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GPs' experiences and perceptions of benzodiazepine prescribing in Western primary care settings: a systematic review and meta-synthesis

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Overview

- What are benzodiazepines?
- What do we know from previous research and what do we want to find out?
- Approach to meta-synthesis
- Core themes identified in the literature (explanatory framework/model)
- Recommendations for practice, policy and future research

Background: What are BZDs and what is the research problem?

- Benzodiazepines are widely prescribed to treat conditions such as insomnia, anxiety and chronic back pain
- The have limited long-term benefits, and are known to have adverse effects and to be addictive
- Consequently NICE guidance recommends that they should only be prescribed short-term
- However, we know that they are used long-term – **why?**

Previous Research

- Previous research has detailed variation in prescribing practice by:
  - Patient demographics
  - GP attributes
  - Different general practice structures
- Variation could also be explained by GPs' own experiences and perceptions – an area investigated in some qualitative studies

Aim

- To synthesise findings from qualitative studies exploring clinicians' experiences and perceptions of benzodiazepine prescribing
- To build an explanatory model of processes underlying benzodiazepine prescribing

Method

- **A meta-synthesis of relevant qualitative research**
- **Step 1:** Identification of relevant studies through **a systematic review** of the literature
  - Developed and applied a search across the following databases: MEDLINE, CINAHL, Social Science Citation Index, Science Citation Index, PsycINFO, Sociological Abstracts and AMED
  - Identified 1110 possible papers for inclusion
  - Removed duplicates and applied inclusion and exclusion criteria to narrow this down

Inclusion / Exclusion Criteria

- Studies assessed by two pairs of reviewers and needed to:
  - Use both qualitative data and analysis
  - Contain GP or nurse generated data on their experiences of prescribing benzodiazepines in Western primary care settings (European country/USA/ Australia/New Zealand)
  - Have been published between January 1990 and August 2011 in a European language
- Result – 8 papers met the inclusion criteria

- **Step 2: Quality Assessment**
  - Included papers were assessed by two pairs of reviewers using the Critical Appraisal Skills Programme checklist (CASP)
  - No studies were excluded from the review on the basis of study quality

- **Step 3: Data synthesis**
  - We used the ‘thematic synthesis’ approach to meta-synthesis:

1. Line-by-line coding of the results sections of papers
2. Creation of descriptive themes
3. Creation of analytic themes

Results

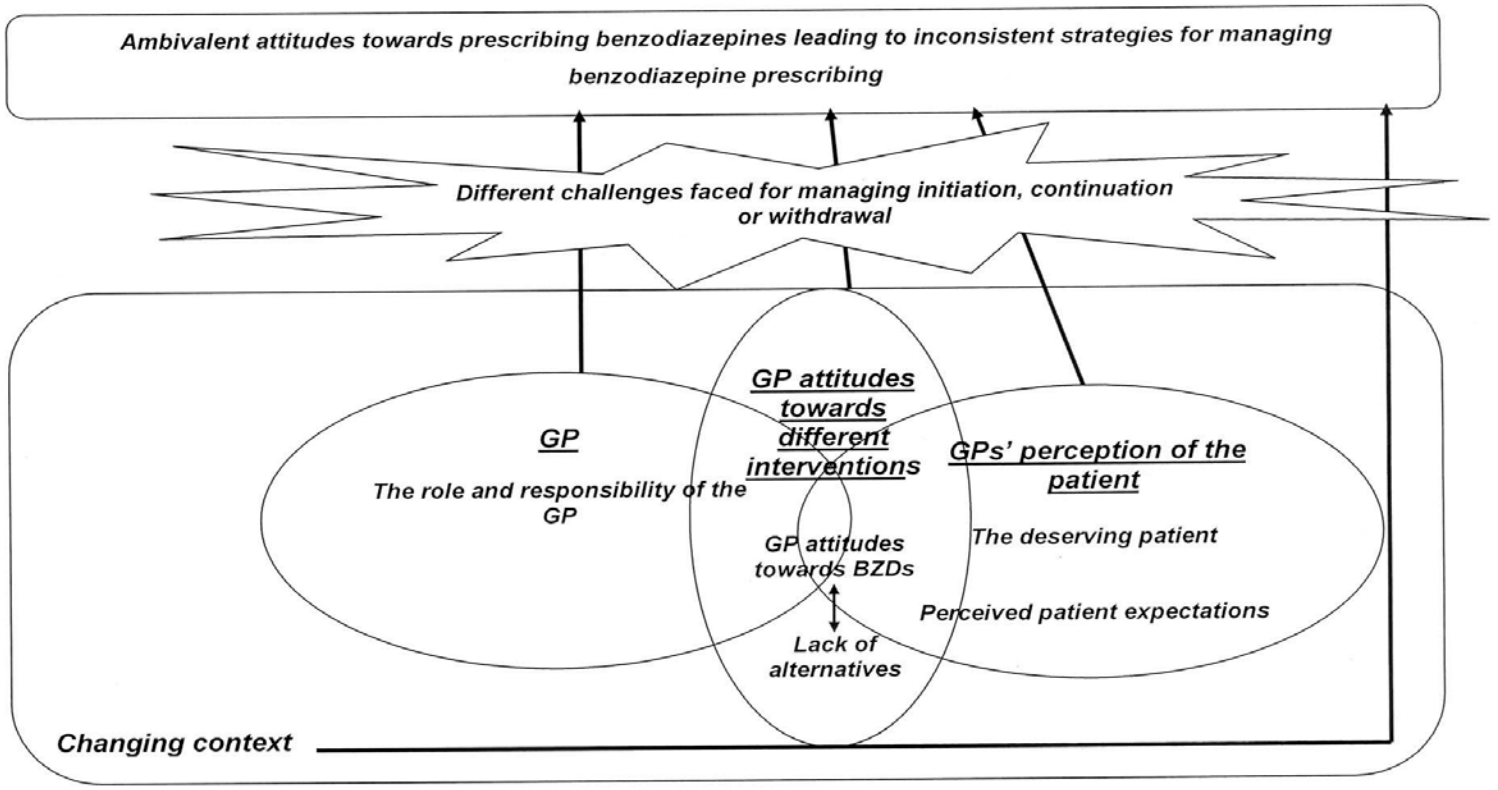
Study Characteristics

The included studies were:

- From 7 different countries
- Published between 1993 and 2010
- Based on semi-structured interview data (n=7) and focus group data (n=1)

Themes

- 7 core themes were identified within the data and used to produce an explanatory model



1. The changing context of BZD prescribing

- GPs stated that they are now better informed about the risks and side-effects BZD use – change from optimistic to cautious culture of prescribing
  - GPs increasingly encounter patients who would previously have been treated in secondary care
  - This theme underpins many of the others (as shown later)

2. The Role and Responsibility of the GP

- Some GPs take on responsibility for ‘correcting’ past prescribing, whilst others state that the adverse effects have been over-stated and/or blame others for initiating prescribing
- Tension between minimising BZD use and wanting to help patients
- Leads to ambivalent attitudes and inconsistent management strategies

3. The ‘deserving patient’

- Need to justify giving or withholding a prescription
- Characteristics such as elderly, female, long-term users, multiple diseases, psychosocial problems
- Also need to elicit public sympathy
- However, rules are not rigidly applied e.g. elderly patients/those that GPs empathise with or know well

4. Perceived patient expectation

- Prescribing was also influenced by the way doctors *perceived* both a patient's expectations, and their motivation and ability to cope
- Often the treatment option chosen is based on assumptions about the patient's preferences rather than direct discussion

5. GP attitudes towards different interventions

- The treatment option GPs chose was influenced by their attitudes towards and beliefs about different interventions
  - Range of views on the nature of BZDs
  - Knowledge of alternative treatments
  - Perception of alternative treatments

6. Different challenges faced for managing initiation and withdrawal

- The ‘deserving patient’ characteristics feed into both initiation and continuation of prescribing
- There may be specific barriers to withdrawal e.g. fear of loss of patients, previous failure at attempting withdrawal, perceived lack of valid alternatives (latter is also a reason for initiation)

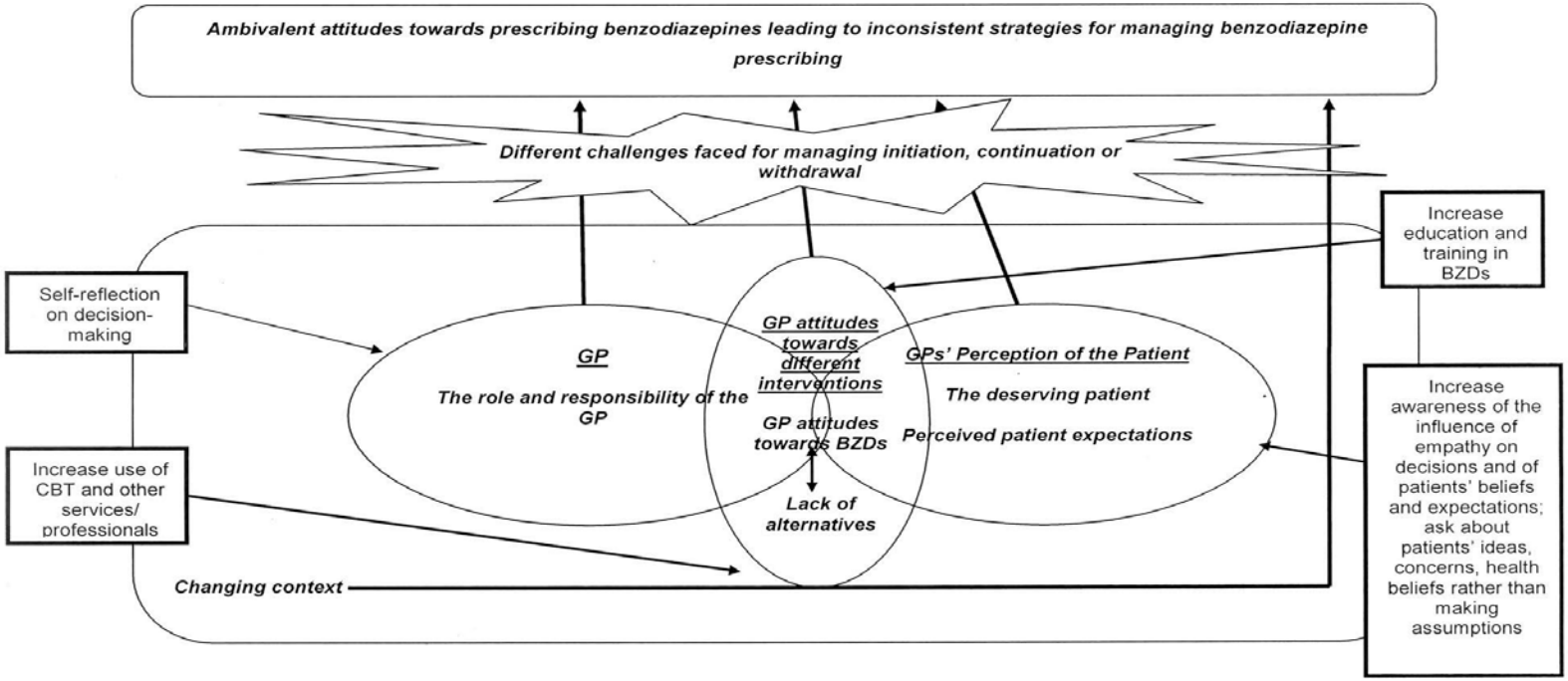
7. Ambivalent attitudes towards prescribing benzodiazepines leading to inconsistent management strategies for prescribing benzodiazepines

- Combination of the factors described previously leads to ambivalent attitudes towards BZDs – continuum of prescribing
- Development of ‘rules’ for prescribing e.g. minimal use/short-term use only/patient education/specific patient characteristics, but these were inconsistently applied

Findings in Context

- Previous study of uncomfortable prescribing decisions (Bradley, 1992) - combination of factors, rather than one single factor which makes it difficult
- Short timescales and uncertainty lead to generalisation – Kahneman's representativeness heuristic
- 'Deserving patient' – affect heuristic – replacing hard question with easier one
- Greater empathy – more impulsive decisions – prescribe
- Assumptions about patients' expections (Dyas et al., 2010)

Recommendations for practice, policy and future research



Continued

- Address knowledge deficits through increasing education and training for GPs (particularly high prescribers)
- Change attitudes towards, and understanding of, alternative types of treatment
- Long-term increase the availability and accessibility of alternatives such as computerised cognitive behavioural therapy for insomnia
- Increase awareness of the impact of empathy and *perceived* patient expectations on decision-making – direct discussion and reflection

Thank-you for listening!

Find out more about our research at:

www.CaHRU.org.uk

References

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