Working together: a qualitative study of effective group formation amongst GPs during a cost-driven prescribing initiative

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Background. The need to control escalating NHS prescribing costs has become another, for many, contentious factor for GPs to consider when prescribing. Furthermore, despite not having a history of collaboration, GPs now need to work together within Primary Care Trusts. There is little in the medical literature about the development of GP groups. We present data from an evaluation of a cost-driven GP group prescribing initiative which fitted within Tuckman’s framework of how groups become established, function and bring about changes to produce outcomes.

Objective. Our aim was to gain insight into GPs’ experiences of working together in a group prescribing initiative.

Methods. Qualitative semi-structured interviews were conducted face-to-face with 32 GPs from a commissioning group pilot (nine GP practices) in Southern Derbyshire in 1999. The interviews were transcribed and analysed using thematic analysis.

Results. Initial reactions to the initiative included feeling anxious and imposed upon. However, reservations about divisive effects on practices and individuals behaving defensively proved largely unfounded. Meeting together enabled participants to discover that their similarities outweighed their differences. Prescribing changes did occur, often facilitated by the support of having group policies. However, for many participants, the most valued outcomes were process orientated: increased interaction between practices and a greater sense of group cohesion. These were regarded by some as providing the basis for further change.

Conclusion. The experiences of the GPs reflected Tuckman’s sequential model of group development to a large extent. The ‘storming’ phase was less problematical than anticipated. This model provides a useful framework against which to judge how near a group is to achieving goals.

Keywords. GPs, group process, organizational change, physician’s practice patterns, qualitative research.

Introduction

Prescribing decisions can be influenced by many factors.1,2 Recently, the need to control escalating prescribing costs has become another such factor. However, cost-driven prescribing initiatives can be contentious for GPs who may not agree with pharmacists’ recommendations3 or health authority advisers’ views on prescribing cost issues.4 Furthermore, the changing context of primary care has shifted the emphasis from single-practice attempts to control these costs to group initiatives. However, the culture of general practice has not been one of collaboration between practices.5 In order for a group to function effectively, members need to co-operate and develop cohesiveness.6 However, there is little in the medical literature about how this happens. Various models of group development exist in the organizational literature, a widely used one being Tuckman’s model.7 This proposes four sequential stages in the development of a group: ‘forming’, ‘storming’, ‘norming’ and ‘performing’. ‘Forming’ brings individuals together and orients them to their task; during ‘storming’, disagreements and frustrations arise; in the ‘norming’ stage, there is a
focusing on the task in hand and creating cohesion; leading to the ‘performing’ stage, when the group can work effectively to achieve its aims. This model was expanded to include a fifth, final stage of ‘adjourning’ when the group may disband, either because the task is achieved or because members have left. Not all groups develop through all the stages; some get stuck in the middle and remain inefficient and ineffective. Key aspects of the first four stages are shown in Figure 1.

In 1997, 36 GPs from nine practices in Southern Derbyshire formed a commissioning group pilot. A condition of this was to remain within a prescribing budget; consequently, they undertook an initiative in 1998 which has been described elsewhere, together with its quantitative outcomes. Group members had very diverse prescribing patterns. As some of them had a history of coming together for educational meetings, they decided to use a meetings-based format for their initiative. Six meetings, with a follow-up meeting 6 months later, were facilitated by a health authority (HA) pharmaceutical adviser and the HA medical advisor, a GP member of the group. The average attendance was 19 GPs. The group achieved their aim and had a prescribing underspend for the first time in 5 years with no detriment to quality markers. As part of the wider evaluation, commissioned by the group, a qualitative study was undertaken to determine the GPs’ views and experiences of the initiative. This paper presents those qualitative data which subsequently were re-interpreted within the framework of Tuckman’s model.

Methods
A semi-structured interview schedule was developed by JW, informed by the group’s requirements and a literature review. It included questions relating to expectations and effects of the initiative; useful aspects; obstacles anticipated and encountered; reservations; and suggested improvements. After piloting with a purposive sample representing high and low levels of involvement in the initiative, an amended schedule based on the same themes was used (see Box 1). It is important to note that the interviews were not carried out using the pre-existing theoretical framework of Tuckman.

Introductory letters, including an outline of the interview schedule as well as assurances of confidentiality and anonymity, were sent to 32 of the original 36 GPs; four were unavailable, either having retired or being on maternity leave. JW then telephoned the GPs to arrange individual interviews. These took place in their surgeries, between May and July 1999. The interviews, which lasted between 20 and 70 min for individual GPs, were tape-recorded, with the GP’s permission. The recordings were transcribed verbatim by JW.

Transcripts were analysed to identify the main themes arising from the interviews. Atlas.ti software was used to help organize the data. The content analysis involved
coding all relevant information from each transcript and clustering these codes to identify themes.

Transcripts were reviewed after each interview in order to inform subsequent interviews, with any emerging themes being followed-up in these interviews. Verbatim quotes were used to reflect the GPs’ perspectives and reduce the possibility of researcher bias. Copies of their quotes, in the context of the relevant sections of the analysis, were sent for approval to the GPs concerned. They could ask for deletion or modification of quotes. This served as a check on the accuracy of interpretation and also helped fulfil ethical considerations, ensuring that all GPs were satisfied with the use of their quotes. Only one GP asked for changes to their quotes; these were grammatical. As well as using respondent checking, trustworthiness of the analysis was also enhanced by initially checking each transcript against the original recording and correcting it where necessary.

Thirteen themes were derived from the initial thematic analysis (see Box 2). Since many themes were suggestive of Tuckman’s theoretical framework, the original thematic analysis was revisited, by both authors, after completion of the evaluation, to see to what extent the themes could be incorporated into this model. Negative case analysis was undertaken to enhance the trustworthiness of this analysis, i.e. data which did not appear to fit Tuckman’s framework were deliberately sought and used to produce a more comprehensive analysis.

Results

Twenty-seven GPs (84%) agreed to be interviewed; five declined. Twenty GPs were interviewed individually, two preferred to be seen together and five as a group. One GP chose not to be recorded; notes were taken during this interview. Data from the interviews are outlined below, structured within Tuckman’s framework, illustrated by verbatim quotes (GP identification number in parentheses).

‘Forming’

Individuals had viewed the prospect of meetings very differently. Some had anticipated positive outcomes for patient care:

“I was very enthusiastic … because I felt that it was an opportunity to talk to other people about clinical issues in a constructive way that would hopefully benefit not only my patients but service delivery to the whole area.” (32)

Some had seen it as an opportunity to meet with the other GPs in the group, regardless of the content of the meetings:

“I was quite pleased that we were actually going to have a series of meetings of doctors involved in the primary care group. … it wouldn’t have mattered whether it was prescribing or whether it was some other issue, I was pleased that we were going to have the opportunity to meet together on a regular basis.” (29)

Whereas others had regarded it as an imposition:

“… an inward groan about more meetings … It’s just yet another thing that we’ve got to do and bow down to the powers that be.” (15)

There had been uncertainty as to the content of meetings, which had initially caused some to feel anxious about being scrutinized:

“… I was worried … we were going to be examined …. I don’t think I looked on it as a possible source of information and getting together. I think I was a bit anxious and.. I can remember people in the practice sounding very anxious.” (19)

Those attending meetings were able, by talking together, to find out how others functioned and discover similarities, which some found reassuring, as well as differences:

“I remember them being very useful … to get us all talking together, you know. Just meeting and actually finding that a lot of us had very similar ways of dealing with a lot of things. And it’s quite reassuring in a way.. some people had got radically different prescribing of various things and that was interesting as well. So I think it was as much as anything getting us all together as a team and … seeing how we all functioned.” (35)
‘Storming’
Anticipations of disagreements appeared to have been greater than the reality. Several GPs had anticipated problems on behalf of their peers rather than for themselves, including the potential for confrontation, divisiveness and defensiveness:

“I thought: … they are going to be confrontational … they’re going to create division between practices, you know, people are going to be very defensive.” (7)

or that peers might resent the initiative, perceiving a reduction of GP autonomy:

“… in a way I think people could be scared of it, thinking: ‘We’re going to have dictated to us what we do and I’m a doctor and I shall prescribe what I want thank you very much’.” (9)

One GP had initially disagreed with the perceived cost-cutting aim of the initiative:

“... trying to get us to reduce money and spend less and less on drugs.” (16)

There had been disagreements about some prescribing recommendations. However, because the GPs were not asked directly about conflict during the meetings, it is not possible to say to what extent these disagreements were between GPs rather than between them and the prescribing advisers. Such disagreements centred on recommendations which conflicted with the GPs’ experience or where conflicting evidence was thought to exist:

“… there was an argument about antibiotics in middle ear infections in children…. there is an opinion that you don’t need to use them. Well, my experience is you do need to give them and I think there have been other papers besides the ones that were quoted, I did disagree with that.” (31)

However, it seemed that, on the whole, anticipated difficulties between individuals at meetings had not occurred:

“… expecting ... it could be quite abrasive or, you know, difficult. I think it worked out very well really.” (5)

‘Norming’
Again, it had been anticipated by members of the group that individuals might not develop into a functioning group. One GP had anticipated a lack of consensus and consequent limited achievements:

“I thought that there might not be a consensus across the whole group that would enable us to see real results. I thought it might be tied down to individuals.” (32)

The three GPs who had initially regarded the meetings as an imposition found that attending them was better than expected:

“But I think when I have been to the meetings, it’s been good actually because it’s been nice to see the other GPs and to talk about things.” (16)

Similarly, the initial fears of one GP of being scrutinized proved unfounded:

“(Now) ... I’m not worried about it at all.” (19)

It was thought that the meetings had been led well by the medical and pharmaceutical advisers:

“I think it was handled very well by (the medical adviser) and (the pharmaceutical adviser). the emphasis was on education and discussion of ideas. So I think his approach was good...” (21)

It was also implied that individuals were not allowed to dominate meetings:

“We’re lucky in (the medical adviser) having ... a pretty balanced view. And an ability to take people on.” (33)

By discussing issues together and discovering that their similarities outweighed their differences, their feeling of group cohesion increased:

“... that’s what came out of the group as well ... the areas we agreed on and the areas where we were similar were vastly greater than the areas where we differed and I think that was quite useful. And produced more cohesion in the group.” (14)

However, one person questioned the motives behind the meetings, seeing them as going beyond reaching a consensus into the realms of bringing people into line, which he deemed outside the role of a GP:

“... the meetings seemed to have several purposes. One is to come to a consensus view; but another is a type of disciplining of people and bringing them into line really by peer review... not what I’m here for.” (33)

‘Performing’
The group achieved their objectives in that specific prescribing changes resulted from the initiative:

“I think that I certainly have changed my antibiotic prescribing as a result of the meetings.” (29)

Some participants thought that having a group policy on various aspects of prescribing had been supportive and enabled them to make changes they may not have made otherwise:

“... had it not been for the comfort and security that you feel within the PCG [Primary Care Group]
framework, I might not have done that. Because you know, you get a patient who’ll say: ‘Well, when I was down at the practice down the road, he gave me this.’ … But the advantage of being in a PCG, if you agree a framework, you’ve got your automatic … support.” (21)

Furthermore, making patients aware of group policies was thought to have influenced patient expectations:

“… being able to have a policy from the group with having produced our own leaflet (which) said that we weren’t prescribing antibiotics for minor illnesses has made quite a difference.” (32)

The knowledge that peers were making similar changes also increased some GPs’ confidence in reviewing hospital prescriptions:

“And it’s certainly made me more confident about.. thinking again about what the hospital has sent the patient out on, because I know I’m not the only person that’ll be doing it.” (7)

Not only did individuals discover how others practised, it was considered that they had learned from each other:

“The spin-off from that was that it actually encouraged all the prescribers to sit down together and talk about prescribing issues. And thereby learn from each other and that was its biggest advantage.” (23)

However, because some GPs disagreed with some of the prescribing recommendations, they consequently experienced internal conflict for the following reasons:

“I think the thing that sort of gets me is that there’s this constant pressure to reduce your costs… that’s fine, if you’ve got equivalent medication, but in cases of hypertension, certain of the cheaper drugs are not always the best. And this pressure to prescribe rather than the best.. it causes a conflict in my mind.” (31)

or if patients reported that recommended cheaper therapeutic equivalents were not as effective:

“So probably what the patients were telling us, that it wasn’t as good was probably true. And to be trying to persuade them to stick with it anyway, and all the time we know that the only reason we’ve made the change is because of cost, I feel uncomfortable about that.” (12)

or if they felt they had been coerced into making changes by the group:

“I’m prescribing fewer (particular drug), which I don’t feel very happy about. That’s an area that the primary care group.. have forced me into …” (20)

Not all the GPs made all the recommended changes. Several GPs mentioned specific changes they were reluctant to make, and presumably had not made, for reasons including experience of side effects with a particular class of drug:

“I don’t like using the older antidepressants either, because I’ve seen too many side effects with them.” (9)

the disruption to the patient’s life caused by prescribing generic drugs to be taken several times a day rather than the once with a branded version:

“… sometimes … a generic means they’ve got to take it twice a day or three times a day instead of just once … I would prefer not to make that type of alteration …. For people who are on quite a number of tablets, particularly if they’re all at different times of the day, … their life revolves around… clock-watching … it’s not conducive to a normal existence, is it?” (15)

or a reluctance to prescribe drugs they would not want to take personally:

“On paper people would be entirely justified to say to me: ‘You’re spending far too much on antidepressants;.. you’re going to have to …cut back on that’ and I don’t think I’d be prepared to do that, because.. I don’t want to use medication that I wouldn’t want to take myself.” (9)

or the change conflicting with their clinical judgement of what the patient needed:

“there are times when I say: ‘Well, blow this, this patient needs the more expensive drug and I’ll prescribe it’.” (31)

However, the benefits of the meetings went beyond prescribing issues. Almost half of the GPs thought that the positive benefits from meeting together per se had been the most useful aspect of the whole initiative. Interaction between practices had improved, breaking down traditional boundaries:

“There’s the individual thing, encouraging doctors to talk to doctors, but there’s also the positive benefit of practices talking to practices; instead of historically there was a thing about practices being very competitive.” (21)

Individuals had gained peer support:

“. . . I was getting the peer support . . . outside the practice, that I.. probably felt I wasn’t getting within the practice.” (34)

A feeling of being part of a team working towards common goals had been engendered:

“I just think it’s enjoyable being in a group of doctors all discussing issues and working together towards certain common goals. Well, that seems the main value of the meetings. … you feel you’re
working in a team, all trying to keep to the same standards. It’s these aspects of the meetings which to me have been more important actually than the individual drugs themselves.” (11)

Thus an overarching benefit of the initiative was that the group identity of the GPs was strengthened:

“… the meetings were very useful … as a way of sort of bonding together I think really, as a group.” (35)

‘Adjourning’

There was a general feeling that the meetings should continue rather than disband following completion of the task. Several GPs suggested broadening the scope of the initiative to include either wider prescribing issues or issues beyond prescribing.

However, one person who viewed the outcomes of the initiative solely in terms of financial savings wondered whether the gains justified the effort expended:

“… it’s something that’s a hell of a lot of workload for not much potential gain. Or certainly . . . to some extent.” (18)

Conversely, another thought that if the momentum was not maintained by holding reviews, there was a danger of backsliding:

“… the only thing is that we mustn’t just do it once and then walk away and forget it. Because I think everything will start climbing back again. I think we do have to have an ongoing round of reviews …” (14)

However, there was some concern that the group might become too dogmatic in its recommendations:

“… only if it got to the point where we were told what to do, what to prescribe, what not to prescribe. I mean we get enough guidance from the government.” (35)

Even if there were fewer meetings in the future, it was still thought necessary to discuss contentious issues so that a consensus could be reached:

“But I think one still needs a meeting now and then because there are areas that we’ll disagree with (the medical advisor). And.. those sort of areas are best dealt with in a meeting where other people’s points of view and judgement can be brought into it… So you’ve got a consensus view of the PCG.” (33)

Discussion

The application of the Tuckman model fits largely with the experience of the participants. There was initial uncertainty and feeling others out. However, ‘storming’ was reportedly more anticipated than actually occurring. A stage of ‘norming’ was reached whereby consensus was largely achieved and a sense of cohesion developed. As regards ‘performing’, objective achievements were reported, although not all the GPs were happy with the changes made or implemented all the recommendations. Several individuals felt that they had gained support from the group, which increased their confidence in making certain prescribing changes. Furthermore, many felt that the formation of the group itself was the most significant achievement.

Data from most of the initial themes fitted Tuckman’s model, except for four: ‘implementation strategies’, ‘obstacles encountered’, ‘patient responses’ and ‘suggested improvements’. However, these themes all related to the practicalities of implementing changes rather than the establishment of the group.

The group differed from Tuckman’s model in that several of the GPs in the group already knew each other and were used to meeting together; there was a predetermined leader, who facilitated the sessions; and their overall goal, of remaining within their prescribing budget, was pre-defined and externally imposed. Some of these factors will have accelerated the group development process; however, others may have hampered it, in particular the externally imposed goal. Despite this, the model does seem to provide a useful measure of assessing how near a group of individuals are to becoming a functioning team which can produce outcomes in health care interventions.

One possible weakness of the study, its retrospective nature, raises questions as to the validity, or credibility, of the interview responses. However, it was felt that difficulties in remembering facts would be balanced by the increased reflectiveness such a time gap allows.

The model highlights the many processes a newly developing group must pass through and, therefore, the considerable time needed before producing outcomes, as evaluations of GP commissioning pilots and total purchasing pilots have reported. Underestimating the time needed can lead to an overestimation of what a developing group can achieve.

Given the potential for conflict inherent in such an initiative, the ‘storming’ phase might have been considerable. However, in this initiative, conflicts appeared to be within rather than between individuals. It appeared that meeting together and discovering that their similarities outweighed their differences had reduced conflict. However, as others have found, the GPs were reluctant to make changes which conflicted with clinical experience or which might endanger the doctor–patient relationship. That the group did achieve their aim of controlling their prescribing costs demonstrates that a functioning group will accommodate some diversity of opinion and practice.

Several GPs found having a common policy supportive when making prescribing changes, reflecting assertions that such policies are needed if prescribing costs are to be controlled. There are several reasons
why group decisions facilitate change: they remove resistance, as discrepancies between individuals and the group are resolved; information is shared about barriers and techniques to overcome them; and a link is forged between motivation to change and action. Furthermore, achieving consensus in the light of all the information available, both positive and negative, leads to a more robust agreement and builds team cohesiveness. In addition, shared decision making leads to individuals feeling they have more control over a change. Consequently, group processes are a powerful way to facilitate change.

Individuals reported learning from each other. This is a likely consequence of developing a culture of trust where sharing of information is accepted, and has been highlighted as an important element in implementing clinical governance.

With regard to prescribing, Ashworth et al. suggest that the motivation to change prescribing may be related to a strongly developed collectivist perspective amongst GPs, and that engendering greater commitment to the professional group may be one way of changing their prescribing. However, individuals vary in the extent to which they are group orientated, and engendering a collective approach implies a reduction in individual autonomy. As GPs traditionally have valued their individual autonomy, a shift to group working implies a cultural change for many. However, as shown by this initiative, meeting together for a specific purpose, discussing issues and discovering similarities can help create group cohesion and a functioning group which is then ready for other tasks. Such collaboration both within and between practices and other members of the health community is what is required of successful Primary Care Trusts (PCTs).

Although commissioning pilots no longer exist, these findings will be of general use to all those primary health care workers who are developing learning sets and trying to facilitate change within their practices. They will be of help not only in monitoring the process of the group towards the achievement of objectives, but also in identifying which parts of the process they need to address if progress has been stalled. They will also be of use to PCTs wishing to implement external initiatives and facilitate change amongst practices in their area. When group-based methods such as those described here are used, the stages described should be anticipated and facilitated so that participants can understand the time it takes to make changes and the conflict which is an inevitable part of the process.

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References