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Original Article

Survey of the adherence to the consensus of gastroesophageal reflux disease before and after the implementation course

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KEYWORDS
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Abstract *Background/Purpose:* The prevalence of Gastroesophageal reflux disease (GERD) is increasing worldwide, including Asia. Although several consensus reports have been published, little is known regarding the adherence of the physicians on the consensus of GERD. We aimed to survey the agreements and adherence of physicians to the Taiwan GERD consensus before and after the continual medical education (CME) courses.
Methods: Two-hundred and twenty-seven physicians, including 81 fellows of gastroenterology, 135 qualified gastroenterologists, and 11 non-gastroenterologist attending physicians were invited to the CME course. Their agreements and adherence to the statements before and after the CME course were assessed by the pre-defined questionnaire with the aid of electronic

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keypads. The adherence rate before and after the CME course were compared by the McNemar test to indicate the changes in their willingness to follow the statements in clinical practice. *Results:* The rates of agreement of the 227 participating physicians were uniformly greater than 80% for all of the 22 statements. However, the adherence rates were lower than 80% in 16 statements before the CME intervention. The adherence rates were significantly ($p < 0.05$) increased in 15 of these 16 statements after the CME intervention. The adherence rate can be improved to greater than 80% for those statements with high level of evidence. *Conclusion:* Although physicians agreed with the statements, the pre-CME survey disclosed limited adherence rates to the statements. The education intervention through the CME courses can improve the adherence of consensus statement, especially for those with higher level of evidence.

Introduction

The prevalence of gastroesophageal reflux disease (GERD) is increasing in many Asian countries, including Taiwan.[1–3] Several international consensus reports have been reported to improve the care of patients with GERD.[4,5] Since there are several differences in the culture, health seeking behavior, and health insurance system between Taiwan and other countries, we developed the consensus of GERD in Taiwan in attempts to improve the quality of care for Taiwanese patients with GERD.[6] However, there are still several barriers to be overcome before the guideline can be widely implemented in clinical practice.[7–11]

There are several barriers that might hamper the adoption of the GERD consensus into clinical practice (Fig. 1).[7–11] First, dissemination of the consensus report is necessary to help the physicians familiar with the statement. Second, whether the primary care physicians agreed with the recommendations proposed by the experts is another problem. They might disagree with the statements due to controversial interpretation of the supporting evidence, lack of confidence in guideline/consensus developer, or lack of direct evidence in their population.[7–11] Even if they agree with the guideline/consensus, whether the recommendations can be translated into their daily practice remains uncertain (Fig. 1).[7–11] The barriers of adherence to the guidelines or consensus include lack of self-efficacy or appropriate training, lack of outcome expectancy (i.e. they do not think it can improve the outcome of patients), or the inertia of previous practice (i.e. they are more accustomed to their previous practice than the new one).[7–11] There are also several other external or practice-related barriers, including lack of time, lack of reimbursement for following the consensus, or patient's preference.[7–11]

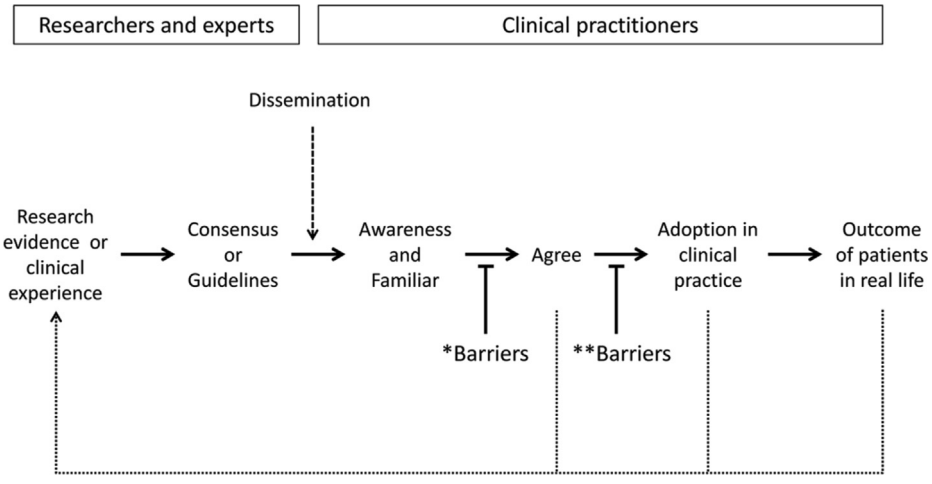

Figure 1 The development and implementation of guidelines or consensus. The guidelines are developed according to the research evidence as well as the clinical experience. After approved by credible body or association, dissemination of the guideline or consensus is needed to acknowledge the clinical practitioners about the contents and to be familiar with them. The clinical practitioners may or may not agree with the guidelines or consensus. Even if they agree with the guidelines, they may or may not adopt them into their clinical practice. Whether the adoption of the guidelines or consensus into clinical practice can improve the outcomes of patients in real life is another important issue. *Barriers to agreement: controversy on the interpretation of supporting evidence; lack of confidence in guideline/consensus developer.[5–9] **Barriers to adherence: low applicability to patient, lack of better outcome expectancy, lack of self-efficacy, not cost-beneficial, lack of reimbursement, lack of motivation to change previous practice habit/behavior.[5–9]

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