Reviewer's report

Title: Why are eligible patients not prescribed aspirin in primary care? A qualitative study indicating measures for improvement.

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Reviewer: Paul Shekelle

Level of interest: A paper whose findings are important to those with closely related research interests

Advice on publication: Accept after discretionary revisions

Journal article review entitled:
Why are eligible patients not prescribed aspirin in primary care? A qualitative study indicating measures for improvement.

This article presents the results of interviews with 15 general practitioners in the West Midlands of England concerning their attitudes toward prescribing aspirin for patients that meet existing English guidelines for aspirin. The themes that were identified included clinical uncertainty with difficulty of translating guidelines to individual patients, patients' reluctance to take aspirin, and then other factors including GP's knowledge of the benefits of aspirin and methods for identifying and targeting eligible patients for aspirin. The authors conclude that the nature and presentation of risk information available to general practitioners and patients must be improved. They also conclude that decision analysis may be one method to improve this. Lastly, they conclude that aggregate prescribing data may not be accurate.

I read this paper with some enthusiasm. The topic is clearly important. Trying to enhance the implementation of evidence-based practice is a key component of health systems everywhere. Qualitative studies such as this one are useful in trying to understand the "why" behind the repeated documentation of less than optimal performance. I think the themes identified here are consistent with past hypotheses and data about potential barriers to appropriate prescribing. One weakness of the methods is that it appears only a single person identified themes. I believe the standard in this field is to have themes identified independently by two or more persons and subsequent consensus resolution of any differences. Using a single reviewer increases the chance that the reviewer's own bias may have inadvertently entered into the coding of the results.

As with any such study, one of the important portions of the paper is what the results suggest in terms of methods to overcome the barriers. The authors proposed decision analysis as one potential means of addressing this. I am not as enthusiastic as they are about for decision analysis, at least as it is normally conceived, as an active process on the part of the GP and or patient, and point to the authors' own data in terms of practical difficulties where they conclude "given the time pressures of primary care consultations, such issues can lead to aspirin not being considered." If GPs cannot
spend the one minute necessary to think and prescribe aspirin in the existing consultation, then it is difficult for me to imagine how they are going to engage the patient in a process of decision analysis during this same period of time. I am more enthusiastic about computerized office systems that contain within them embedded decision support that can both more appropriately recognize eligible patients by capturing some of the individual patient specific circumstances the authors note, and then provide an alert or reminder to the provider.

While I am also sympathetic to the need for more clinical detail to more precisely define patient eligibility for certain process measures such as prescribing aspirin, I am not as negative as the authors about the value of aggregated prescribing data in helping to inform and potentially improve practice. For rare processes, then there is no question the authors are correct. If the GP only has the opportunity a handful of times a year to offer or prescribe a certain drug or therapy, then errors of attribution can be magnified. But for therapies that can be offered many dozens or even hundreds of times per year, then aggregate measures can be useful, unless there are very strong reasons to suspect large differences in case mix between practices or between years in a given practice. Consider the case of two practitioners in the West Midlands. Practitioner A has aggregate level aspirin prescribing data showing a rate of 30% and Practitioner B has a value of 90%. Is it reasonable to expect that case mix differences between these two practitioners could account for this difference? Similarly, consider if Practitioner A had a value of 30% before implementing a computer-assisted decision support system and has a value of 90% after implementation. Would this not be evidence that the computer-assisted decision support system had a beneficial effect on prescribing? I agree that as the difference between comparative values of prescribing get smaller, the need for precision on those estimates gets greater, and greater and greater clinical detail is needed to have more confidence that the observed values represent best clinical practice. But I do not dismiss it as "impossible" for aggregate level data to be useful.

**Competing interests:**

None declared.