INTRODUCTION
This year’s regional meeting of the United Kingdom Drug Utilization Research Group (UK DURG) was hosted by the Department of Medicines Management, Keele University.

The papers presented at the conference focused around the themes of:
- Psychotropic drugs, audits in mental health
- Prescribing in nursing homes
- Controlling prescribing and budget setting in primary care
- Horizon scanning and uptake of new drugs

In addition to the oral presentations, nine poster presentations were displayed and viewed by conference delegates throughout the day.

For the first time, delegates of a DURG conference were given the opportunity to participate in an electronic voting system to obtain their views on a number of key issues relevant to the availability of medicines within the new NHS. Voting was repeated following a debate on prescribing and PCGs on the motion ‘Hippocrates was utilitarian?’

Professor Stephen Chapman, Professor of Prescribing Studies, chaired the morning session.

MORNING SESSION
Professor Richard Lilford, Director of R&D, NHS Executive, West Midlands ‘Guidelines for medicines research in the NHS’

Professor Lilford opened his presentation by referring to the new arrangements for bringing treatments into use in the new NHS through the establishment of the National Institute for Clinical Excellence (NICE) and clinical governance. He said that the UK is ‘by no means in the vanguard’ of moves to control the availability of medicines within health services and he cited several examples of other countries where decisions about accessibility to medicines (e.g. by health insurance companies) are made separately from national licensing decisions (e.g. by the FDA in the United States). He argued that the move to provide explicit criteria of cost-effectiveness is a world-wide development. For example, New Zealand has been quite clear about the need to develop systems to make decisions about medicines for many years.

Going on to consider the role and conduct of clinical trials, Professor Lilford drew a distinction between those trials where the medicines involved were already freely available and those involving an experimental treatment where access to the medicine was restricted to the trial setting. It was the former that the remainder of his presentation would address, he said.

Ideally such trials would be conducted from a position of equipoise, where there was uncertainty about the possible benefits of one treatment over another. Doctors should offer patients the opportunity to participate in a trial where there was uncertainty about which treatment might be better. However there were difficulties, for example post-licensing, where a new treatment may look promising but definitive evidence is not available. Thus the prescriber’s personal opinion may favour the promising treatment, with implications for the way that information about different treatments is then given to the patients who might participate in a trial, i.e. equipoise has not been reached. Prescribers use both direct (e.g. clinical trials) and indirect (e.g. biological plausibility of the medicine) evidence in reaching a belief about a particular treatment, he argued. Professor Lilford persuaded
his audience that there were some occasions where societal need over-rode the prescriber’s responsibility to put the individual patient first. However head-to-head trials of existing treatments did not fall into this category where equipoise did not exist. It would be unethical, he suggested, for a prescriber to withhold their personal opinion if asked for it by the patient.

For the future Professor Lilford predicted that pharmaceutical companies would conduct more of the sorts of trials required to provide evidence for NICE during pre-licensing stages.

Dr Umesh Kadam, Industrial & Community Health Research Centre, Keele University ‘Practice based health needs assessment: Anxiety and depression’

Dr Kadam began his presentation by describing the changes in the NHS which had resulted in the emergence of health needs assessment at a local level, and its importance with regard to Primary Care Group (PCG) commissioning. He explained that Bradshaw’s Criteria of Need was the popular description used in health needs assessment, and that this particular project had focused on two of these: expressed need (where the patient goes to a practice and consults a physician); and normative need (the doctor makes a diagnosis and decides whether or not the patient requires treatment). Three objectives were defined for the study: population measure of health need; practice-defined health need; and patient-defined needs. The methodology involved three phases to address these objectives. Dr Kadam informed the audience that his presentation would focus on phase 1 (a questionnaire survey to identify cases of anxiety and depression), and phase 2 (the computer record review that was used to identify the patients for the survey).

Phase 1 of the study used the Hospital Anxiety and Depression (HAD) questionnaire, a questionnaire that had been previously validated for use in community settings. The case and control groups were defined as having a score of 11 or greater, or 7 or less, respectively. Phase 2 of the study, the computer record review, was initially carried out 12 months before the survey and repeated 5 months after. Drug therapy was recorded and classified into anxiolytics and anti-depressants.

A total of 2906 responses (response rate 66%) were received for phase 1 of the study. The overall prevalence for anxiety was found to be 15.2% and 5.3% for depression. Comparing gender, the prevalence amongst women was higher than in men with regard to anxiety, but there was no difference between the sexes for depression. The results were comparable to previous national surveys. Dr Kadam said that the results of the questionnaire survey showed that: anxiety and depression co-exist; both increase in prevalence with female sex and Townsend Deprivation Score; and depression increases in prevalence with older age groups.

The retrospective results from phase 2 of the study showed that practice contact was high (91%) for the case group, compared to the control group (73%). Overall, the median contact rate per person with their GP was double that for the cases compared to control. The retrospective survey also showed that diagnosis of anxiety or depression was higher in the case group (24.3%) compared to the control group (3.3%). With regard to drug treatment, the use of anxiolytics or antidepressants was much higher in the case group (26.7%) than in the control group (3.3%). Drug dose and duration amongst those on treatment was compared with WHO recommended divided daily doses (DDDs). Dr Kadam reported that for anxiolytics, the median dose ratio was 70% of that recommended by WHO, and 90% for antidepressants. Differences between median duration of treatment in the study group and that recommended by WHO were also noted in the study for both anxiolytics and antidepressants. Five months after the study, 79.1% of the patients in the case group had seen their GP. Dr Kadam also reported that, for the case group, diagnoses and drug therapies were given more for those patients who had a prior history compared to those who did not.

Dr Kadam concluded that epidemiological survey and record review provided a useful contrast in defining the health needs of a practice population. Phase 1 of the study had shown that population health need for anxiety and depression is high. The record review after the survey showed that anxiety and depression needs are more likely to be identified for those patients who are already known to have these problems than those who do not.

Ms Helen Boardman, Department of Medicines Management, Keele University ‘Can pharmacists influence psychotropic drug use in nursing homes?’

The objective of this study, said Ms Boardman, was to evaluate the effect of an educational outreach programme on the prescribing of psychotropic medication (benzodiazepines, antipsychotics and antidepressants) in nursing homes. A randomized, controlled trial was used to test whether an
there were no significant changes in the percentage impairment. Ms Boardman said that, overall, patients on antipsychotics were more likely to have increased dependence, and patients on anxiolytics were more likely to have increased confusion, patients on hypnotics were more likely to have increased cognitive impairment. With regard to particular psychotropic drug groups, Ms Boardman described how criteria were used to match the level of psychotropic drug use, cognitive and behavioural assessments and number of participants at the home. The study addressed three topics: treatment of insomnia; use of thioridazine in anxiety and agitation; and depression awareness and need for review. The GPs and nursing homes in the intervention group participated in an educational session, and GPs also received two follow-up mailings. Evaluation was carried out by analysis of prescribing changes and by postal questionnaire. A 'wash-out' period of 3 months was allowed after the educational session to allow the implementation of changes before re-collecting the data.

Ms Boardman reported that 176 patients from 14 nursing homes across the three areas were recruited into the study. Of these, almost two-thirds (63%) were taking psychotropic medication. Taking withdrawals and exclusions into account, Ms Boardman reported that four pairs of homes with 92 residents completed the controlled trial. Cross-tabulations performed on the baseline data showed no age-related effects. However, participants prescribed psychotropic drugs were more likely to have increased confusion and cognitive impairment. With regard to particular psychotropic drug groups, Ms Boardman reported that patients on antidepressants were more likely to have increased cognitive impairment, patients on hypnotics were more likely to have increased confusion, patients on anxiolytics were more likely to have increased dependence, and patients on antipsychotics were more likely to have increased dependency, confusion and cognitive impairment. Ms Boardman said that, overall, there were no significant changes in the percentage of patients taking psychotropics in terms of class of drug or number of drugs. Behavioural dependency increased over the study for both groups of patients, and the change in the intervention group was significantly greater than the control groups. Staff-rated levels of confusion showed a slight increase in the intervention group, and a slight decrease in the control group. Cognitive impairment showed a small improvement for both groups over the study period. Drug change scores for paired intervention and control homes showed a positive change in the intervention group and also a positive change in the control group — overall there was no difference observed between control and intervention group.

Ms Boardman reported that the results from the evaluation questionnaire to GPs and nursing home staff showed that both groups were positive about the educational programme and said that they would like more education in the same format. The study showed that the level of prescribing psychotropic medication was similar to other recent UK studies. However, Ms Boardman said that reports also showed that many of these drugs are still being prescribed inappropriately. Overall, the educational programme was well received by the GPs and nursing home staff, who reported prescribing changes and discussion, although they also reported difficulties in achieving change.

Ms Boardman told the audience that several issues had been highlighted by this research: the prescribing of psychotropic medication in nursing homes is not as bad as the literature suggests; the recruitment method was complex and time-consuming, involving a consent process for residents, nursing home staff and GPs, leading to concerns that a skewed sample of the keener GPs may have been obtained, thereby not reflecting the general picture in nursing homes; the difficulties in recruitment meant that the study was insufficiently powered; and the 'wash-out' period of 3 months may have been too short to implement changes.

Dr Sheila Greenfield, Senior Lecturer, University of Birmingham ‘Controlling prescribing expenditure in primary medical care: UK experiences’

Dr Greenfield presented a paper on the methods GPs have used to attempt to control prescribing costs, influences and constraints on prescribing and the effectiveness of external monitoring and reporting mechanisms. The project was carried out in the knowledge that cost is of great concern since it is increasing, and also it is capable of being controlled. Dr Greenfield reminded the audience that
Dr Greenfield concluded by saying that the study had shown that formal attempts to try and make GPs reduce prescribing costs had been effective in so far as the GPs were making some attempt to reduce prescribing. The study had also shown that a wide range of approaches to cost control were used thereby indicating a very individualistic approach by GPs. The complexity of the decision-making process and additional constraints in relation to patient- and hospital-led prescribing were also highlighted as issues. Dr Greenfield commented that phase 2 of the study had shown that every theme from the qualitative phase was reflected in the quantitative phase. She said that the size of the practice seemed to differentiate prescribing behaviour and was the factor in the second phase used to determine prescribing behaviour. Dr Greenfield concluded by asking the audience to reflect on a scenario where the 16 practices involved in the phase 1 study could have been part of a single PCG, and asked them to consider the wide range of behaviour exhibited and consequently the challenge for the future with regard to controlling prescribing expenditure.

Ms Kay Wood, Pharmacy Practice Group, Aston University ‘Therapeutic substitution: GP and patient perspectives’

Ms Wood presented the work that was carried out over a period of 2½ years in two GP practices in the West Midlands. The aim of the study was to encourage safe, effective and economic prescribing in the practices. Most of the time was spent on quality issues, but Ms Wood indicated that cost was important too. Ms Wood described three methods of changing maintenance medication: generic substitution; change of delivery device; and therapeutic substitution. The study looked at GPs’ and patients’ perceptions of all of these, but Ms Wood’s presentation focused on therapeutic substitution, e.g. the change from ranitidine to cimetidine from the perspective of the five GPs interviewed.

Ms Wood reported that the GPs’ perspectives on therapeutic substitution included issues around whether it was clinically appropriate; the time and organization needed to make the change; pressures from patients against the change; moving away from old habits; outside influences, such as secondary care prescribing and the pharmaceutical industry; and some indicated that cost was a low priority. Ms Wood presented some quotes from the GPs to elaborate on their feelings about cost issues.
and their perceptions of patients’ attitudes. GPs also gave a number of reasons why some patients were not approached, and consequently no switch was made with their medication. Of the 25 patients that were interviewed, 23 were interviewed at home and two within the GP practice. The main themes that emerged from these interviews were around their feelings about the change, the doctor/patient relationship, changing back to ranitidine, cost, and communication. Ms Wood gave examples of some of the things that patients had actually said with respect to these key themes. ‘Trusting their doctor’ was specifically mentioned by 16 of the 25 interviewees. For all, Ms Wood concluded that the therapeutic change was well accepted by these patients, and that good communication was the key. In this respect and personalized letter to each patient, printed on headed paper and signed by the GP, was felt to have made a major contribution to ensuring that the patients accepted the change. The lack of adverse feedback and positive attitude of patients helped build the GPs’ confidence.

Dr Miren Jones, Department of General Practice, Birmingham University ‘Influences on the introduction of new drugs in clinical practice’

Dr Jones presented a study that was funded by the NHS Primary–Secondary Care Interface programme. The study looked at the factors which influenced the introduction of new drugs into clinical practice and particularly the extent of those operating at the primary/secondary care interface. The methodology was divided into six parts, two of which Dr Jones presented to the delegates.

Dr Jones described how interviews were conducted with 38 consultants from one teaching and one non-teaching hospital, and 56 GPs who were regular users of the teaching hospital. The collection of prescribing data for nine study drugs formed the second part of the methodology. Data were collected for 3 years using hospital pharmacy prescribing data and PACT catalogue data for 50 GPs to find out when they initially started to prescribe the drug, and for how long. The study drugs included lansoprazole, nicorandil, losartan, venlafaxine, nefazodone, citalopram, alendronate, efomoterol and interferon beta-1b.

Dr Jones reported that a number of themes had emerged from the interviews with the consultants. Consultants appeared to be selective, choosing only to prescribe new drugs in their own speciality. When prescribing outside their own speciality, they tended to take advice from colleagues. They reported to have a good relationship with drug representatives in their own field, who would be the first source of information about a new drug. They reported to be primarily influenced by scientific literature and meetings within their own specialist area, but also used drug reps and hospital pharmacists to get information about new drugs. The Drug & Therapeutics Bulletin also featured as a key reference source. The main reason for consultants opting to use a new drug was failure of existing treatment. Dr Jones went on to give examples of quotes collected from the consultants.

Dr Jones then contrasted the consultants’ responses with those from the interviews with GPs. The main themes to emerge from these interviews were that: GPs first heard about new drugs from advertisements, and hospital letters requesting them to prescribe it; they used a different approach for each drug when asked to prescribe; they tended to reserve new drugs for ‘difficult’ patients in whom other treatments had failed. GPs also reported having limited contact with consultants. This was interesting, said Dr Jones, since consultants in the study felt it was the GPs’ duty to find out about new drugs without the input from a consultant.

Dr Jones then went on to describe the influences on GPs to introduce new drugs. Consultant acceptability was regarded by most GPs as key. Drug company literature was reported to often be the only source of information they referred to, but the Drug & Therapeutics Bulletin was the most popular source of impartial reading. Other influences included: the availability of effective alternatives; efficacy, side-effects, convenience and simplicity of dosage; cost, health authority budget constraints; and past experience of using a new drug. Dr Jones then went on to describe the approach taken by one GP to each of the study drugs.

In conclusion, Dr Jones said that the study had shown that consultants were influenced primarily by scientific sources within their own discipline, and colleagues outside their own discipline, whereas GPs were influenced by a much wider range of factors and usually several different factors are involved for each drug.

Professor Andrew Stevens, Department of Public Health, Birmingham University ‘Horizon Scanning for the new NHS’

Professor Stevens began by describing the background to the establishment of the National
Horizon Scanning Centre (NHSC) at the University of Birmingham. The NHSC provides information for the Department of Health and its recommendations are used to inform the National Institute for Clinical Excellence (NICE). Professor Stevens gave examples of where horizon scanning might have helped in the past, e.g. widely used technologies ultimately shown to be harmful, unnecessary delay in the introduction of valuable technologies, to demonstrate the need for the centre. He described how the Centre operates an early warning system to scan the future, and indicated that the NHSC looks mainly at plausible futures within a 5-year period, with its purpose to manage change. In this context, customers include the NCCHTA (health technology assessment), the Department of Health (costing medical advance), and NICE (clinical guidance and guidelines). Professor Stevens described the NHSC's scope of activity which includes pharmaceuticals, devices, diagnostic tests and procedures, interventional procedures, rehabilitation and therapy, service delivery and organizational topics, and professional boundaries. He indicated that scanning is made more difficult because of the number of new developments around at any time.

Professor Stevens outlined the methods used by the NHSC to gather information. Primary, secondary and tertiary sources are used for scanning — the area of focus is then identified from documentary and expert iteration. Professor Stevens then went on to describe the information sources used by the Centre for new healthcare technologies, and also Internet sources. The National Prescribing Centre, the Drug Information Pharmacists’ Group, the Medical Devices Agency, Medical Research Council and other research councils, are among a UK network of organizations used as tertiary sources of information. Professor Stevens explained how collaboration with other countries in Europe ‘EUROSCAN’ is used to share information. Organizations in Canada are also part of this sharing network.

AFTERNOON SESSION: A DEBATE — HIPPOCRATES WAS UTILITARIAN?

Dr John Ferguson introduced the motion. Professor Tom Walley spoke for and Dr Steve Field against.

Professor Tom Walley, Department of Therapeutics & Therapy, Liverpool University

Professor Walley argued that there was a conflict between the Hippocratic ethic and the wider societal approach, creating a tension between the benefit of the individual and that of the population as a whole. He used an example of two treatments for TB, with almost an equal cure rate, but with drug B costing 10 times more than drug A. Using this example, he argued that Hippocrates and utilitarianism start to coincide. He argued that equity should be one of our major aims in the health service, as should cost-effectiveness. He said that the key issues in medical ethics today were equity, transparency, effectiveness and safety. He argued that community values also need to be taken into account, and that the health service needs to inform patients when rationing decisions are being made, and be presented with an opportunity cost in relation to the population as a whole, but not forgetting the tension between the needs of the individual and society. Professor Walley argued that it was up to the individual practitioner to manage this ‘balancing act’.

Dr Steve Field, Postgraduate General Practice Education, NHS Executive, West Midlands

Dr Steve Field argued that the GP is the advocate of the patient, and that patients need to be assured that the GP will do the best for them. Dr Field developed his point by referring to the concept of beneficence and non-malevolence. He said that there were many problems with utilitarianism, including that it can harm the individual, it can restrict individual autonomy and it can devalue the concept of duty. He described how Dostoevsky (1879) challenges utilitarianism and stresses the importance of the individual. Dr Field said that the role of the GP is to focus on the individual. He felt that GPs are currently having problems in the NHS because they work with individuals rather than patients.

Dr Field proposed a ‘Hippocrates for the new millennium’ where the rights of the individual within society are important and that Hippocrates ideals are reaffirmed based on Kant’s Ethical Framework. He argued that this would allow the development of the new NHS based on sound moral principles. He concluded by proposing that Hippocrates was a Deontologist and not a utilitarian, that the individual was important and a moral code needed to be developed with regard to this, based on the Hippocratic way.