What do pharmacists think of peer review of medicine use reviews?

By Geoffrey Harding and Michael Wilcock

Medicine use reviews (MURs) have been offered from community pharmacies for over three years. Available evidence of their clinical and economic impact is insufficiently developed to enable a judgement of their effectiveness. As such, we need to learn more about their impact on patients, how they are being delivered and the challenges they present to pharmacists. There are currently no national systems in place to monitor their quality and the current funding structure provides an incentive for delivering MURs in volume, anecdotally viewed as a means of increasing income.

As professionals, community pharmacists will be familiar with the concept of delivering a quality service. Improving the quality of pharmacy services through continuing professional development (CPD) was one of the elements of a clinical governance strategy recommended by the Royal Pharmaceutical Society and by the Department of Health. Continuing professional development has become a significant issue for pharmacists, including pharmacy. Pharmacists must not only acquire new knowledge and skills, but must also maintain existing competencies to ensure there is no deterioration in their abilities. Issues affecting competency can be particularly problematic since many pharmacists tend to work alone, without benefit of peer support or benchmarking from other pharmacists. It is in this context of CPD and quality improvement that the recent White Paper has indicated government concern to ensure continuous improvements in the service quality of MURs and an effective means of monitoring their delivery and outcomes.

The White Paper suggests peer review audit as one possible approach, although it is rather sparse on the detail of how this proposal will actually operate. For instance, there is no definition of peer review and it is unclear which elements of the MUR service are to be peer reviewed, though views have been expressed elsewhere.

Indeed, in recognition of the lack of support and feedback for the average community pharmacist when actually undertaking MURs, mechanisms for providing peer support and peer review have been discussed as has service evaluation. However, although there has been some research into the pharmacists’ perception of MUR training, attitudes to MUR assessment and barriers and facilitators to MURs, there has been little published work into how pharmacists view CPD and quality improvement around MURs and, in particular, the role and function of peer review.

To explore pharmacists’ views of peer review as a means of MUR quality assurance, we convened a group of pharmacy community pharmacists all of whom had experience of providing MURs. The group was convened as a cost-effective means of allowing us to draw on the multiple beliefs, experiences and perceptions of pharmacists in a forum that allowed for active reflection. We also explored the degree of consensus among the group on the role and function of peer review in regulating MURs.

Method

An invitation was issued to all 88 community pharmacies in Cornwall. The letter explained that we were seeking 12 pharmacists, accredited to conduct MURs, to participate in a focus group meeting that would explore the Government suggestions on the MUR service. In addition, we purposely invited two pharmacists working for the primary care community pharmacists, otherwise there is a risk that peer review will be seen as a negative experience rather than a positive supportive one.

The focus group was convened at a local hotel one evening in June 2008 and lasted approximately two hours. One of us (GH) facilitated the group and used a topic guide derived from a review of the literature. Proceedings were tape-recorded and transcribed for subsequent analysis. The other author (MW) took contemporaneous notes which were used to corroborate the transcripts. Analysis involved indexing the transcript and assigning codes to the issues which were then aggregated to form themes.

Before the start of the meeting, participants were asked to complete a brief questionnaire designed to capture some basic demographic data and to elicit anonymous responses on a five-point Likert scale (“strongly agree” through to “strongly disagree”) to two questions about their MUR service.

Results and discussion

Nine community pharmacists and two PCT pharmacists (four male, seven female) attended the focus group meeting. In general the group was self-selecting. Five were employed for large multiples and three worked for independents. One was a locum and two described themselves as “other”. However, all were experienced at delivering MURs (one had less than six months’ experience, two had six to 12 months’ experience and eight had more than 12 months’ experience). Many had participated in our earlier study.

All 11 indicated that they strongly agreed or agreed with the statement “I feel confident in how I undertake MURs” and 10 indicated that they strongly agreed or agreed with the statement “If peer review was ever to occur, I would be confident that in general my MURs would be viewed as acceptable”. During the focus group three loosely defined themes were identified: defining peer review, political context of peer review, and peer review as professional self-regulation.

Theme 1: Defining peer review

Because we did not start the meeting with an agreed explanation of peer review, initial discussions regarding a definition of peer review were far ranging.

Peer review as a concept was considered initially by the group largely to involve an element of intra-professional performance judgement with greater weighting given to negative or neutral than to positive judgments.

Your work is being assessed or evaluated by other professionals — hopefully within the same field or level of interest. Someone saying to me “that’s complete rubbish in my opinion” was O.K.

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Peer review was regarded not as a learning experience but a form of evaluation — identifying poor or acceptable practice against an acceptable quality standard of practice. A key requisite for this was that the peer reviewer would have to have experience of the specific activities that were being reviewed (in this case conducting MURs).

This notion of the community pharmacist as the reviewer is at odds with moves towards inter-professional collaboration and education in health care as an important area for development. Inter-professional peer review may meet many of the aims of inter-professional education as it can provide a forum for healthcare staff and students to be “engaged in learning with, from, and about each other”.20

The sense of peer review being implemented as a form of performance evaluation was a shared concern. There was some reluctance towards peer review viewed as a form of assessment, especially if used to inform the commissioning or decommissioning of services, and it was especially seen as intimidating if the reviewer was an “outsider.”

Peer review is constructive if you have the criteria of trust, respect etc. in that it’s for you to improve but I can’t see how you can constructively link it in with the power to decommission a service — that’s an inspection point which is a different relation to a peer review point.

Others believed peer review to be unnecessary because their qualification to undertake MURs was itself a quality indicator guarantee:

We’ve already worked hard to get the MUR qualification and we are already qualified to do this so for somebody to come along and assess you ... but I’m quite happy with the way I’m doing MURs anyway ... and I think I’m giving good quality ... we are doing quality ones rather than quantity.

Key to the issue of quality (echoing our findings from a previous study) was the pharmacists’ level of confidence in undertaking MURs — particularly as developing an intimate pharmacist/patient relationship was central to this service.

That’s the main thing — how you communicate with that patient at that time.

We are not used to being in a GP situation.

We haven’t had that training in an intimate one-to-one situation like the GPs and nurses have.

It takes a while to develop your own “bedside manner”... build up your confidence ... you’re learning all the time.

Equally there were concerns and scepticism that any review by experienced peers did not necessarily equate with quality experience. This was particularly the case in regard to MURs.

Problem with peers as mentors is that the ones who have done the most MURs aren’t necessarily the experts (due to corporate pressure). Issues are who are the experts in this field and how did they become experts?

Rather than appealing to a sense of professional experience as a hallmark of the quality of professional service, pharmacists put greater store by personal qualities of peers:

It has to be somebody you respect and trust and can feel totally honest with... you can be honest about your failures.

This theme raises a number of interesting points. Part of the discussion appeared to align peer review more closely with peer evaluation as a form of testing,21 and had a sense of being more applicable to an undergraduate or trainee situation.

The community pharmacists struggled with a clear idea of who could really be their peers. We note that others2 have briefly described the role of PCT pharmacists as mentors to their community colleagues with the aim of improving the confidence of pharmacists to do MURs and also the quality of the service. Unless these PCT pharmacists had experience of undertaking MURs it is likely that our group would have categorised (and possibly rejected) them as “outsiders”.

Theme 2: Peer review as audit

The concept of peer review was also considered in a political context — introduced in order to evaluate pharmacists’ performance:

Peer review is more about the NHS wanting more quantitative service... and it [NHS] doesn’t know how to judge it, it doesn’t know what markers it should be putting on it, doesn’t know how to grasp it.

For pharmacists employed by large multiples and who are expected (often indiscriminately) to undertake a targeted number of MURs there is a clear concern that peer review might be a vehicle for imposing a set standard for undertaking MURs. Concerns expressed centred on the inherent difficulty of defining the hallmark characteristics of a quality MUR.

All agreed that peer review, when undertaken as a form of evaluation, was not appropriate to audit MUR activity because a clear and comprehensive definition of a “quality” MUR had many facets and was best understood as an inordinately complex process.

Its quality could not be judged by predefined outputs — indeed a quality MUR might have no output — for example, a review may conclude there is no action required and that the patient is taking his/her medicines appropriately and effectively. Similarly, auditing the process of delivering an MUR by, for example, checking that certain procedures had been completed, itself does not provide any indication of the quality of the process.

If peer review is top down — checking quality, it’s going to have a totally different feel from peer review with us wanting to share best practice, wanting to share learning points, personal development plans... all the positive things of peer review if its driven by the peers as opposed to being the focus of coming top down with the focus being on quality.

Sometimes you don’t know it’s going to be a quality MUR until you’ve asked some questions.

The NHS demands me to deliver this package of material for this £25 in a professional and proper manner... So it’s actually the process and interaction that is being evaluated rather than the endpoint outcome. One of the main problems we have is that you don’t know whether or not it’s going to be a quality MUR until you start.

It is apparent that pharmacists were at best hesitant to suggest ways MURs could be audited and at worst, somewhat cynical of the NHS as an external agency to the profession in an approach to ensure the quality of MURs.

The NHS will examine the process not the outcome... “have you filled in this section and that section and that section?” and if you haven’t they say you need to look at this because you are not filling in the form.

Defining the quality of an MUR posed a challenge because three equally valid perspectives were prevalent: the pharmacist, the patient and the GP. For example, while a patient might consider an MUR to have been a waste of time in that it did not lead to any recommendations, paradoxically, the pharmacist might consider this a positive outcome and a source of professional satisfaction:

Some patients hate the whole experience... from a clinical point of view or from the point of view of them taking their medication correctly they have learnt something and it has helped them but they absolutely hate it being in a room wasting their time that was their opinion.

Some pharmacists were equally unsure whether “quality” should or should not equate with tangible outputs following the MUR:

In the early days of doing MURs it was almost like a patient review... I suddenly thought if I’m picking up all these things it is a reflection of how poorly I’ve been counselling them.

A quality MUR is one where the patient is taking their medication in the right way at the right time... whether that’s no action or not, but the people who are paying us to do the MURs are going to be looking at the social and economic benefit... so their definition of a quality MUR is one that saves money, improves health — they are the ones by definition where there is to be an action point, but for the endpoint service user that’s probably what there definition of quality is... that’s why quality becomes such a complex issue because you are starting from two different points.
Theme 3: Peer review as shared learning

The idea of peer review as a mutual learning experience rather than a form of evaluation was accepted by the group when considered in the context of professional development:

It would be quite good if we could sit in with other people — that would be good from a learning point of view. Different pharmacists have different areas they specialise in.

However, on reflection the group’s understanding broadened beyond initial concerns that peer review had an evaluative element:

You have continued learning and you have peer review. I think you can learn from your peer review.

Peer review is about improving what you are doing already — how you engage with people.

These sentiments concur with the arguments expressed elsewhere that a formative review undertaken by a colleague can be a powerful method for encouraging lifelong learning. The insights that derive from an honest, confidential discussion of strengths and weaknesses with an informed peer can set an agenda for personal development, can bring about change in professional practice, and have the potential to support the clinical governance agenda. Indeed, on further reflection the group concurred that:

Peer review doesn’t have to be negative — could be someone says that’s a terrific idea I’m going to copy that. Difference between peer and mentor — is mutuality.

In this theme the pharmacists are again revisiting the distinction between the supportive formative review described above, and a review that has aspects of assessment and looks at performance against a range of indicators that may be less about patient care than about cost and conformance. This negative type of appraisal is likely to lead to the pharmacist attempting to comply with the indicators to avoid undesirable outcomes or penalties. It is suggested that such appraisals would not lead to effective learning but ritualistic activity designed to avoid painful effects. One proposed evaluation of the MUR service includes quality of service measures (such as patient feedback analysis, assessment of the quality of GP referrals), process measures (eg, number of MURs completed, number and type of recommendations to patients and to GPs), and value for money measures, and is described as being supportive, rather than as an assessment.

Limitations Our group was composed of self-selected pharmacists, many of whom knew each other, and it is acknowledged that the group process has an impact on the data obtained. With only 11 pharmacists, the data obtained from the group are not necessarily representative of the whole community pharmacy population and will not have captured the wide range of perceptions about peer review of MURs; for instance none of those attending had negative views about MURs. However this was designed as a preliminary exploration to identify important issues arising from the White Paper, and we noticed that, as the meeting progressed, initial discussions became enriched as all participants started to contribute and became more thoughtful and reflective in their responses.

Conclusion

At the heart of pharmacists’ concerns for peer review as a shared learning experience lies a sense that colleagues’ professional status itself is not recognised as a guarantee of competency to undertake MURs.

In relation to medication review, pharmacists may require more individual support and feedback that would enable them to advance to develop their competence. In this context peer mentoring workshops for CPD have been shown to provide one model for skills training for practitioners who, for a variety of reasons, may not have maintained the expected level of competency.

We doubt, however, that our small sample of community pharmacist would accept the suggestion of PCT pharmacists as their mentor.

The inter-personal communication skills necessary to undertake MURs are acquired by experience rather than underpinning professional post-registration training. The practice of exercising professional judgements in undertaking MURs while employed by and subject to subtle (and not so subtle) company policies setting MURs targets does little to foster a shared sense of professional practice. Indeed, the function of undertaking MURs — in addition to promoting benefit to the patient was also considered to benefit the pharmacy economically. According to one participant: “It’s a really good loyalty builder.”

If the White Paper proposal is to be carried forward and peer review is established as a means of improving the quality of the MUR service, it is important that note be taken of concerns and recommendations on the use of peer review in other health professions. For instance, it has been shown that while peer review is frequently used in nursing and midwifery practice, there is a lack of high quality, published evidence upon which to base good practice. Likewise, experience of peer review in the medical profession suggests that clear arrangements on the aims of peer review and on the use of criteria should be made and well designed methods should be used.

References