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**ORIGINAL ARTICLE**

# The lesser evil? Initiating a benzodiazepine prescription in general practice

## *A qualitative study on GPs' perspectives*

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**Abstract**

*Objective.* Chronic benzodiazepine (BZD) use is widespread and linked with adverse effects. There is consensus concerning the importance of initiating BZD as a crucial moment. Nevertheless specific research in this field is lacking. This paper addresses the views of GPs on why they start prescribing BZDs to first-time users. *Design.* Qualitative study with five focus groups analysed using a systematic content analysis. *Setting.* Regions of Ghent and Brussels in Belgium. *Subjects.* A total of 35 general practitioners. *Main outcome measure.* The GPs' perspective on their initiating of BZD prescribing. *Results.* GPs reported that they are cautious in initiating BZD usage. At the same time, GPs feel overwhelmed by the psychosocial problems of their patients. They show empathy by prescribing. They feel in certain situations there are no other solutions and they experience BZDs as the lesser evil. They admit to resorting to BZDs because of time restraint and lack of alternatives. GPs do not perceive the addictive nature of BZD consumption as a problem with first-time users. GPs do not specifically mention patients' demand as an element for starting. *Conclusion.* The main concern of GPs is to help the patient. GPs should be aware of the addictive nature of BZD even in low doses and a non-pharmacological approach should be seen as the best first approach. If GPs decide to prescribe a BZD they should make plain to the patient that the medication is only a "temporary" solution with clear agreements with regard to medication withdrawal.

**Key Words:** *Benzodiazepine, family practice, general practitioner, prescribing behaviour, qualitative research*

## Introduction

During the 1960s and '70s, people felt that taking medication was a safe and justifiable way of coping with the stresses and strains of everyday life. It was in this sphere of "pharmacological enthusiasm" that the prescription of benzodiazepines (BZD) grew dramatically [1]. BZDs comprise one of the most commonly taken psychotropic drugs, [2] even though GPs regard prescribing of BZDs as one of the most demanding and uncomfortable tasks in their clinical work because of the restrictive attitudes of both society and health authorities [3].

Prolonged use of BZDs is a widespread phenomenon in medical practice [4]. There are the potential

Chronic benzodiazepine (BZD) use is a widespread phenomenon. To prevent long-term use, it is important to explore GPs' attitudes and beliefs concerning initiation of BZDs.

- GPs feel overwhelmed by psychosocial problems of patients and show empathy by prescribing
- GPs use certain strategies to support the reasons behind initiating and on the whole they find BZDs to be "*the lesser evil*".

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side effects of hypnotic drugs, evidence of long-term use contrary to licensed indications, and a lack of evidence distinguishing short-acting BZDs (alprazolam, lorazepam, lormetazepam, temazepam) and newer hypnotics, the so called Z-drugs (zaleplon, zolpidem, and zopiclone) [5–6]. Among the risks of inappropriate BZD prescription are the development of physical and psychological dependence, withdrawal symptoms when discontinuing the treatment [7–8] and particularly in the elderly cognitive impairment, falls, and consecutive hip fractures [9–11]. In a study by De las Cuevas et al., dependence was identified in 47% of those on BZD therapy for more than one month [12].

The best way to avoid dependence is by careful prescription and, where possible, by avoiding initial prescription and using non-pharmacological treatment strategies. It is therefore important to explore the reason why GPs prescribe a BZD to a patient for the very first time. To the best of our knowledge so far, there are no studies that look specifically at the views and motives of GPs concerning the initiation of BZDs, as most research articles talk about BZD prescribing behaviour in general [3,13–16] or about chronic usage [17–20].

This study aimed at describing GPs' views surrounding the reason for initiation of BZD treatment and their perceptions of non-medical alternatives.

## Material and methods

We used a phenomenological qualitative approach as we were concerned with experiences and views of individuals [21]. Focus groups were chosen, taking into consideration that, first, "reasoning" is affected and influenced by group norms and, second, focus groups offer an effective method of data collection [22–23].

### *Sampling and data collection*

The aim was to obtain a sample of GPs which varied in terms of practice setting (city/rural). We contacted GP quality circles from four different regions by letter. Thirty-five out of 58 GPs agreed to participate in the study. The GPs willing to participate constituted five focus groups with a wide range of experience and knowledge. Each group comprised between six and eight GPs. To facilitate the interviews and to ensure that the same issues were discussed in all of them, an interview guide with open-ended questions was compiled and piloted. An experienced moderator facilitated the group discussion by asking clarifying questions and each group session lasted approximately 1.5 to 2 hours. The discussion began by asking GPs about their general experience with BZDs and moved on to how they felt about initiating BZD treatment. During the interviews, one member of the research team was present to observe the proceedings. The researcher who was present debriefed with the moderator and reviewed field notes after each session.

### *Data analysis*

All five focus-group discussions were audiotaped and transcribed verbatim. Data management was undertaken manually. Systematic content analysis [24] was performed by three interdisciplinary researchers (psychologist, sociologist, and GP) in the interests of reliability and reflexivity and to set aside any preconceptions [25]. Emerging themes were developed by repeated study of the transcripts and the attribution of codes to text segments. Rather than impose a framework a priori, this was allowed to evolve from the data. It was then gradually refined by grouping related categories [26] and analysing relationships between sub-themes in order to produce a descriptive phenomenological set of results [27–28]. Attention has been given to deviant case analysis [29].

### *Findings*

The GPs' views were grouped into four themes: GPs perceived BZDs as the lesser evil, as a method of consolidating the doctor–patient relationship in "difficult times", as a way to deal with their feelings of helplessness and uncertainty, and because there are limits to alternatives for BZD medication.

### *BZD as the lesser evil*

GPs mentioned that they were cautious when initiating a BZD prescription, especially when providing new prescriptions. Patients were informed that they would only receive their prescription on a short-term basis:

> *We do not prescribe BZD any more for people who have constant anxieties. We prescribe BZD in acute situations and always within a time limit. (N467)*

GPs initiate BZD treatment if they felt that the patient need it in order to function properly in his/her social or professional life, to get some rest from his/her problems, or to reduce the burden of suffering. Moderate use of BZD should be put into perspective, as there are some real advantages for the patient:

*If you can take the pressure away and give the patient some rest, then at least after some time they will have the energy to tackle their problem, otherwise they will never get out of it. (A245)*

*If it is a really intense problem, then I will easily prescribe a BZD. (A233)*

GPs stated that dependence was not really a problem for first-time users. BZDs were seen as an efficient, cheap, and easy option that does not have too many side-effects:

*People do not die from benzos. (R102)*

They pass on the responsibility of dependence to the patient or to a specialist.

*1: We have problems of dependence. 2: But I think that has more to do with the character of the person. 3: Yes, I agree, someone can have an addictive nature. 4: I disagree, benzos do give problems of dependence. 2: OK, those who take them in big amounts and on a regular basis, but those are induced by a psychiatrist. (N321)*

A doctor's own personal experience of BZDs has an influence on prescribing behaviour:

*Your own attitude towards and experience of the product definitely has an effect on prescribing. We, ourselves, take a lot of benzodiazepines. (Followed by general agreement in the group) (R445)*

*Consolidating the doctor–patient relationship in "difficult times"*

GPs find it difficult to say "no" to well-known patients. They empathize with the suffering of their individual patients and empathy is shown by giving a prescription. Sometimes GPs have to negotiate with the patient as well, to try and find a solution that suits both doctor and patient and sometimes this can result in conflicting views:

*The patient says: I do not want to become dependent for the rest of my life. But sometimes, you just have to prescribe a benzo to stabilize the patient. So we cannot just say we won't prescribe benzos anymore. (N322)*

Patients are often very satisfied if the GP prescribes a BZD for them and they show their happiness towards their doctor which makes the doctor feel as if he/she has done something useful:

*If you do prescribe them a BZD, they are very grateful. They come back to you and they are so happy because they have finally managed to sleep. That is so important, it makes you feel good. (S295)*

*Feelings of helplessness and uncertainty*

GPs have difficulties with establishing boundaries on how far they can question their patients about their problems. GPs find it easier to try and solve the problem by initiating a BZD prescription. GPs also feel uncertain how to deal with psychosocial problems, as a result of insufficient training:

*I have to do a lot of "psycho". Whether I want it or not but I haven't got the training for it. What do I do? I prescribe. . . . (S348)*

A complex psychosocial situation is often the cause of the distress and the GP feels powerless in such situations. But the resolution of these problems does not always belong within the medical sphere; nevertheless, GPs look for a medical solution and they find BZDs to be the "lesser evil":

*You have to think that if you were in their situation you would not know what to do either. In this situation this person needs a BZD to give him some support for the things that are unbearable. (S1066)*

*Limits to alternatives*

GPs expressed the view that there was an inverse relationship between time spent on consultation and the prescription of BZDs. The absence of remuneration for time spent on counselling is perceived as an obstacle in a "fee for service" system. Prescribing BZDs was considered to take less time than convincing the patient of a non-pharmacological approach or actively providing counselling during the consultation.

*I do try and talk to my patients, but it takes time. It is so much easier just to prescribe than to listen and talk to them for three-quarters of an hour. (A264)*

It was perceived that there is limited access to psychological services in primary care. Hence the GPs felt there was often no alternative regarding treatment but to prescribe a BZD:

*There just isn't an alternative. And yes, I do admit we do prescribe too quickly. (G253)*

They stated that some patients just want a medical solution or are "unwilling" to actively engage in the treatment.

Treatment options were thought to be influenced by socioeconomic status, gender, and age:

*We do not suggest counselling to the elderly. They don't know any psychologists and they have never been to one. (N166)*

Non-pharmacological alternatives were also viewed as much more expensive and less accessible for patients with limited financial resources. The perception of the GP towards non-pharmacological alternatives plays a role in whether or not to refer a patient:

*I also have the feeling that a psychotherapist is a bit like a tape recorder. He/she says to the patient "tell me your story" but in the end he doesn't do anything with it. (A316)*

GPs looked mainly for alternatives within their medical sphere. A wide range of medication such as antidepressants or neuroleptics was seen as an alternative. Other GPs were more inclined to use plant extracts because of a lower risk of dependence but at the same time they acknowledged a placebo effect:

*Sometimes we give patients a phytotherapeutic agent. We give it because it looks like a pill. So if it works for them, so much the better. . . . (S82)*

## Discussion

We found that GPs feel overwhelmed by the psychosocial problems of their patients and show empathy by prescribing. GPs use certain strategies to support the reasons behind initiating BZD treatment and on the whole GPs find BZDs to be "the lesser evil". The fact that patient demand was not an element that was mentioned for initiating prescription was striking; this is in contrast with studies on chronic use [30].

BZDs are judged to be effective and beneficial by both patient and GPs without causing too many side effects. Similar findings were found in a recent British study [31]. These beliefs are based on personal experience and are not concordant with studies which have shown that BZDs have many side effects and tolerance appears very rapidly [7–11]. GPs are aware of the potential addictive nature. They do not, however, perceive it as a problem when initiating treatment using therapeutic doses. These findings agree with a study by Boixet et al. who have shown that GPs believed that the use of BZDs in therapeutic doses was not associated with risk of dependence [13]. Problems with BZD initiation also depend on package size, explanation given, and follow-up consultation. However, we have shown in a previous study that little or no information is given to patients when initiating treatment [32].

GPs do realize that it is not the ideal solution to the problem and BZDs are often used as a "quick fix solution", but they cannot think of an immediate alternative. Research has shown that non-pharmacological alternatives are not routinely offered to patients [33], although such an approach has been demonstrated to be effective [33], thus the decision to prescribe medication is seen as the most effective way to help a patient [14]. Our findings could be context specific for a fee-for-service system. However, observations in other healthcare systems are similar: GPs prescribe BZDs too often [31].

Our findings might also reflect the fact that doctors perceive themselves as individual players in primary healthcare and find it difficult to overcome certain barriers to involve social workers or psychotherapists. Studies have shown that GPs have an extremely low rate of referral to these programmes [34] perhaps because they are not familiar with such resources and anticipate the reaction of patients. GPs should try to find out what the patient's attitude is with regard to counselling instead of using medication. With some training, certain aspects of cognitive behaviour therapy can be transferred to the GP consultation [35]. Yet more complex psychosocial problems will still need referral.

The GPs' sense of helplessness, feelings of powerlessness, frustration, and their strong willingness to help the patients may trigger a BZD prescription. GPs do sympathize with the patient but they respond with a pharmacological answer to existential problems. Empathy is shown with a prescription. For the doctor, the act of prescribing may also help to maintain a sense of accomplishment [36]. BZDs provide the doctor with an opportunity to "do something" and to prescribe a "rational treatment" for non-specific psychosocial problems in a manner that complies with the expectations associated with the role of a doctor [36]. If patients present psychosocial symptoms, which are difficult to define, GPs may feel the need to prescribe simply in order to reduce their feelings of inadequacy in managing health problems in the community. In the literature this has been called a "symptom management approach"; the GP prescribes psychotropic drugs on the basis of patients' emotional and social symptoms without making a diagnosis [34]. The use of BZDs could thus be seen as a coping strategy by the GP. The role of crisis is reported to push GPs towards medicalization of the problem [37].

In contrast to studies on chronic usage, which have shown that patient demand was perceived to be a strong influencing factor for prescribing [16,38], GPs did not mention this as an element to initiate

BZD treatment. The patient's demand might be a typical element of chronic usage due to the addictive nature of the drug once it has been introduced to the patient. This is an extra argument to be cautious in initiating BZDs.

In conclusion, this study gives insight into the GPs' viewpoint leading to their decision to prescribe BZDs to patients for the first time. GPs' main concern is to help the patient. GPs should be aware of the addictive nature of BZDs even in low doses and a non-pharmacological approach should be seen as the best first approach. If GPs decide to prescribe a BZD, they should make it clear to the patient that the medication is only a "temporary" solution with clear agreements with regard to medication withdrawal.

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## References

[1] Pelligrino ED. Prescribing and drug ingestion: Symbols and substances. Drug Intell Clin Pharm 1976;10:624–30.

[2] Belgische Gezondheidsenquete 2004 [Belgian national health questionnaire]. Available at: http://www.iph.fgov.be/epidemio/epinl/index4.htm

[3] Dybwad TB, et al. Why are some doctors high prescribers of benzodiazepines and minor opiates? A qualitative study of GPs in Norway. Fam Pract 1997;14:361–8.

[4] Van Hulten R, Bakker BA, Lodder CA, Teeuw KB, Bakker A, Leufkens GH. The impact of attitudes and beliefs on length of benzodiazepine use: A study amongst inexperienced and experienced benzodiazepine users. Soc Sci Med 2003;56:1345–54.

[5] Dundar Y, Dodd S, Strobl J, et al. Comparative efficacy of newer hypnotic drugs for the short term management of insomnia: A systematic review and meta-analysis. Hum Psychopharmacol 2004;19:305–22.

[6] Dundar Y, Boland A, Strobl J, et al. Fewer hypnotic drugs for the short-term management of insomnia: A systematic review and economic evaluation. Health Technol Assess 2004;8:1–125.

[7] Tinetti ME, Speechly M, Ginter SF. Risk factors for falls among elderly persons living in the community. N Engl J Med 1988;319:1701–7.

[8] Ray WA, Griffin MR, Downey W. Benzodiazepines of long and short elimination half-life and the risk of hip fracture. JAMA 1989;46:71–6.

[9] Reinken J, Sparrow M, Campbell AJ. The giving and taking of psychotropic drugs in New Zealand. NZ Med J 1982;95:489–92.

[10] McIsaac W, Naylor CD, Anderson GM, O'Brien BJ. Reflections on a month in the life of the Ontario Drug Benefit Plan. CMAJ 1994;150:473–7.

[11] Greenblatt DJ, Shader RI, Abernethy DR. Drug therapy: Current status of benzodiazepines. N Engl J Med 1983;309:354–416.

[12] De las Cuevas C, Sanz E, De la Fuente J. Benzodiazepines: More behavioural addiction than dependence. Psychopharmacology 2003;167:297–303.

[13] Boixet M. Benzodiazepines in primary health care: A survey of general practitioners' prescribing patterns. Addiction 1996;91:549–56.

[14] Damestoy N. Prescribing psychotropic medication for elderly patients: Some physicians' perspectives. CMAJ 1999;161:143–5.

[15] Bendtsen P. Prescribing benzodiazepines – a critical incident study of a physician dilemma. Soc Sci Med 1999;459–67.

[16] Bjorner T, Laerum E. Factors associated with high prescribing of benzodiazepines and minor opiates. Scand J Prim Health Care 2003;21:115–20.

[17] Taylor D. Current usage of benzodiazepines in Britain. In: Freeman H, Rue Y, editors. Benzodiazepines in current clinical practice. London: Royal Society of Medicine Services; 1987. p. 13–17.

[18] Baker RH, Tait C, Fraser RC. Use of benzodiazepines. BMJ 1994;309:412.

[19] Hamilton IJ, Reay LM, Sullivan FM. A survey of general practitioners' attitude to benzodiazepine overprescribing. Health Bull (Edinb) 1990;48:299–303.

[20] Iliffe S, Curran HV, Collins R, et al. Attitudes to long-term use of benzodiazepine hypnotics by older people in general practice: Findings from interviews with service users and providers. Aging Ment Health 2004;8:242–8.

[21] Beck GT. Phenomenology: Its use in nursing research. Int J Nurs Stud 1994;31:499–510.

[22] Morgan DL. Designing focus group research. In: Stewart M, Tudiver F, Bass M, et al., editors. Tools for primary care research. Thousand Oaks, CA: Sage Publications; 1992.

[23] Stewart DW, Shamdasani PN. Focus groups: Theory and practice. London: Sage Publications; 1990.

[24] Pope C, Mays N. Reaching the parts other methods cannot reach: An introduction to qualitative methods in health and health service research. BMJ 1995;311:42–5.

[25] Malterud K. Qualitative research: Atandards, challenges, and guidelines. Lancet 2001;358:483–8.

[26] Pope C, Ziebland S, Mays N. Qualitative research in health care: Analysing qualitative data. BMJ 2000;320:114–6.

[27] Mays N, Pope C. Qualitative research in health care. London: BMJ Publishing; 1996.

[28] Miles MB, Huerman AM. Qualitative data analysis. London: Sage Publications; 1994.

[29] Kitzinger J. Qualitative research: Introducing focus groups. BMJ 1995;311:299–302.

[30] Mant A, Mattick R, de Burgh S, Donnelly N, Hall W. Benzodiazepine prescribing in general practice: Dispelling some myths. Fam Pract 1996;12:37–43.

[31] Siriwardena AN, Qureshi Z, Gibson S, Collier S, Latham M. GPs' attitudes to benzodiazepine and Z-drug prescribing. Br J Gen Pract 2006;56:964–7.

[32] Anthierens S, Habraken H, Petrovic M, Deveugele M, De Maeseneer J, Christiaens T. First benzodiazepine prescriptions: Qualitative study of patients' perspectives. CFP 2007;53:1200:e.1–5.

[33] Dollman WB, LeBlanc VT, Roughead EE. Managing insomnia in the elderly – what prevents us using non-drug options? J Clin Pharm Therapeut 2003;28:485–91.

[34] Craven MA, Allen CJ, Kates N. Community resources for psychiatric and psychosocial problems: Family physicians' referral patterns in urban Ontario. CFP 1995;41: 1325–35.

[35] Morin CM. Measuring outcomes in randomised clinical trials of insomnia treatments. Sleep Med Rev 2003;7: 263–79.

[36] Rayenes N. Factors affecting the prescribing of psychotropic drugs in general practice consultations. Psychol Med 1979;9: 671–9.

[37] Hislop J, Arber S. Understanding women's sleep management: Beyond medicalisation and healthisation. Sociol Health Illness 2003;25:815–37.

[38] Bradley CP. Factors which influence the decision whether or not to prescribe: The dilemma facing general practitioners. Br J Gen Pract 1992;42:454–8.