Features

Chroniques

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Can Med Assoc J 1997;156:876-8

"Academic detailing" improving prescribing practices in North Vancouver, conference told

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In brief

PHYSICIAN PRESCRIBING PRACTICES WERE THE FOCUS of a recent 1-day conference in Toronto. A BC hospital pharmacist outlined a successful initiative that provides physicians with impartial prescribing advice, saying it has resulted in considerable savings and improved prescribing practices in North Vancouver. *Drugs of Choice* author Dr. Joel Lexchin says such initiatives, called academic detailing, along with peer feedback, are cost-effective ways to improve prescribing habits.

En bref

UNE CONFÉRENCE D'UNE JOURNÉE ORGANISÉE RÉCEMMENT À TORONTO portait sur les pratiques d'ordonnance des médecins. Un pharmacien d'un hôpital de la Colombie-Britannique a décrit l'initiative couronnée de succès qui donne aux médecins des conseils impartiaux sur l'établissement d'ordonnances. Il a affirmé qu'elle a entraîné d'importantes réductions des coûts et amélioré les pratiques d'ordonnance à Vancouver-Nord. Le Dr Joel Lexchin, auteur de *Drugs of Choice*, affirme que de telles initiatives de formation théorique, ainsi que les commentaires des pairs, sont des façons rentables d'améliorer les habitudes d'ordonnance des médecins.

A local initiative that provides doctors with impartial prescribing advice has successfully reduced prescription drug costs in North Vancouver, a recent conference on cost-effective drug therapy was told.

The project led to public-sector savings of about $430 000 over 2 years and also reduced costs to third-party insurers and consumers, said Bob Nakagawa, director of pharmacy at the Lions Gate Hospital.

Physician prescribing habits, including over-prescribing and inappropriate prescribing, were discussed at the Toronto conference, which was organized by Dr. Michael Rachlis, a health policy analyst. Topics included initiatives to improve prescribing and contain escalating drug costs.

Public- and private-sector spending on prescription and nonprescription drugs climbed to 12.7% of total health expenditures in 1994, up from 8.8% in 1975, said Frank Fedyk, director of Health Canada's Health System and Policy Division.

Although spending in sectors such as hospitals is declining, drug-related expenditures continue to grow. Today, he said, 60% of visits to physician offices result in the writing of a prescription.

Several conference participants said prescribing habits are most easily improved by initiatives at the local level, but they admitted that barriers exist, such as a lack of incentives for physicians to change.

Nakagawa, president of the Canadian Association of Hospital Pharmacists, said the North Vancouver project has succeeded because "physicians want to do right . . . and we make it easy for them. We'll come to them privately. People are more relaxed, freer to ask questions than they are, for example, during grand rounds."

The project began after officials noted that the costs of BC's Pharmacare program were rising much faster than other financial indicators, such as overall government spending, incomes or inflation.

Between 1988 and 1993, said Nakagawa, Lions Gate Hospital experienced an increase in prescription drug costs of about 9% annually. Meanwhile, the cost of prescription drugs in the community, measured by Pharmacare costs, rose at an annual rate of about 14% during the same period.

"We wondered whether, if hospital pharmacists worked with local family doctors, we could reduce that 5% spread with the community," he told about 150 people at the conference.

A key reason for the cost increases was a shift in prescribing behaviour, with doctors prescribing newer, more costly and heavily promoted versions of an established drug.

"There is a societal belief that if you pay more, you get what you pay for — that newer is better," said Nakagawa. "But this is not necessarily the case when you look at it critically. For example, in 1995 there were very few [new] breakthrough drugs."

This "academic detailing" — distinct from the "detailing" visits of drug-company representatives — involves 15-minute personal sessions 2 to 3 times a year. Topics are selected largely in response to doctors' enquiries.

In an interview, Nakagawa said that in private consultations physicians sometimes defend their choice of a costlier new version of an equally effective older drug by saying, "my patient deserves it." But when relative cost and effectiveness are discussed, the physicians often change to a less expensive medication.

North Vancouver comprises 3 municipalities with a population of about 200 000 people, and has about 100 family physicians. The Lions Gate Hospital project, launched in 1993, built on relationships with local doctors to generate savings to the Pharmacare program in 2 ways.

First, a clinical pharmacist makes individual visits to local doctors several times a year to provide unbiased education about drugs and prescribing. The pharmacist's salary is paid by Pharmacare.

This "academic detailing" — distinct from the "detailing" visits of drug-company representatives — involves 15-minute personal sessions 2 to 3 times a year. Topics are selected largely in response to doctors' enquiries. They include requests for information about NSAIDs, antihypertensives and the best treatment for respiratory-tract infections. "The only time we discuss cost," said Nakagawa, "is if 2 drugs are equally effective but 1 costs more."

Second, the project produces a newsletter customized to meet the needs of local FPs, which is reviewed by medical specialists at the hospital. *The Review*, an objective comparison of frequently prescribed medications, is published 3 or 4 times a year and "is deliberately nonglossy to contrast with publications from the drug companies."

The North Vancouver project, which may be unique in Canada, appears to have addressed a need expressed by doctors for unbiased, easily available information about prescription drugs. It was introduced because of the efforts and interests of Nakagawa and others in the community, and it built on existing relationships between the hospital and the community.

Dr. Joel Lexchin, a Toronto emergency physician and pharmaceutical-industry analyst, outlined the results of many studies that reveal the medical profession has fallen short of the goal of appropriate prescribing.

He said appropriate prescribing occurs when efficiency is maximized, risk and cost are minimized, and communication with patients about therapeutic options is improved.

Lexchin said that 10% to 20% of people over age 55 who are admitted to hospital are there because of adverse drug reactions. "You can't eliminate that totally, but you can cut it down by about 75% by improving prescribing habits."

Prescribing habits cannot be changed by lectures, conferences, mailed material, delisting certain drugs from a provincial formulary or issuing government warnings, he added. What does work is academic detailing — the sharing of unbiased information with individual doctors by other health care professionals — and detailed audits and feedback concerning physicians' prescribing habits.

"These approaches are expensive, but have been shown to be cost-effective," said Lexchin. However, he noted that academic detailing "has not been instituted on a sustained basis" and detailed audit and feedback has typically been employed in a family-practice clinic or outpatient-clinic setting. "It is hard to do this in other settings because of the fragmented nature of Canadian physicians' practices."

Guidelines plus peer influence have been effective, said Lexchin, coeditor of the CMA's *Drugs of Choice*, a problem-oriented formulary for primary care physicians. Peer review of prescribing habits also is effective but hard to institute, since many Canadian FPs and GPs are in solo practice. Lexchin said attempts to change practice patterns, such as encouraging group practices, would facilitate better prescribing.

He also supports a different payment model. "When GPs are not paid on a piecemeal basis they have more time to communicate with their patients. . . . Very often, a patient's demand for drugs is really a wish for better communication. If they're satisfied with the level of communication, they don't care if they get a drug or not."

To make changes "all players have to recognize that the problem is serious, and they need the necessary resources to bring about change," he added.

Linda Tennant, director of Ontario's Drug Programs Branch, suggested that some of the impetus for change may come from health care reform. Ontario has "flatlined its health care budget, but prescription drugs are taking up an increasing proportion of that budget," she said. Sectors that are getting squeezed, such as hospitals and home care, may begin to challenge the growing share claimed by prescription drugs.

Dr. Geoffrey Anderson, faculty member at Ontario's Institute for Clinical Evaluative Sciences, told the conference about the newly formed Ontario Round Table on Appropriate Prescribing (ORTAP). The vision of the nonprofit organization, which first met last September, is to "optimize drug utilization through stakeholder collaboration." The organizational goal accepted by ORTAP's diverse membership, which includes pharmaceutical and insurance companies, employer groups, professional associations and the Consumers' Association of Canada, is "to reduce waste."

Anderson said "waste" includes situations in which patients get drugs but don't take them, develop an intolerance to a drug, get drugs but don't need them (for example, antibiotics for a viral cold) and don't get drugs that they need.

ORTAP plans to implement guidelines to improve treatment for a limited number of conditions such as asthma and postmyocardial-infarction care. Various approaches will be used, including hospital rounds, printed material, faxes, a website, help lines and academic detailing.

ORTAP also hopes to launch trial prescriptions, so patients can ascertain their tolerance to newly prescribed drugs, and a compliance program that would, for example, improve compliance among those who have had a heart attack and are prescribed lipid-lowering drugs. ?