General practitioners and clinical guidelines: a survey of knowledge, use and beliefs

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SUMMARY

Background. *Clinical practice guidelines are being developed for a variety of reasons. To date, there has been little investigation of the perspectives of those who are recommended to use them.*

Aim. *The survey reported here set out to investigate how familiar general practitioners are with a range of published guidelines, to assess whether they have used them, and to describe their attitudes to the guidelines and the methods of implementing them.*

Method. *A postal questionnaire was sent to a random sample of 559 general practitioners in the North and Yorkshire region in March 1995. Questions were organized around the topics of: knowledge; use; practice change; beliefs; pressure felt to use the guidelines; and methods of implementation. Basic classificatory data on gender; year of qualification; partnership and fundholding status were also collected.*

Results. *Replies were received from 300 doctors (54%). Knowledge and use of the three selected guidelines varied, but was generally towards the 'high' end of the scale. Doctors showed a high degree of homogeneity in their attitudes to guidelines, which were generally positive. Only single-handed practitioners varied from this pattern of responses. Most of the pressure to use the guidelines was felt to come from the Department of Health, and the least pressure from patients. Doctors felt that the methods of implementation that involved them in educational events and discussion with colleagues were most likely to have an impact on them.*

Conclusion. *General practitioners are receptive to guideline initiatives, and their views are in line with existing or proposed implementation strategies. More investigation of the concept of 'use' is needed.*

Keywords: clinical guidelines; general practitioners' attitudes.

Introduction

IT is not difficult to understand why leading clinicians and health service managers are interested in clinical guidelines. In a recent review, Klazinga[1] attributes the burgeoning development in this area of medical practice to three factors. The first of these he labels 'professionalization'. According to this view, guidelines perform a function for any professional group by helping to define the best practice or 'the state-of-the-art'. Such guides may be particularly helpful to practitioners in areas like medicine, which is both broad in scope and known to be characterized by the rapid development of knowledge and large amounts of uncertainty.[2] The second factor concerns accountability. Clinicians, it is suggested, are increasingly having to cope with a variety of external pressures generated by reports of variations in practice[3] and the side effects of medical interventions,[4] as well as the empowerment of patients through such initiatives as the Patients' Charter. One product of these pressures is the guidelines, because they provide critics, monitors, and auditors with a tool with which they can evaluate practice against standards. In this sense, clinicians are experiencing the same kind of scrutiny as other public sector professionals (for example, teachers and the National Curriculum, and core objectives for constabularies, etc.). Finally, and perhaps in relation to the previous points, guidelines are being promoted as a mechanism for improving efficiency. They will have a prima facie attractiveness to health service managers and administrators because they promise a greater degree of standardization and predictability, both of which are seen as prerequisites of cost control.

The perspectives of those who are being encouraged or recommended to use guidelines in their everyday work are less well understood. Grol's study of general practitioners in the Netherlands[5] showed a generally positive attitude towards standard-setting, but an indication that this did not always translate itself into following particular guidelines. In a subsequent paper Grol noted that there are a number of barriers which may hinder the process of implementation.[6] Whilst some of these barriers are related to the characteristics of guidelines themselves and the way they are disseminated, others concern the personal characteristics of doctors. Included in the list of such personal characteristics are: age; experience; membership of professional associations; self confidence; and attitudes. According to psychologists, the latter concept refers to positive or negative evaluations of persons, groups, or objects, and subsumes both beliefs (a cognitive component), and feelings (an emotive component).[7]

In this paper we focus on the general practitioner's knowledge, use, beliefs and feelings about clinical guidelines. We were interested to find out whether doctors knew about already-published guidelines, whether they had used them, and whether they considered that their practice had changed since they began using the guidelines. Secondly, we wanted to know how doctors would respond to a set of statements generated from debates in the current literature. Thirdly, we wanted to learn about the kinds of pressure they might be feeling while using the guidelines. Finally, we were concerned to find out what sort of implementation strategies are most likely to have an impact on doctors. We hoped to relate knowledge, use and beliefs to personal (gender and year of qualification) and practice (size and fundholding status) characteristics.

Method

A postal questionnaire was sent to 559 general practitioners in the North and Yorkshire region, randomly selected from lists supplied by each Family Health Service Authority (FHSA) in the region. Overall, the selected sample comprised 1 in 7 general practitioners in the region.

Each general practitioner selected was sent a questionnaire

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consisting of five sections. Section 1 asked doctors to rate their knowledge of the content and recommendations of three published guidelines: the British Thoracic Society's (BTS) guidelines for the management of asthma;[8] the Royal College of Radiologists' (RCR) guidelines for making the best use of radiology departments;[9] and the Royal College of General Practitioners' (RCGP) guidelines for the care of patients with diabetes.[10] These guidelines were chosen from the responses to a pro forma sent to all Medical Audit Advisory Group (MAAG) chairs in the region prior to the fieldwork. They were asked to state any nationally produced guidelines which had been disseminated to general practitioners in their area in the past two years. The three guidelines chosen represent those most frequently mentioned. Ratings of knowledge were made on a five-point scale where a score of one indicated 'never heard of...', and a score of five indicated 'very familiar with...'.

In addition to assessing their knowledge of guidelines, Section 1 asked doctors to rate their level of usage of the above guidelines in the past six months on a five-point scale ranging from 'very frequently' (score = 5) to 'very infrequently' (score = 1). We also asked whether doctors felt their practice had changed for the better or the worse as a result of their awareness or use of these guidelines (again using a five-point scale where a score of five indicated 'improved my practice a great deal' and a score of one indicated 'worsened my practice a great deal').

Section 2 presented doctors with 13 belief statements on the usefulness of clinical guidelines.

Beliefs about clinical guidelines

My using clinical guidelines will:

1. Help me learn more about diagnosing and managing particular conditions.
2. Result in me practising 'cookbook medicine'.
3. Help me improve the quality of care.
4. Turn me into an instrument of government cost-cutting.
5. Make me more defensive in the way I practice.
6. Reduce the amount of autonomy I have.
7. Stop me being innovative.
8. Reduce my patients' confidence in me.
9. Enable me to use the latest knowledge derived from research.
10. Narrow my clinical freedom.
11. Create more competitiveness between doctors.
12. Make me more satisfied with my work.
13. Increase the standardization of my practice around the average.

These statements were derived from recent articles as a result of a literature search on Medline. This identified articles published between 1990 and 1994 that used the terms 'practice'/'clinical guidelines', 'standards' and 'protocols', singly and in combination. Respondents were asked to indicate, on a five-point scale, the strength of their agreement or disagreement with each statement.

Section 3 asked doctors to indicate how strongly they felt that a range of persons and agencies were pressurising them to use clinical guidelines. The persons cited were professional partners, patients, other professional colleagues, FHSA managers, and hospital consultants. The agencies cited were the MAAG and Department of Health. Ratings were made on a five-point scale where a score of five indicated '...strong pressure to use' and a score of one indicated '...no pressure to use'.

Section 4 asked the doctors to indicate the likely impact of eight common methods used to facilitate the uptake of guidelines. The methods cited ranged from published articles to putting guidelines on computer. The scoring system for this question was the same as in other sections: a score of five indicated 'very likely to make me use the guidelines' and a score of one 'not at all likely...'. The final section of the questionnaire asked for details about the doctor (for example, year of qualification) and his/her practice (for example, number of partners and fundholding status).

Statistical analysis of the data was performed using the SPSS package. Descriptive statistics and comparisons of means are reported. To compare the differences between groups, *t*-tests and ANOVAs (analysis of variance methods) were used. For purposes of tabular presentation, doctors were classified as qualifying before or after 1975 (this being the mid-point of the range of years reported), as single-handed practitioners, or as working in partnerships (of one to three partners or of four or more), and as fundholders or non-fundholders.

Results

In total, 300 usable questionnaires were returned, representing a response rate of 53.7%. An analysis of non-respondents using basic classificatory data from the Medical Register (151st Edition), showed that there was a higher proportion of single-handed practitioners among the non-responders than among the responders (36% versus 7.3%). Apart from this, there were no other readily identifiable differences between non-responders and those participating in the study.

Mean scores for general practitioners' knowledge about, use of, and assessment of the effect of three clinical guidelines on practices, are shown in Table 1. Doctors were most familiar with the BTS guidelines followed by the RCGP guidelines on diabetes, and the RCR guidelines for radiology referrals. This ordering is irrespective of the year of qualification and the partnership or fundholding status. Raw scores for the knowledge of guidelines indicated that only 4 (1.3%) doctors had never heard of the BTS guidelines, while 50 (16.6%) had never heard of the RCR guidelines. Usage followed a very similar pattern and all of the mean scores indicated that the guidelines were more likely to be frequently used than not used at all. Assessments of the impact of the guidelines on practice were all in the direction of improvement, albeit towards the middle of the response range.

Table 2 shows the doctors' responses to the set of belief statements listed above. In general, there was a tendency to agree with statements 1, 3, and 9, which were phrased in a positive way. Thus, statement 3 (that using guidelines will 'help me improve the quality of care') received the greatest endorsement, irrespective of the year of qualification and the partnership or fundholding status of the doctor. Correspondingly, there was a tendency to disagree with the remaining statements, which were phrased in a negative way. Thus, statement 8 (that using guidelines will 'reduce my patients' confidence in me') was repudiated, as was statement 11 concerning increased competitiveness. Some mean scores (statements 5 and 6, for example) were very close to the mid-point of the response range, which might indicate uncertainty. In a pattern of scores which exhibits a great similarity of views amongst doctors, the main differentiating factor seems to be that of partnership status. Single-handed practitioners appear to have a rather more pessimistic set of beliefs about guidelines than doctors in partnerships. They show significantly less agreement with positive statements (statements 1, 3, and 12), and significantly greater agreement with the negative statement about competitiveness (statement 11).

Table 3 shows the mean scores for general practitioners'

Table 1: General practitioners' knowledge, use, and assessment of practice change with respect to three clinical guidelines: mean scores by year of qualification, partnership, fundholding status, and for all respondents.

	Year qualified		Size of practice			Fundholding status		All
Guideline	Before 1975 (n = 104)	After 1975 (n = 196)	Single (n = 22)	1-3 partners (n = 150)	4 or more partners (n = 123)	Fund holder (n = 100)	Non-fund holder (n = 200)	(n = 300)
Knowledge								
BTS	4.3	4.4	4.0*[a]	4.4	4.4	4.5	4.3	4.4
RCR	3.0	2.8	2.7	2.9	2.9	3.0	2.8	2.9
RCGP	3.7**	3.2	3.6	3.3	3.3	3.5	3.3	3.3
Use								
BTS	3.7	3.9	3.4	3.9	3.8	3.9	3.8	3.8
RCR	2.8	2.6	2.4	2.6	2.7	2.8*	2.5	2.6
RCGP	3.0	2.8	3.4	2.8	2.9	3.3**	2.7	2.9
Practice change								
BTS	3.7	3.7	3.5	3.7	3.8	3.8	3.7	3.7
RCR	3.1	3.1	3.1	3.1	3.1	3.1	3.1	3.1
RCGP	3.5*	3.3	3.5	3.4	3.4	3.4	3.3	3.4

*P<0.05; **P<0.01; [a] = difference between 'Single' and '1-3 partners'. Note: For 'Knowledge', high mean scores indicate 'very familar with'; for 'Use', high mean scores respresent 'very frequent use'; and for 'Practice change', high mean scores represent a 'great deal' of reported improvement in practice.

Table 2: General practitioners' responses to 13 belief statements about clinical guidelines: mean scores by year of qualification, partnership, fundholding status, and for all respondents.

	Year qualified		Size of practice			Fundholding status		All
Belief	Before 1975 (n = 104)	After 1975 (n = 196)	Single (n = 22)	1-3 partners (n = 150)	4 or more partners (n = 123)	Fund holder (n = 100)	Non-Fund holder (n = 200)	(n = 300)
Help quality improvement	3.7*	3.9	3.5*[b]	3.8	4.0	3.9	3.8	3.8
Learn more	3.4**	3.8	3.1**[ab]	3.6	3.8	3.8	3.6	3.7
Use latest knowledge	3.4	3.5	3.2	3.5	3.6	3.6	3.4	3.5
Standardize practice	3.2	3.3	3.0	3.3	3.3	3.3	3.3	3.3
Work satisfaction	3.0	3.3	2.5**[ab]	3.2	3.2	3.2	3.2	3.2
Defensive medicine	3.1	3.1	3.2	3.1	3.1	3.1	3.1	3.1
Autonomy	3.0	3.0	2.8	3.1	3.0	3.0	3.0	3.0
Narrow clinical freedom	2.9	2.8	2.5	2.9	2.7	2.8	2.9	2.9
Cookbook medicine	3.0	2.8	2.9	2.9	2.8	2.8	2.9	2.8
Innovation	2.9	2.7	2.6	2.8	2.7	2.7	2.8	2.8
Cost cutting	2.7	2.5	2.8	2.6	2.5	2.5	2.6	2.6
Competitiveness	2.1	2.1	2.5**[b]	2.1	1.9	1.9*	2.1	2.1
Patients' confidence	2.1	1.9	2.4	2.0	1.9	1.9	2.0	2.0

*P<0.05; **P<0.01; [a] = difference between 'Single' and '1-3 partners'; [b]=difference between 'Single' and '4 or more partners'.
Note: Higher scores indicate greater agreement with statement.

Table 3: General practitioners' ratings of felt pressure to use guidelines emanating from seven person(s)/bodies: mean scores by year of qualification, partnership, fundholding status, and for all respondents.

	Year qualified		Size of practice			Fundholding status		All
Person(s)/body	Before 1975 (n = 104)	After 1975 (n = 196)	Single (n = 22)	1-3 partners (n = 150)	4 or more partners (n = 123)	Fund holder (n = 100)	Non-Fund holder (n = 200)	(n = 300)
Dept. of Health	3.7	3.6	3.5	3.6	3.7	3.5	3.7	3.6
MAAG	3.4	3.3	3.2	3.4	3.4	3.2	3.4	3.4
FHSA managers	3.4	3.3	3.4	3.4	3.3	3.2*	3.5	3.4
Hospital consultants	3.0	3.2	3.1	3.2	3.1	3.0*	3.3	3.2
Other professional staff	3.0	3.0	2.8	2.9	3.1	3.1	2.9	3.0
Partners	2.9*	2.6	2.0**[bc]	2.5	3.0	3.0**	2.5	2.7
Patients	2.1	2.0	2.0	2.0	2.0	2.1	2.0	2.0

*P<0.05; **P<0.01; [b]=difference between 'Single' and '4 or more partners'; [c] =difference between '1-3 partners' and '4 or more partners'.
Note: Higher scores indicate greater felt pressure.

responses to a question which asked them to indicate how strongly they felt certain persons and bodies wanted them to use clinical guidelines. All of the doctors felt that the greatest pressure came from the Department of Health, followed by the MAAG and FHSA managers. The least pressure was felt to have come from patients, partners, and other professional staff. This sequence tends to be the same over all of the categorizations used in the analysis. Doctors in fundholding practices seem to feel different pressures from those experienced by the non-fundholding doctors. These fundholding doctors felt significantly more pressure coming from their partners, but less pressure from hospital consultants and FHSA managers. Doctors in practices with four or more partners felt significantly more pressure from their partners than doctors in smaller partnerships.

Section 4 of the questionnaire asked doctors to express their views regarding the impact of guideline implementation methods on them. The results are shown in Table 4. Most doctors regarded 'continuing medical education events' as the method most likely to persuade them to use guidelines, followed by 'discussion with local colleagues', 'feedback on individual practice', and 'published articles'. There is a gap between these four methods and the others owing to 'mass media coverage' being a relatively ineffectual outlier. Differences amongst doctors lie not so much in the ranking of these methods' effectiveness, as in the strength of their perceived impact. Thus, doctors qualifying before 1975 have significantly lower mean scores than doctors qualifying after 1975. Single-handed practitioners have significantly lower mean scores than doctors in partnerships, with respect to 'discussion with colleagues' and 'feedback on practice'.

Discussion

The response rate of 54% was satisfactory for a mailed questionnaire and the analysis of non-responders showed that the participants did not differ greatly from the non-participants, except for the under-representation of single-handed practitioners. This may have resulted in a positive bias in the results, since it has been shown that 'innovativeness' is inversely related to the size of practices .[11]

Awareness of two of the three guidelines selected for citation in the survey (BTS and RCGP) was towards the 'high' end of the rating scale, while knowledge of the RCR guidelines was rarely beyond the mid-point of the scale. Similar variations in familiarity were reported in an American study of internists' attitudes to guidelines.[12] Unlike the present study, Tunis and his colleagues[12] included a fictitious guideline (to assess respondents' desire to appear knowledgeable) and 7% of responders reported familiarity with the non-existent guideline. The findings reported here, therefore, may be inflated to some extent.

The use of guidelines followed a similar pattern to awareness, though at a lower level. None of the guidelines were used 'very frequently', but this may represent a literal response from general practitioners. They may use these guidelines when they need to, but this may not be very often. Questionnaires are notoriously blunt instruments and it is difficult to probe such nuances without making a schedule long and complicated. What is indicated, however, is the need for some investigation of what the term 'use' means in relation to guidelines. The definition of a spectrum of use tied to a notion of 'need for' might be of practical importance to those concerned with the development and implementation of guidelines.

There are two further messages for guideline development in the survey's findings. First, the generally positive responses to the belief statements (Table 2), and the tendency to report practice changing 'for the better' as a result of using the guidelines (Table 1), suggests that the general practitioners in this sample are receptive to this type of initiative and are similar in their attitudes to the doctors in Siriwardena's sample.[13] While there was no attempt to locate this sample of doctors on Grol's 'stages of development',[6] it would be fair to suggest that this group was aware and accepting of guidelines, and that a large number have probably incorporated their recommendations into everyday practice. Such receptivity to change at an individual level is an essential prerequisite for change at the level of the practice team.[14]

The second message from this study concerns methods of guideline dissemination and implementation. In a recent review of 91 studies of guideline introduction, Grimshaw *et al.*[15] concluded that "the more overtly educational the dissemination strategy, the greater the likelihood that guidelines will be adopted." The present study confirms this from the recipients' point of view. Doctors prefer methods which involve them as part of an ongoing development and dialogue within their professional community. The more impersonal or 'managerial' the strategy is seen to be, the less likely it is to have a strong impact.

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Table 4: General practitioners' views about the likely impact on them of eight different methods used to facilitate the uptake of guidelines: mean scores by year of qualification, partnership, fundholding status, and for all repondents.

	Year qualified		Size of practice			Fundholding status		All
Method	Before 1975 (*n* = 104)	After 1975 (*n* = 196)	Single (*n* = 22)	1-3 partners (*n* = 150)	4 or more partners (*n* = 123)	Fund holder (*n* = 100)	Non-Fund holder (*n* = 200)	(*n* = 300)
CME events	4.0	4.1	3.8	4.0	4.1	4.1	4.0	4.0
Discussion with colleagues	3.9*	4.1	3.4**ab	4.0	4.1	4.1	4.0	4.0
Feedback on practice	3.8	4.0	3.4**ab	3.9	4.0	4.0	3.9	3.9
Published articles	3.6**	3.9	3.5	3.8	3.9	3.8	3.8	3.8
Reminders from source	3.3	3.4	3.1	3.4	3.4	3.4	3.4	3.4
Computers	3.3	3.3	2.8	3.3	3.3	3.5*	3.2	3.3
Visits from IMAs	2.9*	3.1	2.8	3.1	3.0	3.0	3.0	3.0
Media coverage	2.4*	2.7	2.6	2.6	2.6	2.5	2.6	2.6

*P<0.05; **P<0.01; [a] = difference between 'Single' and '1-3 partners'; [b] = difference between 'Single' and '4 or more partners'. Note: Higher scores indicate greater impact.

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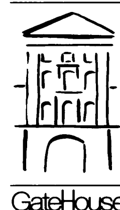

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Increasingly, GPs are able to influence the development of primary care, whether through fundholding, commissioning groups, or through their representative organisation. GPs need to develop skills of leadership and communication in a manner which maximises this potential. One third of all GPs are women and it is vital that their particular strengths are fully employed, whether in health care delivery or in planning and policy.

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5. **Flexible Working** Dr Geraldine Bynoe, Policy Advisor, Women in Medicine, NHS Equal Opportunities Unit, Consultant Haematologist and former Associate Postgraduate Dean for Women Graduates.
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