before commencement of the study (approval reference no. BGSIEC/CER/028/2026; IEC study reference no. 13/2026; dated 30 March 2026). Eligible participants were informed about the purpose of the study, and written informed consent was obtained from each participant. Data were kept confidential and used solely for research purposes.

Inclusion and Exclusion Criteria: Foreign Medical Graduates registered with the National Medical Commission or the relevant State Medical Council, who had been working in outpatient departments for at least three months and were willing to provide informed consent, were included. FMGs working exclusively in inpatient departments, those unavailable during the study period, and those who submitted incomplete questionnaires were excluded.

Sample Size: The sample size was estimated using the standard prevalence-based formula, assuming 50% adequate knowledge of prescription writing, with a 95% confidence interval and a 5% margin of error [16]. Convenience sampling was used depending on the feasibility and availability of participants, and a total of 78 FMGs were enrolled.

Study Tools: A pre-tested, structured, self-administered questionnaire was adapted from the knowledge, attitude, and practice assessment of prescription writing described by Nivethitha et al. [17], with modifications for the present study population and scoring scheme. It comprised three sections assessing the knowledge, attitude, and practice of prescription writing and prescription audit. The knowledge section contained 10 items covering the parts and format of a prescription, the meaning of the symbol Rx, the required drug, doctor and patient details, the criteria for a complete prescription, and the NMC prescription-writing and dispensing guidelines. The attitude section contained 11 statements rated on a Likert-type scale addressing the need for prescribing guidelines, undergraduate training, disclosure of prescriber details, patient counselling, allergy and drug-interaction checks, and legible generic prescribing. The construct, content and face validity of the questionnaire were tested, and reliability was assessed before administration.

For the practice domain, a prescription audit was performed by reviewing outpatient prescriptions written by the participating FMGs against a checklist based on the WHO prescribing indicators and the NMC prescription format [6,12].

drawing on the prescription components evaluated by Nivethitha et al. [17]. The checklist assessed the presence of the prescriber's details (name, qualification, registration number and address), the date, patient details (name, age, sex and weight), the Rx symbol, the drug written in capital letters by generic name, the dosage form, dose, frequency and duration, the signature and seal, and legibility. A prescription that satisfied the essential criteria was scored as adequate practice (1); otherwise it was scored as inadequate (0).

Scoring: Each correct knowledge response was scored 1 (maximum 10). Each favourable attitude response was scored 1 (maximum 11). The composite practice-audit outcome was scored as adequate (1) or inadequate (0). Domain scores were summarised as frequency distributions, as mean $\pm$ standard deviation with median and interquartile range, and as the proportion of participants achieving each criterion, and were displayed as box plots.

Statistical Analysis: Data were entered in Microsoft Excel and analysed using SPSS software (IBM, version 26.0). Categorical variables were summarised as frequencies and percentages, and the domain scores as mean $\pm$ standard deviation together with the median, interquartile range and range, and were displayed as box plots. The chi-square test was used to examine associations between categorical variables. One-way analysis of variance (ANOVA) was used to compare knowledge, attitude, and practice scores across gender and age groups; for each comparison the ANOVA F-statistic (the ratio of the between-group variance to the within-group variance) and its P value are reported. A P value < 0.05 was considered statistically significant, with a 95% confidence interval.

RESULTS

A total of 78 Foreign Medical Graduates participated in the study. Of these, 42 (53.8%) were female and 36 (46.2%) were male. By age group, 46 (59.0%) were aged 25 years or younger, 31 (39.7%) were 26–28 years, and 1 (1.3%) was older than 28 years. The demographic profile of the participants is summarised in Table 1.

The participants had obtained their primary medical qualification from a broad range of countries, most commonly China (29.5%), the Philippines (20.5%), and Georgia (19.2%), followed by Russia (7.7%), Ukraine (6.4%), Kyrgyzstan (5.1%), and Uzbekistan (3.8%), with the remainder from Mauritius, Armenia, Moldova, Kazakhstan, and the United Kingdom. This diversity of training backgrounds reflects the heterogeneous undergraduate exposure characteristic of Foreign Medical Graduates.

When asked where prescription writing was first taught during their undergraduate training, most participants identified the department of Pharmacology (57.7%), followed by Medicine, including general and internal medicine (28.2%); a small number cited a Latin language module (3.8%), Surgery, Community Medicine, Paediatrics, or medical ethics teaching. Most participants had first been taught prescription writing during the third year of their undergraduate course (42.3%), followed by the second year (26.9%). At the time of the study the FMGs were posted across a wide range of clinical departments, most commonly Community Medicine (28.2%), General Medicine (12.8%), General Surgery (11.5%), and Obstetrics & Gynaecology (10.3%). These characteristics are presented descriptively and were not subjected to further statistical analysis.

Table 1: Demographic profile of the study participants (N = 78)

Variable	Category	n	%
Gender	Female	42	53.8
	Male	36	46.2
Age group	≤ 25 years	46	59.0
	26–28 years	31	39.7
	> 28 years	1	1.3
Country of primary medical qualification	China	23	29.5
	Philippines	16	20.5
	Georgia	15	19.2
	Russia	6	7.7
	Ukraine	5	6.4
	Kyrgyzstan	4	5.1
	Uzbekistan	3	3.8
	Mauritius	2	2.6
	Armenia	1	1.3
	Moldova	1	1.3

Variable	Category	n	%
	Kazakhstan	1	1.3
	United Kingdom	1	1.3
Year prescription first taught	1st year	4	5.1
	2nd year	21	26.9
	3rd year	33	42.3
	4th year	13	16.7
	5th year	7	9.0
Department that first taught prescription	Pharmacology	45	57.7
	Medicine (general/internal)	22	28.2
	Latin (language module)	3	3.8
	Pharmacology and Medicine	2	2.6
	Community Medicine	2	2.6
	Surgery	2	2.6
	Paediatrics	1	1.3
	Medical ethics/conduct	1	1.3
Department currently posted	Community Medicine	22	28.2
	General Medicine	10	12.8
	General Surgery	9	11.5
	Obstetrics & Gynaecology	8	10.3
	Orthopaedics	4	5.1
	Respiratory Medicine	4	5.1
	ENT	3	3.8
	Paediatrics	3	3.8
	Anaesthesia	3	3.8
	Radiology	2	2.6
	Dermatology	2	2.6
	Psychiatry	2	2.6
	AYUSH	2	2.6
	Ophthalmology	2	2.6
	Forensic Medicine	1	1.3
	Emergency Medicine	1	1.3

Overall Knowledge and Attitude Scores

The descriptive statistics of the overall knowledge and attitude scores are summarised in Table 2. The mean knowledge score was 6.83 ± 2.11 out of a maximum of 10 (median 7; interquartile range 5–8; range 1–10), and the mean attitude score was 10.33 ± 1.29 out of a maximum of 11 (median 11; interquartile range 10–11; range 5–11).

Table 2: Descriptive statistics of the overall knowledge and attitude scores (N = 78)

Score	N	Minimum	Maximum	Mean $\pm$ SD	Median	IQR
Overall knowledge (max 10)	78	1	10	6.83 ± 2.11	7	5–8
Overall attitude (max 11)	78	5	11	10.33 ± 1.29	11	10–11

SD, standard deviation; IQR, interquartile range. Values as reported in the SPSS descriptive-statistics output and box plots.

Knowledge Domain

Overall knowledge scores (maximum 10) were distributed as follows: 1 (n = 2), 3 (n = 6), 4 (n = 1), 5 (n = 12), 6 (n = 7), 7 (n = 15), 8 (n = 19), 9 (n = 10) and 10 (n = 6); the most frequently obtained score was 8 (n = 19). The box plot of the overall knowledge scores showed a median of 7 (interquartile range 5–8), no outliers, and a slight negative skew [Figure

1]. Item-wise, correct responses were highest for the content of the inscription (92.3%) and the criteria for a complete prescription (91.0%), and lowest for naming four drug details to be included in a prescription (28.2%) and correctly listing the parts of a prescription (35.9%). Awareness of the NMC prescription-writing guidelines was 83.3%. The item-wise knowledge responses are presented in Table 3.

Table 3: Item-wise correct responses in the knowledge domain (N = 78)

Item	Knowledge item	Correct (n)	%
K1	Parts of a prescription (correctly listed)	28	35.9
K2	Correct component of the superscription	60	76.9
K3	Correct meaning of the symbol Rx	59	75.6
K4	Content of the inscription	72	92.3
K5	Named 4 drug details to be included	22	28.2
K6	Doctor's details to be written	36	46.2
K7	Named 4 patient details to be included	57	73.1
K8	Criteria for a complete prescription	71	91.0
K9	NMC prescription-writing guidelines (except)	65	83.3
K10	Dispensing instructions to the pharmacist (except)	63	80.8

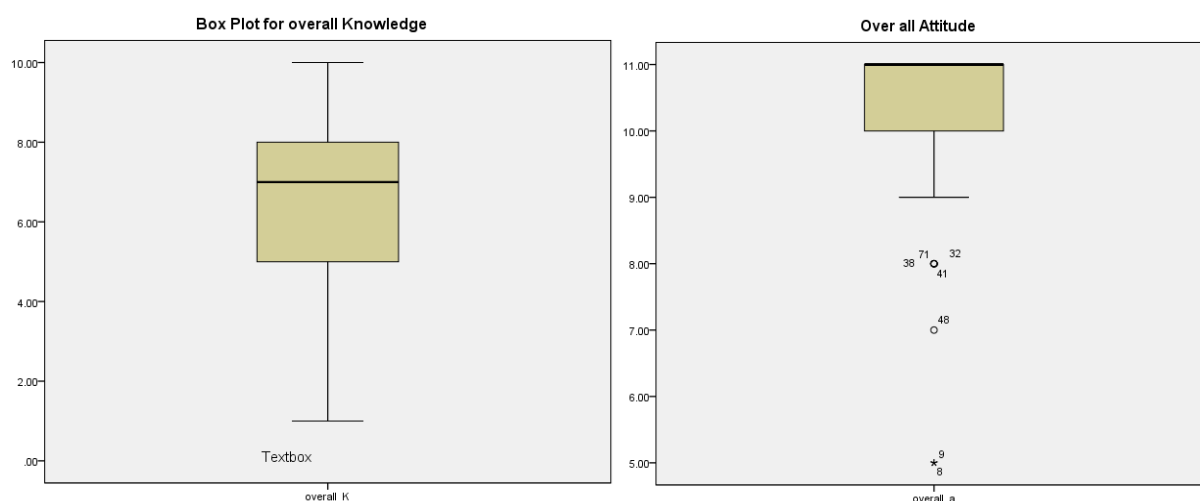


Figure 1: Box plot of the overall knowledge scores (median 7, interquartile range 5–8, range 1–10; no outliers); **Figure 2:** Box plot of the overall attitude scores (median 11, interquartile range 10–11, range 5–11; negative skew with lower outliers)

Attitude Domain

Overall attitude scores (maximum 11) were distributed as follows: 5 (n = 2), 7 (n = 1), 8 (n = 5), 9 (n = 4), 10 (n = 13) and 11 (n = 53); most participants obtained the maximum score of 11 (n = 53). The box plot of the overall attitude scores showed a median of 11 (interquartile range 10–11) with a marked ceiling effect and a few lower-scoring outliers [Figure 2]. At least 89.7% of participants gave a favourable response to every attitude statement. Agreement was near-universal for asking about prior drug allergy (97.4%), checking for drug interactions when prescribing more than one drug (97.4%), and writing prescriptions legibly without abbreviations (96.2%). The item-wise attitude responses are shown in Table 4.

Table 4: Item-wise favourable responses in the attitude domain (N = 78)

Item	Attitude statement (favourable response)	Favourable (n)	%
A1	Guidelines for proper prescribing are needed	74	94.9
A2	Prescription-writing should be taught in the UG curriculum	74	94.9
A3	The prescriber should provide his/her details	70	89.7
A4	Dispensing instructions to the pharmacist are necessary	70	89.7
A5	The patient should be advised on the correct way to take a drug	72	92.3
A6	Patient height, weight and gender are important while prescribing	72	92.3

Item	Attitude statement (favourable response)	Favourable (n)	%
A7	Prior drug-allergy history should be asked	76	97.4
A8	Drug interactions should be checked when ≥ 2 drugs are prescribed	76	97.4
A9	The patient should be briefed on probable side effects	73	93.6
A10	Prescriptions should be written legibly without abbreviations	75	96.2
A11	Training on prescription writing is needed before internship	74	94.9

Table 5: Comparison of knowledge, attitude and practice scores by gender (one-way ANOVA)

Domain	Between-groups SS	df	F	P value
Knowledge	3.302	1, 76	0.739	0.393
Attitude	2.528	1, 76	1.539	0.219
Practice	0.060	1, 76	0.235	0.630

F, ANOVA *F*-ratio (between-group variance $\div$ within-group variance); *SS*, sum of squares; *df*, degrees of freedom. Values as reported by one-way ANOVA (gender). All comparisons were non-significant ($P > 0.05$).

Practice Domain

On prescription audit, 37 of the 78 FMGs (47.4%) wrote prescriptions that satisfied the essential criteria and were classified as demonstrating adequate practice, while 41 (52.6%) had one or more deficiencies. Thus, although attitude was highly favourable, fewer than half of the participants translated this into an adequate prescription on audit, highlighting a knowledge–attitude–practice gap.

Comparison by Gender

One-way ANOVA showed no statistically significant difference between males and females in knowledge ($F(1,76) = 0.739$, $P = 0.393$), attitude ($F(1,76) = 1.539$, $P = 0.219$), or practice ($F(1,76) = 0.235$, $P = 0.630$). Adequate prescribing practice was recorded in 21 of the 42 female and 16 of the 36 male participants. The gender comparison is summarised in Table 5.

Comparison by Age Group

One-way ANOVA across the age groups showed no statistically significant difference in knowledge ($F(2,75) = 0.463$, $P = 0.631$), attitude ($F(2,75) = 0.284$, $P = 0.753$), or practice ($F(2,75) = 2.842$, $P = 0.065$). Overall, neither gender nor age was significantly associated with the knowledge, attitude, or practice of prescription writing among the participants (Table 6).

Table 6: Comparison of knowledge, attitude and practice scores across age groups (one-way ANOVA)

Domain	Between-groups SS	df	F	P value
Knowledge	4.178	2, 75	0.463	0.631
Attitude	0.957	2, 75	0.284	0.753
Practice	1.370	2, 75	2.842	0.065

F, ANOVA *F*-ratio (between-group variance $\div$ within-group variance); *SS*, sum of squares; *df*, degrees of freedom. Age groups: ≤ 25 , 26–28 and > 28 years. All comparisons were non-significant ($P > 0.05$).

DISCUSSION

This cross-sectional study assessed the knowledge, attitude, and practice of prescription writing and prescription audit among 78 Foreign Medical Graduates working in the outpatient departments of a tertiary-care teaching hospital in North Bengaluru. The FMGs demonstrated a strongly positive attitude toward safe and rational prescribing (mean 10.33 ± 1.29 out of 11; median 11) but a more moderate level of knowledge (mean 6.83 ± 2.11 out of 10; median 7), and fewer than half (47.4%) wrote an adequate prescription on audit. This dissociation between a favourable attitude and suboptimal practice mirrors the knowledge–attitude–practice gap repeatedly described in prescribing research [11,13].

The most striking knowledge deficits concerned the ability to list the parts of a prescription (35.9%) and to name four essential drug details (28.2%), even though most participants could identify the contents of the inscription (92.3%) and the requirements for a complete prescription (91.0%). This pattern suggests that FMGs recognise the components of a good prescription when prompted but are less able to reproduce them unaided — a gap that is best closed by hands-on prescription-writing exercises and audit-based feedback rather than by didactic teaching alone [10,18].

These findings are broadly consistent with the study by Nivethitha et al. among 150 Indian interns, which identified deficiencies in prescription-writing knowledge and practice despite a positive attitude [17]. Their study used a questionnaire to assess knowledge and attitude and evaluated prescriptions written for a common illness, whereas the present study

assessed FMGs using a modified questionnaire and an outpatient prescription audit. Differences in the scoring schemes preclude direct comparison of the domain scores. Unlike the present study, Nivethitha et al. observed statistically significant gender differences in knowledge and attitude, although the difference in practice scores was not statistically significant. The high proportion of favourable attitude responses in the present study, particularly for asking about drug allergy (97.4%) and checking drug interactions (97.4%), indicates that FMGs value patient safety and may be receptive to structured training [8].

The absence of significant gender- or age-related differences suggests that the observed gaps are systemic rather than confined to a particular subgroup, and are therefore likely to respond to a uniform orientation programme delivered to all incoming FMGs.

Prescription audit remains one of the most effective and inexpensive tools for improving prescribing quality, and the WHO recommends it as a routine quality-improvement activity [5,6]. The finding that only 47.4% of audited prescriptions met the essential criteria reinforces the need to embed regular audit-and-feedback cycles into outpatient practice, especially for prescribers trained under differing curricula [9,15]. Integrating the NMC model prescription format, the concept of generic prescribing, and a simple audit checklist into the induction of FMGs could measurably improve prescription quality and reduce avoidable medication errors [4,12].

The strengths of this study include the use of a validated, structured questionnaire combined with an objective prescription audit, and a focus on FMGs — a growing but under-studied group in the Indian health-care system. Certain limitations should be acknowledged. The study was conducted at a single centre with a convenience sample, which may limit generalisability. The practice domain was assessed as a composite adequate/inadequate outcome rather than an item-level score, and prescribing behaviour may be influenced by patient load and departmental practice. Finally, the study did not evaluate the effect of an educational intervention; a follow-up interventional study measuring prescription quality before and after structured training would help quantify the scope for improvement.

CONCLUSION

This study demonstrated that Foreign Medical Graduates working in outpatient departments hold a highly favourable attitude toward safe and rational prescribing, but that this attitude is not fully matched by their knowledge or their prescribing practice. Knowledge gaps were most evident for correctly listing the parts of a prescription (35.9%) and naming the essential drug details (28.2%), and fewer than half of the participants (47.4%) wrote a prescription that met the essential audit criteria. Knowledge, attitude, and practice did not differ significantly by gender or age, indicating that the gap is systemic rather than confined to any particular subgroup.

There is therefore a clear need to sensitise FMGs to the National Medical Commission prescription format and the use of generic names, and to embed the principles of prescription audit, through structured orientation at induction and periodic audit-and-feedback, before they undertake independent outpatient prescribing. Delivering this through integrated teaching between the department of pharmacology and the clinical specialties could improve prescription quality, promote the rational use of medicines, and reduce avoidable medication errors.

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