

# The influence of specialists on prescribing by GPs

## A qualitative study

Jane Robertson, Carla J Treloar, Arn Sprogis, David A Henry

Jane Robertson, BPharm, MMedSc, PhD, is Lecturer in Pharmacoepidemiology, School of Medical Practice and Population Health, Faculty of Health, The University of Newcastle, New South Wales.

Carla J Treloar, BSc (Hons), PhD, is a Research Fellow, National Centre in HIV Social Research, University of New South Wales.

Arn Sprogis, MBBS, FRACGP, is Executive Director, Hunter Urban Division of General Practice, Newcastle, New South Wales. David A Henry, MB, FRCP, is Professor of Clinical Pharmacology, School of Medical Practice and Population Health, Faculty of Health, The University of Newcastle, New South Wales.

**OBJECTIVE** To investigate specialists' influence on prescribing by general practitioners.

**METHOD** A focus group study of 35 GPs.

**SETTING** Hunter Urban Division of General Practice, New South Wales.

**RESULTS** Although GPs thought specialists had only a small influence on their prescribing overall, it was substantial in some clinical areas, in complex conditions and conditions seen infrequently. Specialists were seen as authoritative and unbiased. Local specialists were particularly influential. Specialist influence came from seeing how specialists managed patients, clinical meetings, and specific verbal advice. It influenced the prescribing of new drugs, selection of drugs within a class and sometimes changed established prescribing practices.

**DISCUSSION** Interventions to change GPs' prescribing practices should address the importance of specialist influence, and not focus on GPs alone.

Specialists are important educators of general practitioners both formally and informally, through referral of patients, specialist letters, telephone consultations, lectures and seminars.<sup>1-5</sup> They are highly regarded as an information source<sup>6,7</sup> because of their expertise and timely provision of information on targeted problems, avoiding the need for the GP to synthesise large amounts of information and adding value to the information from their own experience.<sup>6,8,9</sup>

We have previously described the direct impact of specialists on GPs' prescribing by examining specific prescribing decisions.<sup>10</sup> Specialist influence may also be indirect, eg. influencing the uptake of new drugs into routine prescribing and changing prescribing practices.<sup>11-14</sup> To

explore this, we assessed GPs' perceptions of the influence of specialists on their prescribing and how this was exerted.

### Methods

In 1998 we sent all GPs in the Hunter Urban Division of General Practice (a total of 367 GPs) not participating in a companion quantitative study (254 GPs) a letter inviting them to participate in a series of four focus groups. Discussions were documented at the time of the focus groups, audiotapes transcribed, and their contents checked and analysed using a coding scheme developed from key words and themes identified in the literature. Analysis was computer assisted.<sup>15</sup> Data were independently reviewed to identify

emergent themes, and interpretation discussed until consensus was reached.

We compared the characteristics of participants with all GPs in the division using the chi-square test. The University of Newcastle Research Ethics Committee granted approval.

### Results

Recruitment was ceased when 45 GPs (18%) accepted the first invitation to participate and 35 GPs attended the focus groups (Table 1). Attendance across the four groups was seven, eight, 11 and nine GPs. The only significant demographic difference between subject GPs and others was place of graduation with graduates of Asian medical schools being over represented (Table 1).

**Table 1. Characteristics of participating GPs compared to all GPs in the HUDGP**

	n (%)	
	Focus group GPs	All GPs in the division
<b>Sex</b>		
<b>Female</b>	13 (37)	125 (34)
<b>Years since graduation</b>		
<10 years	1 (3)	40 (11)
10-19 years	10 (29)	21 (33)
20-29 years	13 (37)	114 (31)
>30 years	11 (31)	92 (25)
<b>Place of graduation (p&lt;0.05)</b>		
Australia	21 (60)	283 (77)
Asia	11 (31)	55 (15)
<b>Total</b>	<b>35</b>	<b>367</b>

## Specialist influence on prescribing

Initially, GPs thought that specialists had only limited influence on their prescribing (Table 2). However, ensuing discussion revealed a broad and substantial influence on prescribing. This influence was not uniform across all areas (Table 2). Specialists had little influence on prescribing for respiratory disease (especially asthma), hypertension, infection, contraception or hormone replacement therapy. This was also true of depression because of poor access to psychiatrists in the Hunter area. Specialists had greater influence on less common conditions, more complex conditions requiring tailored therapy interventions, and difficult to manage patients (including oncology, cardiology, endocrinology, second line drugs for rheumatoid arthritis, severe renal failure, complicated epilepsy, autoimmune diseases and complicated asthma).

They influenced GPs' drug use in a number of ways: observation of drug use by specialists, clinical meetings with specialists and discussion (direct and by telephone) about individual patient management.

**Table 2. Specialist influence on prescribing**

### Extent of specialist influence

'Not in the everyday patient, there's very little really...' (G1)

'...there's a lot of things a specialist will never see' (G1)

'...specialist(s) really don't have such a strong influence on what we're prescribing...to do with the number of prescriptions we write...it's not that big...it's what everyone says...different circumstances' (G3)

'...some specialists understand that their job is very different to a GPs...we have a broader knowledge but not as deep. We need their advice for those deeper issues...' (G3)

'...that original (prescribing) regimen you feel comfortable with, it's probably directly or indirectly come from a specialist at some time...subtly, I think the influence probably runs a little deeper than we all care to think...' (G3)

'...we develop a body of knowledge, but we may not be able to quote a certain study as to why we are using this...' (G2)

### Methods of specialist influence

'...there are two ways of influence. One is a patient of the specialist...he prescribes the medication, you will continue that. But there's the other influence of patients that we're treating ourselves, without specialists' help, but we will use, tend to prescribe things that we know the specialist uses...' (G2)

'...telephone conversations, referral letters, meetings where specialists might give some clinical information, journal articles written by specialists... all these things are influential...' (G3)

NB: Verbatim quotes were assigned by focus group number to maintain anonymity

**Table 3. Communication issues**

'...if you don't really know what's going on with a patient...I quite look forward to getting back those letters to see what they think and what they've done' (G1)

'...I've stopped using a lot of the hospital specialists simply because I think the letters don't come back and it is not fair' (G1)

'...I may not necessarily want to treat the patient (oncology, palliative care) but I must know what are the current medications...because sometimes I used to completely lose touch...we just come to know when they are back home, literally bed ridden...and we haven't got a clue...so I insist...I must know what is going on. Because in the middle of the night, they're not going to call the specialist, they're going to call us...' (G1)

'...the specialists guide us in when to start these medications, but they don't often guide us when to stop...becomes open ended...' (G4)

## Communication issues

Letters from specialists (regarded as fundamental to professional communication) were an important source of ongoing education for GPs. Some GPs reported problems: late reports and letters (especially with hospital based specialists) and lack of guidance on the appropriate dura-

tion of treatment and when drugs should be ceased (Table 3). Ongoing communication was regarded as necessary even for patients whose care specialists had taken over.

## Choice of drug

Many participants described themselves as conservative prescribers, preferentially

## Table 4. Choosing a drug

### Conservative prescribers

'...things which I'm used to and I've used for a long time rather than starting on new medications...' (G1)

'...I wait till the specialists are using it...there've been so many false starts with new drugs lately that I tend to be a fairly late starter (prescribing new drugs)...' (G2)

### Early adopters

'...we've far more opportunities to prescribe it (any new drug) first even before the specialist gets to them...by the time it comes into Australia, everywhere else in the world (it) has been tried anyway. So I don't want to be another five years behind. So I'm happy to try it out as soon as it comes out, I don't mind...' (G1)

### Using new drugs

'...the specialist tends to go for the new drugs...it's their one area of interest, so they're aware of all these new drugs and all the studies that have been done and they're all ready to use them as soon as they're available...' (G1)

'...my thing is drug reps backed up by some specialist here coming along and talking about it at a clinical meeting...and I'm more happy if they get one of the local people to talk than if they get somebody from overseas or Sydney...' (G2)

'...drug reps play a role too...introducing new drugs... and then you talk to your colleagues, talk to the specialist, and you also look in the journals...' (G3)

'...for most (new) drugs I take about a year or two years...but for something that's got an effect on a patient group that is not well managed at the moment...I think I'd start it' (G3)

'No, I think there are quite a few new drugs that GPs can use now safely without waiting a year or two...' (G3)

'...I didn't see that it (Posicor) had a particular niche market...I've got no reason to start the drug. I don't feel comfortable with it and I'll let it prove its value...' (G3)

### Existing practices

'...if you've got a high regard for a particular specialist and he is doing something, it tends to, perhaps subliminally make you use that drug...' (G4)

'...I have changed my ACEs about a year or two ago...specialist input that made me, not made me change but made me think about changing...a specialist who I felt very confident with...he was using X ACE inhibitor for Y reason. And I thought Y reason sounds all right...and I wanted to get to know one ACE. And also it was a cheaper ACE than the one I was tending to use...so that made me change' (G3)

using drugs that they knew. The opportunity for rapid adoption of new drugs was recognised and circumstances that made GPs more comfortable in quickly adopting new drugs into their prescribing repertoire were described. Seeing a role for the new drug was important (Table 4).

Drug companies and their detailers were often the first source of information about a new drug, and specialists a second source, with GPs learning from their feedback and their presentations at clinical meetings. In addition to influencing prescribing of new

drugs, specialists also influenced changes in existing practices, and the selection of drugs from within a class (Table 4).

### Specialists as an educational resource

Specialists provided a shortcut for GPs without skills or time to assess all the evidence about drugs. They were valued as authoritative and unbiased information sources. Specialists, particularly local ones, were an important influence on prescribing practices (Table 5).

## Table 5. Specialist as an educational resource

'...it is an unbiased opinion and informed' (G1)

'...they (specialists) would've done the sifting and weighing of evidence that you may not have the skills or resources or the time to...' (G1)

'...most of us have our own band of consultants...these are, in a sense, our teachers...' (G4)

'...(specialists) give us talks...when a new drug comes out...we can ask more questions ...then we're more confident...' (G1)

'...they're there to try and help you with the problems you can't solve...and you learn from the feedback...' (G2)

## Discussion

The results of qualitative studies need careful interpretation. However, the independent evaluation of the data by two researchers strengthens the credibility of these results.<sup>16</sup> The GPs might have been representative of divisional GPs. However, although expressed opinions were consistent (suggesting no need for further focus groups<sup>17</sup>) they may not be representative of the views of all GPs, nor canvass all possible opinion. Possible selection biases include GPs who rarely refer patients to specialists (because they are less likely to volunteer their time for such a study). We focussed on only one of many possible influences on prescribing decisions<sup>18</sup> and did not explore the relative importance of specialists on prescribing.

Nevertheless, this study confirms the important influence of specialists on GP prescribing. The pattern of uptake of new drugs described by participants mirrors that observed in other studies.<sup>8,12-14,19-23</sup> Drug companies provided the early information as part of a gradual accumulation of knowledge from a variety of sources, but recommendations from specialists

were generally additionally required before new drugs were prescribed. This influence is not limited to new drugs; it includes which drugs are used within a class and changes in established practices. This influence is well recognised by the pharmaceutical industry which uses visiting and local specialists as opinion leaders to promote new drugs.

Programs designed to change prescribing behaviours that focus solely on GPs are unlikely to succeed. Clinical meetings, telephone informal conversations, and letters about referred patients might be exploited as a communication and educational resource for GPs.

Conflict of interest: none known.

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### Correspondence

Email: jroberts@mail.newcastle.edu.au