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Original article

The use of clinical practice guidelines in primary care: professional mindlines and control mechanisms

Joan Gené-Badia[a,b], Pedro Gallo[c,*], Jordi Caïs[c], Emília Sánchez[d], Carme Carrion[e,f], Liliana Arroyo[c], Marta Aymerich[e,g]

[a] Department of Public Health, University of Barcelona, Barcelona, Spain
[b] CAPSE - Catalan Institute of Health, Barcelona, Spain
[c] Department of Sociology and Organizational Analysis, University of Barcelona, Barcelona, Spain
[d] Blanquerna School of Health Science, Ramon Llull University, Barcelona, Spain
[e] TransLab Research Group, Department of Medical Sciences, School of Medicine, University of Girona, Girona, Spain
[f] Agency for Healthcare Quality and Assessment of Catalonia (AQuAS), Barcelona, Spain
[g] Health Sciences Department, Universitat Oberta de Catalunya, Barcelona, Spain

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ABSTRACT

Objective: To identify the relevant barriers and enablers perceived by primary care professionals in implementing the recommendations of clinical practice guidelines (CPG).
Methods: Two focus groups were conducted with primary care physicians and nurses in Catalonia (Spain) between October and December 2012. Thirty-nine health professionals were selected based on their knowledge and daily use of CPG. Finally, eight general practitioners and eight nurses were included in the discussion groups. Participants were asked to share their views and beliefs on the accessibility of CPG, their knowledge and use of these documents, the content and format of CPG, dissemination strategy, training, professional-patient relationship, and the use of CPG by the management structure. We recorded and transcribed the content verbatim and analysed the data using qualitative analysis techniques.
Results: Physicians believed that, overall, CPG were of little practical use and frequently referred to them as a largely bureaucratic management control instrument that threatened their professional autonomy. In contrast, nurses believed that CPG were rather helpful tools in their day-to-day practice, although they would like them to be more sensitive to the current role of nurses. Both groups believed that CPG did not provide a response to most of the decisions they faced in the primary care setting.
Conclusions: Compliance with CPG recommendations would be improved if these documents were brief, non-compulsory, not cost-containment oriented, more based on nursing care models, sensitive to the specific needs of primary care patients, and integrated into the computer workstation.

El uso de guías de práctica clínica en atención primaria: entre el conocimiento tácito y los mecanismos de control

Palabras clave:
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RESUMEN

Objetivo: Identificar barreras y facilitadores percibidos por los profesionales de atención primaria en la aplicación de las recomendaciones de las guías de práctica clínica (GPC).
Método: Dos grupos focales con profesionales médicos y de enfermería (atención primaria) en Cataluña entre octubre y diciembre de 2012. Se seleccionaron 39 profesionales según su conocimiento y uso de las GPC. Finalmente se incluyeron ocho médicos/as de familia y ocho profesionales de enfermería. Se solicitó a los/las participantes compartir sus opiniones y creencias sobre accesibilidad, conocimiento y uso de las GPC, su contenido y formato, difusión, capacitación, relación profesional-paciente, y su utilización por parte de la estructura de gestión. Los contenidos fueron grabados, transcritos y analizados utilizando técnicas de análisis cualitativos.
Resultados: Los/las médicos/as creen que las GPC son en general de relativa utilidad práctica y con frecuencia se refieren a ellas como un instrumento de control burocrático que amenaza su autonomía profesional. Por el contrario, el grupo de enfermería consideró las GPC como herramientas bastante útiles en la práctica, aunque aún poco sensibles al papel actual de la enfermería. Ambos grupos creen que las GPC no ofrecen una respuesta a la mayor parte de las decisiones en el ámbito de la atención primaria.

* Corresponding author.
E-mail address: pgallodep@ub.edu (P. Gallo).

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Conclusiones: El cumplimiento de las GPC mejoraría con recomendaciones breves, no obligatorias, no orientadas a la contención de costes y sensibles a las necesidades específicas de los/las pacientes en atención primaria, integrándolas en la estación de trabajo clínica.

Introduction

Clinical practice guidelines (CPG) are defined as a set of recommendations based on scientific evidence and designed to assist both healthcare professionals and users in selecting the most suitable diagnostic and/or therapeutic options to address a specific clinical condition. Although the implementation of CPG has not been fully proven to improve health outcomes,[1] health professionals generally accept that clinical care must be evidence-based and understand that CPG are among the best means available to translate scientific evidence into clinical practice.[2,3] Despite the fact that family doctors believe in evidence-based practice, current health care assessments indicate variability in clinical decisions with a low level of adherence to CPG recommendations.[4–6]

Many factors have been identified that could influence CPG implementation. These factors could act as either a barrier or an enabler in areas such as professional behaviour and attitudes, patient characteristics, the professional-patient relationship, the organizational context, the guideline itself, and the wider environmental factors.[1,6–10] A recent systematic review has revealed there are few rigorous studies that assess the effectiveness of a CPG implementation strategy, concluding that multifaceted interventions seem to be more effective than isolated ones.[1]

In Catalonia, Spain, CPG have been frequently used as a management tool for quality and efficiency improvement in primary care services. Despite the relative absence of published reports on their impact, CPG are extensively used as the bases for service contracts between the public regional purchaser of health services (CatSalut) and health care providers in the region. CatSalut lays out guidance for the management and prevention of the main chronic and acute conditions, for preventive care for the healthy population and for drug prescriptions. Primary care providers transfer the responsibility of achieving target objectives to family doctors and nurses through pay-for-performance schemes.[11,12] There are economic incentives for general practitioners who prescribe drugs based on a very restrictive list. An accurate assessment of family practitioners' performance is conducted using a scoreboard of quality indicators. Data is extracted from audits of electronic registries and drug prescription practices.[13–15] Originally, target objectives were related to quality of care indicators, but under pressure due to financial crises, a more cost-containment-based approach has been adopted.[16,17] Indeed, drug prescription targets were formerly linked to adherence to a recommended list of drug products. However, today, primary care teams have a ceiling in their annual prescription budget. We have moved from a "soft management" type of care strategy to a rather "hard management" approach.[18]

To date, few studies have reported on barriers to and enablers of the use of CPG in Catalonia, and they are concerned largely with aspects that relate mainly to the CPG itself, such as adequate alignment with Health Plan for Catalan priorities, methodological rigor in their development, CPG accessibility, and user friendliness.[19,20] There is thus a need to explore further the importance of these and other barriers and enablers in a context of considerable financial constraint, in which professionals remain under a pay-for-performance scheme. The Catalan context is suited to this purpose, and the hope is that the results of this research will provide tailored recommendations for policy measures and suitable management changes. In brief, this paper aims to identify relevant barriers to and enablers of CPG implementation as they are perceived by primary care doctors and nurses in Catalonia, Spain.

Methods

We carried out two discussion groups with sixteen medical doctors and nurses in the primary care field in Catalonia.[21–23] The discussion groups were conducted in Barcelona in October 2012 and in November 2012. Thirty-nine professionals were selected based on their knowledge and use of CPG on a daily bases. It is worth pointing out that we aimed at regular nursing and medical staff, with no particular specialised training on CPG, coming from both rural and urban areas, and randomly selected from a primary care staff database owned by the IDIAP Jordi Gol Institute (a reference public institute devoted to research in primary care in Spain). Potential participants received a formal letter of invitation from the project leader explaining the purpose and methods of the study. Participation was confirmed by e-mail and telephone calls. Finally, eight family doctors and eight nurses accepted participation and were included in the discussion groups. All participants signed a written informed consent letter to take part in the study.

This study was financed by the Spanish Ministry of Science and Innovation and no ethical approval was necessary since it does not involve any human experimentation or the use of biological samples of human origin.

Information gathered from a previous systematic literature review on barriers to and enablers of the use of CPG was used to help draft a semi-structured interview protocol, which was used in both discussion groups.[24] The interview protocols consisted of a series of open-ended questions. Participants were asked to discuss their views, perceptions and beliefs on a number of key dimensions in the use of CPG in their daily practice. These dimensions include accessibility of knowledge and use of CPG, content and format of the guidelines, guideline dissemination strategy, the importance of training, the professional-patient relationship, and the use of CPG by the management structure in the organization. The ultimate aim was to gather and process key informants views on barriers and facilitators for CPG in their context.

A highly experienced focus group manager in the health care area conducted the two discussion sessions assisted by two observers who took field notes. The manager piloted the sessions, ensuring that all relevant topics were covered. No group interviews lasted more than two hours, including coffee breaks.

All the information retrieved was audio and video recorded and then transcribed verbatim in full. Participants validated the final versions of transcripts before the analysis was performed. For the analysis, qualitative data were managed and processed using Atlas.ti 7.0. Content analysis was done by one coder with a double-check codification. The starting point was a code list based on the abovementioned literature review, which contained 164 codes organized into six categories and nineteen families.[24] Thirty-six additional new codes were created based on data processing, following the grounded theory approach.