Anna: *You're listening to Changing Minds: Transformative Talks for Healthcare Improvement. Grab a coffee or tea and join our team as we chat with leaders in the academic detailing space. For more information on academic detailing, visit us at narcad.org.*

Anna: Hello and welcome back to *Changing Minds*. I'm your host, Anna Morgan-Barsamian, and I am joined today by Deborah Rowett. She is an advanced practice pharmacist and has led an academic detailing team in Australia for over 20 years. She's an experienced detailer with expertise in designing, developing, training, implementing, and evaluating academic detailing programs. We're so happy to have you on the podcast today, Deb. How are you doing?

Deb: I'm doing very well. Thank you very much, Anna, and very pleased to be part of the NARCAD podcast series.

Anna: Yeah, thanks, Deb. Can you share the origins of the academic detailing program in Australia and the primary goals of the program?

Deb: Well, thank you very much for that question. Yes, academic detailing started in Australia more than 30 years ago. It's important, I think, to look back at the policy environment and also our focus at that time around medicines, trying to optimize the outcomes from medicines and really to minimize the harms. There was a lot of increasing awareness of some of the harms related to medicines. I just wanted to share with you, at that time, we did have a review that was undertaken to try and better understand what might be required to support not only general practitioners, but hospital doctors, doctors in training, pharmacists, nurses.

At that time, the landscape resulted in a publication that was called Issues in Pharmaceutical Drug Use in Australia and that was published in June 1992. At that time, the proposal in that document was that a national pharmaceutical drug education program be established with the following functions that included to evaluate different methods of cost effectively providing drug education services, including the use of academic detailers and the use of community pharmacists within local and institutional networks. It was emphasized in this document and in the recommendation that a variety of approaches would need to be used according to the setting, such as, as I said, for community doctors and hospitals. And the educational messages and campaigns be about maybe specific classes of medicines.

At that time, it was benzodiazepines, but also they recognized large-scale campaigns about more general prescribing in older people. And so the proposal was to develop education programs directed at improving communication between health professionals about drug use issues, and also to improving communication between health professionals and patients. So it had that focus around improving interprofessional communication between health professionals, but also a central tenant was how we can improve our communication with patients and consumers.

This resulted from, in Australia, the development of our national medicines policy, of which quality use of medicines was a focus of that work. So, it was really interesting that back in 1992, there was that recognition that academic detailing be part of this national approach to enhancing quality use of medicines.

That was at the national program and the Drug and Therapeutics Information Service, DATIS, which is what we'll be talking a little bit about today, had started in 1991, because we'd read the papers of Professor Jerry Avorn at that time, and we were really keen to implement this technique of academic detailing in Australia. So this, I think, was part of the beginning of academic detailing in Australia.

Anna: What an interesting start to your program! What are the core areas of focus for your detailing efforts? Are there specific therapeutic areas that are prioritized?

Deb: Well, it's a really great question. And as you know, building on from this policy development and funding, well, DATIS started in 1991 through this initiative that was funded through our federal government, our Commonwealth government, was that the National Prescribing Service was then developed in 1998 and commenced operating in 1999 with their first of their programs.

So across this time, what I might focus on is then the Drug and Therapeutics Information Service. And our programs have been really those programs where there's been either a really clear change in practice, new therapies, maybe using older therapies for new indications, where there's a recognized harm, where, again, supporting general practitioners with new guidelines, new guidance. So there've been areas that you might expect, so management of heart failure, medicines in older people.

At the time when there was the new funding for some of our mental health programs, there's been a focus on mental health. And so really, it's been across the therapeutic areas, but also programs on multimorbidity, recognizing the challenges that general practice face with increasing multimorbidity as well.

Anna: I'm curious to hear about some of your team's successes with these topics. Could you discuss some of the key successes or outcomes the program has achieved over the years?

Deb: Yeah, thanks very much, Anna. So when we first started, one of the key areas that we focused on at the first program was around non-steroidal anti-inflammatory drugs. And at the time it was early 1990s, there was many more non-steroidals coming onto the market, and there was that increasing recognition of some of the potential harms in at-risk patients. And that included increasing risk for peptic ulcer bleeds, but also hypertension, renal function problems as well.

So that program was our first program, and we were able to demonstrate, because of the methodology that we had used, where we tried to see all doctors within a defined geographic region surrounding our teaching hospital. And so in that very first program, we were able to reach more than 85% of the doctors in that defined geographic region, and they include both general practitioners and medical specialists.

And using a pharmaco-epi approach, we were able to review the admissions to hospital for people who lived in those areas where those practices were, and to see a decrease in the hospitalizations for peptic ulcer bleeds. Now, it wasn't about attributing causality, but it certainly was one of the first programs where we were really looking not only at drug utilization changes, but at presentations to hospital. And from there, we've been able to, I think, build on that success, and at a national level, where the National Prescribing Service was able to implement programs at a national level, they have published some of those outcomes.

But at a local level, Anna, one of the really key things for me has been the ongoing, continuous provision of service to those general practitioners for now approaching 30 years. And I think it's that trust that has been built up, and that ongoing support for those doctors has led to us being able to provide a continuous service now for 30 years.

Anna: That's incredible. And while we're talking about successes, it makes me think about the challenges as well, right? So what are some of the challenges you've encountered in implementing academic detailing in Australia, particularly in rural or remote areas of the country?

Deb: Again, thank you for that question, because regional and rural is a very big part of our service. So in South Australia, we would see about 30% of our doctors overall within regional South Australia. And when I say 30, that accounts for about the number of GPs that we would see in regional.

But when we look at regional, we are approaching probably about 40, I suppose, about 90% of all general practices in regional South Australia, we would be able to visit. Now, there's distance, there's that journey of distance. It might be, you know, 800 or 900 kilometers, but certainly it's very much appreciated when we actually visit them in person.

And we've built those trusted relationships across many years by continuing to visit them in person. Clearly, when we've experienced the COVID pandemic and the rapid translation and needing to be able to provide successful educational visiting online and virtual visiting, and we've still maintained that with our regional doctors as well. We do go in person and we're currently visiting in person at the moment at our program.

And that's been very much appreciated by those regional doctors. As you probably be aware, there's a lot of change in the practices and doctors leave those practices. But I think overall, a blended model of visiting in person, as well as virtual visiting has enabled us to continue to provide services to those regions.

And they have different needs to our metropolitan doctors, because many of those doctors are not only providing those services to general practice, but they then are also the doctors in the regional hospitals. So they, when we might be doing a program on stroke, for example, or myocardial infarction or acute coronary syndromes, they will be managing them in the hospital environment, as well as continuing that care in general practice. So we do need to tailor our programs for general practitioners in the regional areas, given the differences in the practice setting.

Anna: It sounds like your team has done a lot of work to overcome challenges, especially by using in-person visits and tailoring your approach to the different environments that clinicians are working in.

I want to talk a little more about the population in Australia. How do you address the diverse cultural needs of the Australian population, particularly Indigenous communities in your detailing work?

Deb: Yeah, it's certainly, we do have a very multicultural society in Australia. And also, importantly, we are working with our Indigenous communities and our Indigenous health professionals. And it's really important in Australia now, we would, in any of the meetings that we would be undertaking in wherever we are practicing, we would be focused on acknowledging the country on which we are either coming to provide our services or where we are currently working. So it would be really important to acknowledge the traditional custodians of the lands on which we meet, work and play, and respect their contribution to, and their ways of knowing, being and learning.

So, but also the cultural diversity is really important in other ways, and learning from those people that, you know, from different backgrounds. And also with many of our doctors and pharmacists and nurses, also coming from a multicultural background, it's really important to get their input and expertise as we develop programs. So it's really, I think, over the 30 years, you asked me at the beginning, some of the things that have changed, but I think really co-designing and co-creating is really a focus of the work we do now.

Rather than consultation at the end of the process, we're engaging with our colleagues from a multi-professional and culturally diverse background from the beginning.

Anna: I love this idea of co-designing and co-creating materials and campaigns in all your detailing work. That's really something we've been teaching folks to do and think about as they're working on new AD projects.

I want to take a step back for a moment and talk about where you see the field of AD going. So how do you see academic detailing evolving in Australia over the next five to 10 years?

Deb: I think one of the things that has really changed across that 30 years that we've been involved is been the, I think that the changes both at a societal level, but also with our understanding of implementation science and how to better support our health professionals. I think there's greater recognition at a policy and funding level.

But I also think that one of the things that we really need to focus on in the next five to 10 years is how critical the underpinning central tenant to me for academic detailing is about building relationships, building respectful relationships. I think despite our rapid shift to online, virtual, a lot more of the continuing professional development being done at a clinician's own pace webinars. And these are important aspects of the building on schools, developing our health professionals of the future.

But I think also the ways in which we build communities of practice and better understand how this learning of academic detailing is very much based on that professional respect and wanting to be of service to others and that we can build this at a local level and also at a national level. So I think that local level of building relationships is going to continue to be important. Despite these other changes, I do think that academic detailing and building trusted professional relationships is still a really important key going forward for the next five years, but embracing some of the technology changes that can support that, but not lose sight of the importance of that, of the trusted professional relationships that develop through this approach of academic detailing.

We want to be of service to the doctors that we visit, and we want to bring something of value to them. So we still really approach everything we do as trying to turn facts into value. And in the next five years, 10 years, there's going to be facts and information everywhere.

And AI generated, chat GPT, all of these changes that we are facing, we will still need the technique of academic detailing to synthesize all of that information into something that is accessible for clinicians to use and other members of the healthcare team to use for individual patients. Because all of that information has to be synthesized into something of value that can be used for an individual patient and personalized for that patient. So it's the personalizing of the information that I think will still be highly valued over these next five to 10 years.

And we will need to learn ourselves about our technique that we're using. And this is something that I've been very interested in doing is better understanding some of the underpinning theory and principles of academic detailing as we move forward.

Anna: Beautifully said. We always say that the core of AD is building relationships, despite, as you mentioned, AI or new technology. So I appreciate you sharing that. And I really do see the benefit of AD, even as we get more into AI because as you said, it personalizes the experience, one for the clinician, and also then for the patient in the long run.

I want to wrap up with another question here. What advice would you give to other countries or regions looking to establish or expand their own AD programs?

Deb: Yeah. Thank you. I think many countries are now developing their own academic detailing programs. And one of the things I think is really important is what we've just discussed.

And that is that we continue to see that we need to co-create, co-design, and work with our general practitioners, our medical and surgical colleagues, our nurse practitioners, nurses, pharmacists, recognizing that the team, the healthcare team is expanding and that team-based care is increasing. And there needs to be good interprofessional communication and practice, by respecting all members of the team. And that for different programs, there might be different members of the team that we will be wanting to aim our academic detailing, work with, not aim, but work with those members of the healthcare team to develop the program.

So I do think that as we move forward and other countries develop these programs, is that we need to have a service philosophy that the most successful academic detailing programs are ones where you recognize and value the contribution of those members of the healthcare team. And how can we enhance the outcomes rather than focusing always on where there might be the gaps, those gaps might need to be addressed, but also reinforcing what's being done well. And where are the positive changes that are being made? One of the things that we have done in DATIS over all of these years has been really how we can support the clinicians and the people that we serve in between the visits.

So we've had the ability to answer clinical questions or making sure that we had a way to follow up in between the visits. So again, really contributing to that service philosophy. So I think that as they move forward, it's working with the whole healthcare team, involving them from the beginning and developing an understanding of what this technique of academic detailing is really about, really understanding that.

And this is one of the areas that I'm working on using a philosophy of science, trying to better understand why academic detailing works, how it works, when it works, if you like, what the ingredients are for successful academic detailing in this new healthcare landscape. Because we are, I think in our fourth industrial revolution, some people have described it as that. And the thing about this, I suppose, industrial revolution that we're in now is the rate of change.

I think it's unprecedented. And I suppose our health systems and society more generally is evolving in an exponential rather than at a linear pace. And so being mindful that we have to be able to be responsive to that rapid change and develop our academic detailing programs in a way that are timely and meet current needs.

Anna: I'm hearing you speak about personalization, the relationship. You're talking about a service that you're providing to clinicians. These are all pieces of a successful AD program and an AD project and are really the core pieces moving forward in terms of where AD is headed.

I really appreciate you taking the time to be with us today, Deb. The way you broke down your AD service was incredibly helpful, and I'm sure our listeners will walk away with a lot to think about.

And to our listeners, thank you for tuning in. We appreciate your support. If you enjoyed today's episode, don't forget to subscribe and share it with someone who might find it helpful. Thanks again, Deb.

Deb: Have a great day. Thank you, Anna, very much.