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Worlds apart? An exploration of prescribing and medicine-taking decisions by patients, GPs and local policy makers

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ABSTRACT

Current healthcare policy in the UK has been shaped by two major forces; increasing accountability to evidence-based standards and increasing patient involvement. Shared decision-making brings the patient into prescribing decisions, and guidelines introduce a third decision-maker, the policy maker, into the doctor–patient consultation. This study explored the decision-making processes used by patients and GPs in comparison to local policy makers.

Method: Qualitative interviews with 8 GPs, 14 patients and 2 PCT Prescribing Advisers, followed by quantitative questionnaires completed by 305 GPs and 533 patients.

Results: Patients made individual medicine-taking decisions based on experience, personal financial and human cost, trust and the relational aspects of their interactions with doctors over time. In contrast local implementation of prescribing guidelines was based on consideration of financial costs, efficacy and risks, based on objective clinical evidence at a population level. GPs adopted a mid-position between these two polar views.

Guidelines are written from a different perspective to the worldview of patients, and they tend to downplay the criteria most important to patients. This has the potential to have a harmful effect on patients' medicine-taking and adherence. Paradoxically, enforcing the use of guidelines could inhibit the achievement of guideline targets.

1. Introduction

Healthcare policy in the UK has been shaped by two major forces; increasing accountability to evidence-based standards and increasing patient involvement. The concept of accountability for the quality of healthcare practice arose with the emergence of "clinical governance" in 1998 [1]. Coupled with the rise of "evidence-based medicine", healthcare policy has become increasingly regulated by guidelines, standards and performance indicators with incentives [2–5]. At the same time the concept of "shared decision making" with patients arose in the late 1990s [6] and the recommendation to make prescribing decisions in partnership with patients through "concordance in medicine taking" [7]. The prominence of these two approaches to healthcare is evident in the UK Government's White Paper "Equity and Excellence" which states that "shared decision making will become the norm" and "clinicians will be held to account against evidence-based standards" [8]. Yet little is known about how these two approaches influence each other within the complexity of "everyday" healthcare practice.

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1. Identification of themes and sub-themes, which were then used to develop an analytical framework;
2. Comparisons were made across and within participant groups;
3. Comparisons were made within and across participant clusters (2 patients and 1 GP per cluster, with 4 clusters per PCT);
4. Synthesis of themes and sub-themes from the previous stages to identify connections between the themes.

Fig. 1. Stages of qualitative analysis.

This study explored the compatibility of these approaches within the context of prescribing in primary care. As previously reported in a parallel paper based on these data [9], areas of tension were identified between evidence-based prescribing guidelines and partnership with patients. Guidelines were sometimes difficult to apply to patients, because of co-morbidities and patients' perspectives. Time constraints limited opportunities for partnership and the enforcement of guidelines had the potential to damage the communication and trust between doctors and patients, as well as limiting patient choice. As a consequence of the tension between guidelines and patient-partnership, 54% of GPs said they would prioritise maintaining the doctor–patient relationship over following guidelines. This paper compares how patients, GPs and local policy makers make decisions about medicines.

2. Materials and methods

Semi-structured qualitative interviews were conducted with a sample of 24 participants (14 patients, 8 GPs and 2 PCT Prescribing Advisers). The GPs were selected using maximum variation sampling to obtain a balance of location, gender and single or group practice across 2 Primary Care Trusts (PCTs) [10]. Each participating GP then recruited two patients using purposive sampling; one prescribed a statin and one prescribed a proton pump inhibitor (PPI). At the time both statins and PPIs were priority areas for UK prescribing policy. The topic guide explored the meanings participants gave to prescribing or medicine-taking decisions. Interviews were recorded and transcribed. The resulting data were analysed in four stages using framework analysis [11] – see Fig. 1.

Themes identified from this qualitative phase were then used in the design of quantitative, closed question questionnaires. Statements were linked across questionnaires for GPs, statin patients and PPI patients to allow cross-comparison.

Questionnaires were distributed to patients by sampling all patients issued with prescriptions for statins or PPIs on a given day in each selected health centre across 5 PCTs (an additional 3 PCTs were recruited in to this second phase to obtain a sufficient sample size). All GP partners were selected and questionnaires were distributed in collaboration with the PCTs. The data were analysed using SPSS [12]. Data analysis for both phases was led by JS in discussion with the co-authors. The questionnaire items were analysed individually; responses from patients and GPs were compared using Mann Whitney statistics. Results from both phases were then synthesised.

Research ethics and research governance approval was obtained. Data collection took place in 2004–05, at a time when the Quality Outcomes Framework (QOF) was first introduced [13] (Table 1).

3. Results

Participants made decisions about prescribing or medicine taking, but the criteria used to inform their decisions, differed across the participant groups: patients, GPs and Prescribing Advisers. Patients tended to adopt an experience-based, relational approach. By contrast the Prescribing Advisers, as local agents of policy implementation, used evidence-based, objective criteria. In general GPs occupied the mid-range between the views of patients and Prescribing Advisers.

3.1. Evidence versus experience based criteria

The qualitative phase showed that participants from all three groups showed some degree of evaluating efficacy and costs in their decision-making, but the criteria considered to be "efficacy" or "costs" varied.

The PCT prescribing strategies strived to increase spending on 'evidence-based' drugs, for example statins, which are used in the primary or secondary prevention of conditions. In contrast they strived to reduce spending on drugs that are used more symptomatically, for example, PPIs. This reflects the concept of cost-effectiveness [14]. Efficacy was assessed from evidence of effectiveness from clinical trials, in terms of a drug having a greater positive clinical effect than negative adverse effect, coupled with financial considerations for the NHS.

GPs made prescribing decisions based on an evaluation of evidence from clinical trials and guidelines, their own prescribing experience, clinical measures, patients' views and some consideration of NHS drug budget costs. Therefore, they used some of the same criteria as Prescribing Advisers, i.e. clinical evidence and financial costs to the NHS, but they often distinguished between these two aspects of cost-effectiveness. In line with Prescribing Advisers, many GPs were supportive of using evidence from

Table 1
Questionnaire response rates.

Patient PPI questionnaires	$n = 132$ (of 257 distributed); 51% response rate
Patient statin questionnaires	$n = 154$ (of 276 distributed); 56% response rate
GP questionnaires	$n = 142$ (of 305 distributed); 47% response rate