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1 Title: A qualitative study of the relationship between the Scottish Medicines Consortium and their
2 clinical experts.

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25 **Structured Summary (248 words)**

26 **Aim:** Internationally, health technology assessments (HTAs) are ubiquitous drivers to health policy. Within
27 Scotland, the Scottish Medicines Consortium undertakes the medicine review process. Input from clinical
28 experts, involved in frontline care, is an integral component of the assessment process. This paper explores
29 the relationship between the clinical experts and the HTA agency within Scotland to better understand what
30 motivates expert clinicians to devote their time to the medicine review process with no remuneration.

31
32 **Methods:** 27 clinical experts from 16 different clinical specialties took part in one-to-one interviews at their
33 place of work between October 2011 and March 2012. Data analysis was inductive and comprised the
34 organisation of data into a framework and a subsequent thematic analysis.

35
36 **Results:** Three distinct themes were identified: (1) recruitment which identified two types of explanations for
37 the experts' appointment: external justification (nominated by another) and internal justification (being
38 recognised as an expert); (2) flexibility of the procedures, with experts able to determine their own response
39 style and negotiate timelines; (3) healthcare systems, demonstrating that their affiliation to the health system
40 underpinned the relationship and their motivation to be clinical experts.

41
42 **Conclusions:** The findings of this study provide insight into the elements important to clinicians who
43 voluntarily contribute to HTA processes. Examination of these elements in the context of the organisational
44 citizenship behaviours (OCB) literature provides a foundation on which to improve understanding of this
45 relationship and sustain and improve clinical expert participation in an increasingly intensified clinical
46 environment and within cash-limited HTA systems.

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53 Introduction

54

55 Health technology assessment (HTA) is a multidisciplinary activity that scrutinises the safety, clinical and cost-
56 effectiveness of health technologies including medicines [1, 2]. The aim of HTA is to provide evidence-based
57 information to inform the use of health technology and allocation of resources. The 1980s and 1990s saw a
58 proliferation in the number of European HTA organisations, with the first HTA agencies appearing in France,
59 Spain and Sweden. This was followed by the Netherlands, Austria, Finland, Latvia, Denmark, Norway, Germany
60 and the United Kingdom[3]. By 2008, 16 European countries had formal HTA organisations[4, 5] and today the
61 number of HTA agencies continues to grow across Europe [6].

62

63 The structure, role and processes of HTA agencies vary between countries but can broadly be divided into 2
64 groups: (1) agencies providing an advisory or regulatory function, often aligned to re-imburement; and (2)
65 independent review agencies generating HTAs to support clinical practice decisions [1]. For example, in France
66 and Sweden, HTA is used to support reimbursement decisions while, in Scotland, the Scottish Medicines
67 Consortium (SMC) provides advice to the National Health Service (NHS) about the comparative clinical and
68 cost-effectiveness of medicines. Similar to SMC, the National Institute for Health and Care Excellence (NICE)
69 provides advice on new medicines to the NHS in England in addition to clinical guidelines, social care guidance,
70 and interventional procedures guidance.

71

72 Good practice for HTA dictates that key stakeholders who may be impacted by the HTA decision must be
73 engaged with in order to improve the quality, relevance and acceptability of HTA [7, 8]. Failure to do so may
74 delay implementation of HTAs due to appeals and disagreement amongst stakeholders [1]. Stakeholders vary
75 according to the role of the HTA agency but often include policy makers, health professionals, patients, and
76 industry [9]. Of these stakeholders, health professionals are of particular importance as they may be involved
77 at a number of stages in the HTA process: topic nomination, review of the evidence, development of the HTA
78 report or appeal of the HTA decision [10].

79

80

81 In Scotland, the SMC recruits healthcare professionals as clinical experts. These are consultant physicians,
82 surgeons, specialist pharmacists and general practitioners who are contacted at the beginning of the medicine
83 assessment process. The clinical experts provide contextual information on current prescribing practice,
84 disease prevalence, unmet clinical need and product fit within clinical practice[11] and gives a vital opinion
85 about a proposed new medicine's use "at the coal-face". However, this is not an explicit part of the clinician's
86 professional role, offers no remuneration or direct reward, and is voluntary with limited external pressure as
87 the recruitment process is anonymous. The need to understand the mechanisms behind this behaviour is two-
88 fold. Firstly, by developing an understanding of the relationship, clinical expert input to the medicine review
89 process may be sustained and even increased within HTA generally. Secondly, due to the financial limitations
90 within which all health care providers operate, through understanding the dynamics within the SMC it may be
91 possible to export the model of voluntary clinician engagement into other healthcare activities.

92
93 No research within health care has examined this relationship in HTAs but the field of psychology could
94 provide a framework from which to consider clinicians' engagement. Organisational citizenship behaviour
95 (OCB) is defined as "*individual behavior that is discretionary, not directly or explicitly recognized by the formal*
96 *reward system, and in the aggregate promotes the efficient and effective functioning of the organization*"[12].
97 Organ and colleagues propose five dimensions within OCB: altruism, courtesy, conscientiousness, civic virtue,
98 and sportsmanship [12]. These dimensions are widely used within the literature, although not universally
99 accepted [for example 13], and offer a basis from which to explore clinician engagement within HTAs. For our
100 purposes "civic virtue" is most relevant as it includes organisationally focused behaviours such as the
101 attendance of non-mandatory meetings, an interest in the organisation and improving its performance, and
102 the willingness of the employee to share their experience and knowledge with others[14, 15]. Two distinct,
103 but related, forms of civic virtue (CV) OCBs have been proposed – information gathering (CV- information) and
104 influence exercising (CV-influence) [16]. While CV-information focuses on activities such as attendance at
105 meetings and keeping up to date, CV-influence includes suggesting change within an organisation [16].

106
107 To the authors' knowledge, there has been no research examining OCBs within the HTA process but it may be
108 that this model, and the associated research, provides a basis for understanding the behaviour – and how to

109 promote it. It is important that the mechanisms for this behaviour be understood within a HTA context, where
110 clinicians include world leaders within their fields and therefore their involvement in medicine review
111 processes is not just desirable but necessary. To this end an exploratory, qualitative evaluation was
112 undertaken to examine why the clinical experts engaged and supported the medicine review process.

113

114 **METHODS**

115 **Ethical Approval**

116 The project was a service evaluation and therefore did not require University of Strathclyde ethical approval
117 [17, 18]. Additionally, NHS ethical review under the terms of the Governance Arrangements for Research
118 Ethics Committees (REC) in the UK was not required as the project is an opinion survey seeking the views of
119 NHS staff on service delivery (as advised by the East of Scotland NHS Research Ethics Service).

120

121 **Materials**

122 A semi-structured interview schedule was developed through discussions within the multidisciplinary
123 evaluation team (comprising pharmacists, social scientists, medical clinician, and information analyst) and the
124 evaluation's steering group. It was designed to capture a wide range of experiences and areas of interest
125 around the role of the clinical expert. The schedule was piloted with a clinical expert and amendments were
126 made as necessary (this participant was not included in the final sample). See supporting information for the
127 schedule.

128

129 **Procedure**

130 The SMC provided details of their clinical experts (n=450) and an email was sent alerting them to the
131 evaluation and inviting them to take part through return email. Fifty-four (12%) responded positively to the
132 request. A purposive sampling strategy was devised to retain the proportions of profession, specialty and

133 geography of the respondents (see Table 1). A total of 30 participants were selected as it was viewed that this
134 would be sufficient for saturation of data (i.e. no new themes would emerge in subsequent interviews).

135 [insert Table 1 around here]

136 One-to-one interviews were conducted at each clinical expert's place of work during office hours over the
137 period between October 2011 and March 2012. Participants read an information sheet detailing what the
138 study would involve, that the interview data would be anonymised and their participation was entirely
139 voluntary. All participants signed the consent form provided by the researcher. All interviews were conducted
140 by EDC, lasted between 30 and 90 minutes, were recorded using a Dictaphone and transcribed verbatim. A
141 framework analysis was applied to the data, allowing the analysis of main themes to be carried out on a large
142 volume of data [19, 20]. RN and EDC coded the data, then met and examined their developed thematic
143 framework and coded data; areas of disagreement were resolved through consensus. These codes were then
144 organised in order to develop themes and sub-themes by EDC.

145

146

147 **RESULTS**

148

149 **Participants**

150

151 Of the 30 clinical experts who had agreed to take part, three dropped out of the study prior to
152 commencement of the interviews. The remaining 27 participants ranged in age from 32 to 63 years (median =
153 48, IQR= 46-53). A third of the sample were female and participants had been clinical experts for between 6
154 months to 10 years (median= 5, IQR= 3-7), and had given advice on between 2 and 60 medicines (median= 5,
155 IQR= 3-10). Two participants had previously been members of the SMC. Participants represented 16 different
156 medical/surgical specialties: oncology/haematology (n=6), anaesthetics (n=3), genitourinary /obstetrics and
157 gynaecology (n=2), neurology (n =2), psychiatry/mental health (n=2), infectious diseases (n=2) and one

158 representative each from paediatrics, cardiology, orthopaedics, general medicine, rheumatology,
159 endocrinology, biochemistry, ophthalmology, nephrology and liver transplant/surgical.

160

161 **Data Analysis**

162

163 Nine randomly selected interviews were read by two researchers who worked independently to derive
164 frameworks of descriptive themes. These researchers then met and compared frameworks; disagreements
165 were resolved through discussion. The remaining 18 interviews were coded and relevant quotes were selected
166 and placed into the framework table and validated by a third researcher; additional quotes were added
167 through discussion. This validated framework was summarised for the subsequent thematic analysis.

168 The thematic analysis identified three distinct themes related to why the clinical experts participate in the
169 medicine review process: (1) recruitment; (2) flexibility of procedure; and (3) healthcare systems. Sub themes
170 within these themes are explored and quotes are used to accompany these. Hesitations have been removed
171 and, on occasion, words contained in parentheses have been added to clarify meaning or disguise any
172 identifying information. Text that has been removed is represented by ellipses. Accompanying each quote, in
173 brackets, are the participant's professional title and clinical expert experience. In general, the themes were
174 expressed in the majority of the interviews unless stated otherwise. The supporting quotes are presented in
175 Figure 1.

176 [Insert Figure 1 around here]

177 **Theme 1: Recruitment**

178 Only one clinical expert reported actively volunteering for the role. Many clinical experts were not entirely
179 sure how they had assumed the role as clinical expert, only that they were approached. Two types of
180 explanations for recruitment were identified: external justifications (recruited or nominated by others) and
181 internal factors (recruited as a result of clinical experience). Both patterns of justification suggested that being

182 considered an expert in a field – either by one’s own opinion or through the nomination of others – may be
183 crucial in engaging the help of the clinical experts.

184 ***External Justification***

185 Most participants reported being approached by SMC to become a clinical expert and either suspected or
186 knew they had been nominated by colleagues, or identified through various committees they had been
187 involved in (Quotation 1). In these cases, participants were often not fully aware of who had nominated them,
188 and they often assumed that they were identified through these channels, with some even stating that they
189 were never ‘formally appointed’ and had been involved almost by default (Quotation 2).

190

191 ***Internal Justification***

192 Some participants reported that they had been recruited as clinical experts due to their level of involvement
193 and expertise in their specialist field rather than referring to a nominator (Quotation 3).

194 **Theme 2: Flexibility**

195 ***Flexibility in Response Style***

196 The way that clinical experts approached providing their advice on new medicines varied. Some experts felt
197 that extra reading was required before giving advice (Quotation 4) whereas others felt that, as an “expert”,
198 their opinion should be informed enough to provide an appropriate and extensive answer. Additionally, the
199 SMC was reported to give limited guidance regarding the length/focus of responses. This promoted the
200 experts’ autonomy, allowing their response style to vary depending on the individual clinician (Quotation 5).
201 However, some clinicians voiced a preference for the SMC to provide them with guidance on the length/focus
202 of response, and feeling confused around how extensively their answers should be researched (Quotation 6).
203 Some participants did identify that there was probably a good reason behind not guiding or influencing clinical
204 experts responses, as the SMC would be looking for an individual clinician’s view rather than one influenced by
205 external factors such as other expert advice. Many observed that the SMC did ask additional questions if their

206 answers had been lacking somehow, and assumed that if they didn't hear otherwise from the SMC and they
207 were asked to provide advice again that they must be fulfilling their role adequately as an advice-provider.

208 ***Flexibility of Engagement Style***

209 Many participants expressed that, although they felt more informed about SMC process since becoming a
210 clinical expert, they still lacked knowledge around what the whole process involved, where they fitted into the
211 process and what contribution their advice actually made to the final decision (Quotation 7). Although some
212 were comfortable with the remote engagement style, many felt that their need to be fully involved and
213 engaged with the SMC would be fulfilled if they were provided with more information and two-way feedback
214 on the full extent of the role clinical experts were expected to play.

215 All participants reported being contacted via email whenever SMC requested their advice, with only a few
216 speaking to an SMC staff member over the phone (this kind of interaction was usually initiated by the clinical
217 expert). The advantage of emails was that they could be stored and responded to when convenient (Quotation
218 8) but some clinical experts expressed that they would appreciate more direct communication from the SMC,
219 with the possibility for more involved engagement (Quotation 9). Little feedback was received by the clinical
220 experts on the advice that they provided or information on the decision made by the SMC. Participants
221 indicated that they usually became aware of the SMC decision through other routes (Quotation 10).

222 ***Flexibility of Response Time***

223 Clinical experts reported that providing advice could be limited, and in some cases not possible, due to
224 time restrictions. Participants also reported that SMC were very accommodating when time was an
225 issue, and would often negotiate a more suitable date by which to provide their advice. This flexible 'no-
226 pressure' approach may be attractive to busy experts, and thus motivate them to continue involvement
227 with the SMC (Quotation 11). Some participants reported suggesting other colleagues to the SMC in the
228 event that they could not provide advice within the timelines or considered that another person may be
229 more appropriate.

230 ***Flexibility in what motivates a clinical expert***

231 When asked what the benefits were of being a clinical expert, participants reported personal, internal and
232 external motivators for responding to requests for advice. One important set of benefits mentioned were the
233 personal development and learning opportunities associated with the role (Quotation 12). Responses ranged
234 from participants finding it “interesting” and beneficial in keeping up-to-date on a scientific and clinical level;
235 to others stating that it was important in alerting them to potential new medicines becoming available. Others
236 felt a sense of personal satisfaction and prestige associated with the role. Many reported that it was rewarding
237 to be recognised as an expert, by the SMC and by their peers, and to feel that they were one of the best
238 informed in their particular field (Quotation 13). Some reported feeling more informed about the SMC in
239 general, and feeling informed not only brought a sense of satisfaction, but being privy to the new medicines
240 review process gave some participants confidence that the process was transparent and fair. Participants also
241 reported the benefits of being able to see the impact of their advice when it was reflected in SMC decisions
242 and guidance. The opportunity to influence SMC decisions was reported by many participants as a benefit of
243 responding to requests for advice. Some saw it as a chance to impact upon prescribing behaviours and
244 practice at a national level, which in turn made them feel part of national decision making in addition to their
245 local NHS Board role (Quotation 14). These personal, internal and external motivators all provide insight as to
246 why clinical experts volunteer their time to the SMC.

247 **Theme 3: Healthcare Systems**

248 ***The profile of the SMC within NHS Scotland***

249 The relevance of the SMC’s decisions to the clinicians’ professional roles was recognised and overall the SMC
250 was viewed positively. When asked their opinions of the SMC and why participants volunteered their time for
251 them, the general consensus was that the organisation was valued (Quotation 15). Many reported trusting
252 the SMC, having confidence in them and believing that they operated in a useful and fair manner, improving
253 year upon year. Many also reported the benefits of the organisation’s speed in making decisions, and praised
254 their ability to provide clear and concise advice for clinicians (Quotation 16). The SMC was seen as
255 approachable, and clinical experts felt valued in their role and praised the SMC for consulting clinicians whose
256 prescribing practices would be directly affected by the outcome of the medicine review process (Quotation
257 17).

258 ***The relevance of the SMC within professional Role***

259 Many participants reported seeing the relevance of being a clinical expert to their current professional role
260 and volunteering as a clinical expert was a natural progression (Quotation 18). For some, being a clinical
261 expert fell under the realm of professional activities expected of them as clinicians. Others also saw
262 contributing to SMC processes as part of their continuing professional development (CPD) which all clinicians
263 are required to record (Quotation 19). Engaging with the SMC as a clinical expert, therefore, provided some
264 personal professional opportunities. Furthermore, some reported that being a clinical expert made them more
265 aware of SMC guidance and more likely therefore to adhere to it. Additionally, participants commented on
266 how being a clinical expert supported the clinician's role of helping and representing patients (Quotation 20).
267 Some also saw being an expert advisor to the SMC as an opportunity to be more privy to information about
268 new medicines, and this was important in managing patient care and expectations more effectively (Quotation
269 21).

270

271 **DISCUSSION**

272 The importance of engaging clinical experts in the HTA process is well recognised internationally[1, 7, 8, 10]
273 but we found no published evidence on why experts engage and how this can be sustained and improved,
274 particularly in an increasingly intensified clinical practice environment. This study identified three key themes
275 that underpin why clinicians volunteer their time to HTA agencies: recruitment; flexibility of the procedures;
276 and, the profile and relevance of the SMC within the health care system.

277 The current study's findings resonate with some of the OCB literature. Firstly, taking part in HTA was
278 rewarding to the expert, although the exact reward depended on the individual. This is in line with literature
279 reporting that helping behaviours, such as those seen with OCBs, are associated with positive consequences
280 such as self-development or feelings of well-being [21]. Rewards such as seeing the results of their advice and
281 the national impact suggest that clinical experts see the meaningfulness of their contribution. An employee's
282 perception of their work as being significant has been positively linked to civic virtue behaviour which aims to
283 change the way of working within an organisation (CV-influence)[16]. Secondly, some clinicians viewed this
284 role as an extension to their professional role and that they had a moral responsibility to their patients to

285 engage in this process. Expressions of OCBs are not always seen by employees as being discretionary [22] and
286 moral obligations are thought to be consistent with OCBs [12]. Thirdly, the clinical experts appeared positive
287 about SMC, and by association the NHS. Employees' perception of their organisation as being fair was an
288 important determinant for OCBs [23], while commitment to the organisation was seen to predict civic virtue
289 behaviours such as keeping up to date (CV-information) [16].

290 How an HTA agency engages their clinical experts is therefore likely to underpin experts' level of commitment
291 to the HTA process. The flexibility offered by the SMC, such as with response style and timescales, may
292 decrease obstacles to the clinicians' involvement in the HTA process. A The SMC engaged directly with the
293 clinical experts and provided flexibility in response style and time, which were both highly valued by the
294 experts. However, the clinical experts voiced that they would welcome increased two-way feedback on their
295 input and the final decision made by the SMC. An investigation undertaken by an HTA organisation in the USA
296 found that a common complaint among stakeholders was the lack of response to written comments submitted
297 [10].

298 Outwith new medicines assessment, the wider clinical guideline development community – for example SIGN
299 and NICE – recognise the importance of expert healthcare provider engagement[24, 25]. However, there
300 remains limited evidence on why they engage and how this is sustained. Consideration of the OCB framework
301 could support the wider engagement of expert clinicians across the HTA portfolio.

302

303 **Study Strengths and Limitations**

304 Participants self-selected into the study, which might imply that these experts were not representative of the
305 group as a whole. It must be recognized that the motivations to reply to the recruitment email may be similar
306 to those that drive involvement with the SMC and the experts who did not reply may represent a distinct
307 group with differing views of SMC engagement. However, the experts interviewed were a heterogeneous
308 sample from sixteen different specialties with a broad range of experiences in the role. It is recognized that by
309 choosing to retain the geographical distribution of our original sample, we "lost" potential participants from
310 three additional specialties (respiratory, prescribing support and colorectal). Motivations within clinicians who
311 work in different clinical specialities may be more different than the motivations between NHS board

312 employees, although there was agreement across the specialties included in our sample. Clinical experts who
313 no longer gave advice, and their reasons for this were not included in this sample, but it would be important
314 for further exploration to involve such experts.

315

316 The issue of generalisability within qualitative research is an important one. For exploratory analysis such as
317 this, interviews give insight to the issues most relevant to the group being interviewed. However, the themes
318 derived from the data reflected the fact that there were many commonalities in their experiences with being a
319 clinical expert, and the lack of new emerging themes as the interviews progressed over time suggested that
320 saturation was reached (i.e. further interviews would not have resulted in additional themes). The extent to
321 which these findings are generalisable between countries is as yet poorly understood – although the OCB
322 literature suggests that cultural differences, for example between collectivist and individualist cultures, are
323 important within organisations [12]- and would benefit from further research.

324 **Future Directions**

325 Evidence suggests that organisations can improve their performance by encouraging OCBs[26].This project has
326 revealed the importance of autonomy, flexibility and awareness of the relevance of work to the national
327 agenda in explaining why clinical experts take part in the medicine review process. Balancing this with a call
328 from clinical experts for increased engagement (guidance on their role and feedback on their inputs) poses
329 challenges for any HTA; there is a balance to be struck between potential improved quality and
330 standardisation of responses through more directive guidance from HTAs and the potential perception, real or
331 not, of increased workload and reduced flexibility impacting on expert retention. Examining future
332 engagement enhancement initiatives through the lens of the OCB literature is a first step in understanding
333 how OCBs can be contextualised within healthcare as an enabler to capitalise on clinicians' expertise.

334 Further research should focus on how to maximise clinical expertise in vital health systems locally, nationally
335 and internationally through a growing understanding of OCB within these different healthcare settings. The
336 result will be the development of an evidence base on how HTAs may best engage this important stakeholder
337 group in their decision making processes.

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349 presented orally and as a NHS Report to the funding body.[27] The study findings have been presented as a
350 poster [28]and oral presentation [29] at the 11thEuropean Association for Clinical Pharmacology and
351 Therapeutics congress.
352

353

354 **COMPETING INTERESTS STATEMENT**

355 All authors have completed the Unified Competing Interest form at
356 http://www.icmje.org/coi_disclosure.pdf (available on request from the corresponding author) and declare:
357 RN and EDC were funded through a grant from Health Improvement Scotland; JWD receives the financial
358 support of NHS Research Scotland, through NHS Lothian; and SH is currently employed by the Scottish
359 Medicines Consortium but was employed at NHS National Services Scotland, Public Health Intelligence during the
360 study period. SMcT and MB have nothing to declare.

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447

448 **TABLE LEGEND**

449 Table 1. Comparison of the medical specialty of SMC experts who agreed to be involved in the study with
450 those who were finally recruited.

451

452

Medical Specialty	All Respondents Total (%)	Participants Total (%)	Difference (%)
Oncology/Haematology	12 (22.2%)	6 (22.2%)	0
Anaesthetics	8 (14.8%)	3 (11.1%)	-3.7%
Genitourinary /OBGYN	6 (11.1%)	2 (7.4%)	-3.7%
Neurology	4 (7.4%)	2 (7.4%)	0
Psychiatry/Mental Health	4 (7.4%)	2 (7.4%)	0
Infectious Diseases	2 (3.7%)	2 (7.4%)	+3.7%
Paediatrics	1 (1.9%)	1 (3.7%)	+1.8%
Cardiology	1 (1.9%)	1 (3.7%)	+1.8%
Orthopaedics	1 (1.9%)	1 (3.7%)	+1.8%
General Medicine	4 (7.4%)	1 (3.7%)	-3.7%
Rheumatology	1 (1.9%)	1 (3.7)	+1.8%
Endocrinology	1 (1.9%)	1 (3.7)	+1.8%
Biochemistry	1 (1.9%)	1 (3.7)	+1.8%
Ophthalmology	2 (3.7%)	1 (3.7%)	0
Nephrology	1 (1.9%)	1 (3.7)	+1.8%
Liver Transplant/Surgery	1 (1.9%)	1 (3.7%)	+1.8%
Respiratory	2 (3.7%)	0	-3.7%
Prescribing Support	1 (1.9%)	0	-1.9%
Colorectal	1 (1.9%)	0	-1.9%

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455

456 **FIGURE LEGEND**

457 Figure 1: Themes and quotations arising from clinical expert interviews

458 **Theme 1: Recruitment**

459 **External Justification**

- 460 1. *I think one of my colleagues must have nominated me. Because I just got an email so I suspect because the*
461 *people I share an office with ... I presume it was [my colleague] that nominated me* (Clinical Effectiveness
462 Pharmacist, clinical expert for 4 years)

- 463 2. *I think I just got emailed ... they send out the email and say, "Do you know anything about this drug? Do*
464 *you feel confident in giving us an opinion on this drug?" ...but there's never been an actual formal*
465 *appointment (Consultant, clinical expert for 7 years)*

466 **Internal Justification**

- 467 3. *I've worked in [specialty] for 15/20 years now since-since qualifying, I've been involved since 1990*
468 *(Consultant, clinical expert for 2 years)*

469

470 **Theme 2: Flexibility**

471 **Flexibility in Response Style**

- 472 4. *It's worth just checking what the current clinical guidelines are and saying well, this medicine fits in to that*
473 *gap, or alternatively, there is no place for this particular drug... So it involves some reading around the*
474 *subject (Consultant, clinical expert for 10 years)*
- 475 5. *It does depend on how much work you feel you've to put into it personally 'cause if you feel you've got to*
476 *go off and do a literature search on it, but that's never the approach I've taken. (Consultant, clinical*
477 *expert for 3 years)*
- 478 6. *I answer the email in a particular way but I don't know if what I'm doing is one hundred per cent correct...*
479 *so there is I suppose a lack of two-way feedback (Consultant, clinical expert for 7 years)*

480

481 **Flexibility of Engagement Style**

- 482 7. *Interviewer: So you don't know anything that happens [with your advice]?*
483 *Clinical expert: Not a clue... [It's] a bit like leaving an exam without a mark (Consultant, clinical expert for*
484 *7 years)*
- 485 8. *I'm quite happy to be contacted in the way that I'm contacted and email seems quite convenient really*
486 *(Consultant, clinical expert for 7 years)*
- 487 9. *I've certainly never been to anything ...they are a little bit distant. (Consultant, clinical expert for 10 years)*
- 488 10. *It would be useful for them to feedback the guidance once it's public ...directly to us rather than having to*
489 *wait to hear (Consultant, clinical expert for 3 years)*

490

491 **Flexibility of Response Time**

- 492 11. *I've missed it, because I was away on holiday ... so I've just emailed back and said, 'I'm sorry, I was away,*
493 *I've missed the date', so they've then emailed back and said, 'Well, can you send your response anyway?'*
494 *(Consultant, clinical expert for 6 years)*

495

496 **Flexibility in what motivates a clinical expert**

- 497 12. *It actually makes me think that, you know, there are new drugs out there. It makes me do the work and*
498 *trawl through the literature ... it keeps you in tune of what's coming out (Consultant, clinical expert for 7*
499 *years)*
- 500 13. *I'm happy to do it... everyone wants to be an expert, don't they? You know, that's like a pat on the head.*
501 *(Consultant, clinical expert for 6 years)*
- 502 14. *It should give me a way to influence their decisions (Consultant, clinical expert for 10 years)*

503

504 **Theme 3: NHS Systems**

505 **The profile of SMC within NHS Scotland**

- 506 15. *I think it's quite nice to have a Scottish organisation taking advice from Scottish experts and producing its own*
507 *opinions, and I do think it's valuable. (Consultant, clinical expert for 5 years)*
- 508 16. *I think it's excellent and the summaries they provide, the assessment of products are very clear,*
509 *comprehensive - they give good guidance, they're timely. (Principal Pharmacist, clinical expert for 5 years)*
- 510 17. *I suppose benefits to the services that I see is it's very useful that they get real life feedback on what*
511 *happens in practice rather than just from reading the papers that the company have submitted or*
512 *whatever. (Clinical Effectiveness Pharmacist, clinical expert for 4 years)*

513

514 **The relevance of SMC within Job Role**

- 515 18. *I think this is, in a way, part of our job... we all have a professional responsibility to practice cost-*
516 *effectively, and also to advise colleagues, because, you know, as specialists in the field, we then need to*
517 *advise, for example, general practitioners. (Consultant, clinical expert for 1 year)*
- 518 19. *I obviously take part in continual professional development, and I do read articles/ literature ...I think you*
519 *focus more if you're being asked to give an expert opinion because you realise there's a responsibility to*
520 *this (Consultant, clinical expert for 1 year)*
- 521 20. *It's a little bit altruistic that you do it for the greater good...if you become a senior consultant or if you become an*
522 *expert in the field, it's part of the payback (Consultant, clinical expert for 10 years)*

523
524
525

21. *Engagement with the SMC allows me to feel that I'm contributing to the availability of exciting new [specialty] drugs for my patients. That's what it's all about (Medical Practitioner, clinical expert for 5 years)*