

“Doctor shoppers”: at risk by any other name

GPs need a means to easily and accurately identify prescription shoppers

THE HEALTH INSURANCE COMMISSION (HIC) defines “doctor shoppers” as people who have 30 or more Medicare consultations a year or see more than 15 different general practitioners to obtain more Pharmaceutical Benefits Scheme (PBS) prescriptions than appear to be clinically necessary. In 1995–96, there were 13 240 Australians who met this definition, and in 1999–2000 this figure had fallen to 8780.¹

Recently, the HIC introduced a new definition of “prescription shopper” as a person who has, in a 3-month period, been supplied prescription drugs by six or more different prescribers, or has been prescribed a total of 25 target pharmaceutical benefits or 50 or more pharmaceutical benefits in total. These broadened criteria have resulted in a new figure of 22 000 prescription shoppers.^{2,3}

The agenda of doctor shoppers is to obtain benzodiazepines and opioid analgesic drugs, either for their own use or to swap or sell. The upper quartile of doctor shoppers work hard at their task, and will have seen up to two different GPs a day for every working day of the year.¹

Doctor shoppers confront GPs with a confusion of our usual roles and trouble us in many ways. They are not like our usual patients and only want drugs, not help.⁴ Their dissembling destroys trust and, when unsuccessful in obtaining prescriptions, they can become aggressive and unsettle regular patients and reception staff. They are also quick to spread the word about any new doctor who has been a “soft touch”.

Although many doctors have ethical and humanitarian concerns for the wellbeing of these patients, most do not want to get involved. Even reputable and dedicated doctors who espouse a philosophy of harm minimisation can face disciplinary proceedings if they are accused of prescribing excessive amounts of drugs of addiction.⁵ Strangely, prescription shopping is not illegal, and doctor shoppers are not subject to the same legal constraints as those who prescribe for them.

For an experienced GP, making a diagnosis of “doctor shopper” can be easier than diagnosing the trickier presentations of cholecystitis. But for less-experienced doctors, used to giving patients the benefit of the doubt, it can be a problem, and requires educational input. Doctor shoppers are of either sex, and most are between 20 and 40 years old. They often present with fairly transparent stories involving severe pain of some description, stress, insomnia, or a request for benzodiazepines to help them withdraw from opiates or alcohol.⁴ They often claim to have recently arrived from interstate and present a letter, which may be forged on a stolen letterhead, attesting to their diagnosis and need for opiates and tranquillisers. They are usually much more medically sophisticated than the average patient and

are quite explicit about the medication they want.⁴ They will tell the GP that tramadol is useless for their pain, which only responds to various derivatives of morphine. Similarly, temazepam tablets do not help them to sleep, but capsules do. Subsequent attempts at getting further prescriptions involve a variety of unlikely stories about the loss of previous prescriptions through various forms of theft, washing machine mishaps, and prescription-devouring dogs.

In this issue of the Journal, Martyres et al (*page 211*) analyse the doctor-shopping behaviour of 202 people aged 15–24 years, who died between 1994 and 1999 after using heroin.⁶ Martyres et al found that the frequency of doctor shopping over a 4-year period increased threefold in the year before death. They see this rapid escalation of doctor shopping as both a cry for help and as an opportunity for GP intervention — even if this is only advice on the options available for help and treatment.⁶

They are also of the view that the government sees doctor shopping (which costs the PBS more than \$30 million a year) as more of an economic than a medical problem. Indeed, the focus of the HIC’s Prescription Shopping Project has a large economic component aimed not only at doctor shoppers, but also at people who hoard drugs or send PBS drugs to relatives in other countries.⁷

Besides its economic cost, doctor shopping is a public health and ethical problem for the medical profession. Most GPs do not write prescriptions for doctor shoppers — half these prescriptions are written by 7.5% of Australian GPs, most of whom practise in one of 10 residential postcode areas.¹ These GPs appear to have an irresponsible, laissez-faire approach to prescribing. The Prescription Shopping Project will provide feedback and educational intervention to excessive prescribers, with the aim of changing their prescribing practices.⁷ The Prescription Shopping Project also gives the HIC “special authority to contact the patient or to give drug information to their doctor without the patient’s consent”.⁷ However, if a young heroin user can see up to 613 GPs in a year,¹ how will the HIC know which of the 613 GPs is that patient’s doctor?

The Prescription Shopping Project legislation empowers the HIC to assist a “prescriber to make decisions about prescribing to the prescription shopper, if that prescription shopper is visiting that prescriber or is a patient of that prescriber”,³ but the immediate need of the busy GP is quick access to information. And the easiest and fastest technology to assist the busy GP is access to a dedicated prescription shoppers’ telephone line.

Until August 2002, a doctor could quickly confirm, to a high level of probability, who was a known doctor shopper by using a dedicated telephone line, “The Doctor Shopping Line”. This was the diagnostic equivalent of the ultrasound

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in confirming the diagnosis of cholecystitis and the number and type of gallstones involved. Indeed, the HIC won a Government Technology Productivity Award for developing the software for generating the required doctor-shopping information within 30 seconds.⁸

Budgetary constraints, fears about privacy provisions, and a re-examination of the secrecy provisions of the *National Health Act 1953* (Cwlth) led to a cancellation of this dedicated telephone line. Its replacement requires patients to sign a voluntary release-of-information form and it takes 7–10 days for the GP to receive the prescription-shopping history. The current system places the legal standing of prescription shoppers above that of the doctors who are trying to deal with them,⁹ and may have placed these individuals' fragile lives at greater risk than is necessary.⁶

If Martyres et al are correct in seeing an escalation in prescription shopping as a cry for help, GPs must have the information on which to act. The success of the federal government's Prescription Shopping Project also depends on GPs accessing quick and accurate prescription-shopping information. The necessary legislation and technology to reactivate the previously effective dedicated doctor-shopping line is already in place.^{3,8} There is no logic in further governmental delay in its reintroduction. Doctors want it

and need it, and will not in the least mind if the new politically correct term is "Prescription Shoppers' Line".

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The science of changing providers' behaviour: the missing link in evidence-based practice

Behavioural sciences can make a substantive contribution

THERE IS CONTINUING EVIDENCE of the failure to translate clinical research findings into existing practice: it is thought that 30%–40% of patients do not receive treatments of proven effectiveness and, more disturbingly, 20%–25% of patients receive care that is not needed or is potentially harmful.^{1,2} However, the mere existence of evidence is not sufficient to ensure the adoption of best practice into routine clinical care.³ It is not surprising, then, that there is a growing interest in making knowledge transfer from research into clinical practice more effective.⁴

Many approaches to changing clinical practice revolve around idiosyncratic beliefs and tradition rather than scientific evidence.⁵ Evidence is needed on which interventions are the most cost-effective for changing clinical practice and healthcare delivery.

A recent systematic review of 235 evaluations of guideline dissemination and implementation strategies concluded that "the majority of interventions observed modest to moderate improvements in care".⁴ However, the quality of reporting of important aspects of the studies reviewed (such as details of the study interventions and contextual factors) was poor, and often the rationale for the choice of intervention was obscure. Further, only 30% of studies provided any economic data. The results of this review should therefore be interpreted cautiously, as the methodological quality of

many of the contributing studies, and of research in this area more generally, is poor.⁴

There is growing interest in developing strategies to encourage the adoption of best evidence into practice, including efforts to change behaviour. The effectiveness of these efforts is likely to depend on a complex interaction between the nature of the clinical activity to be changed and the costs and benefits of adopting the change for the healthcare professionals, patients and organisations involved.

At a recent National Institute of Clinical Studies meeting, involving multidisciplinary experts in the field of promoting the uptake of research evidence,⁶ these issues were discussed. Delegates agreed that behavioural scientists, working within multidisciplinary teams of researchers, are important players in the process of understanding how change in healthcare providers' behaviour may be achieved. Behavioural science refers to a broad range of disciplines, including psychology, sociology, management science and education. This disciplinary group may contribute in several ways to the scientific study of changing healthcare providers' behaviour.

Use of behavioural change theories. Behavioural scientists have developed a number of theoretical frameworks to explain how behavioural change is achieved. These include