Clinical guidelines on depression: A qualitative study of GPs' views

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Practice recommendation

- Health planners may help enhance guideline use if resources are available for implementation, recommendations are consistent across multiple guidelines, and audit and feedback mechanisms are developed (**C**).

Abstract

Background Clinical guidelines have become an increasingly familiar component of health care, although their passive dissemination does not ensure implementation. This study is concerned with general practitioners' (GPs) views of guideline implementation in general practice. It focuses specifically on their views about guidelines for the management of patients with depression.

Objective To elicit and explore GPs' views about clinical guidelines for the management of depression, their use in practice, barriers to their use, and how best to implement guidelines.

Design Qualitative study using in-depth interviews with a purposive sample of GPs.

Setting General Practices across the Scottish Grampian region, and Northeast England.

Methods Eleven GPs who had participated in a previous questionnaire based depression study were interviewed. Interviews were transcribed and analyzed using the "framework technique."

Results Several participating GPs did not agree with recommendations of the current depression guidelines; some thought they were insufficiently flexible to use with the variety of patients they see. The volume of guidelines received, lack of time and resources (particularly mental health professionals for referrals) were seen as the main barriers to guideline use.

Conclusions A range of factors contributes to variability in compliance with guidelines for the management of depression. For guideline use to increase, GPs in this study said they would like to see more resources put in place; a reduction in the number of guidelines they receive; incorporation of guideline recommendations onto computer decision support systems; and regular audit and feedback to allow them to monitor their practice.

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Clinical practice guidelines have become a common aspect of clinical care.[1] Guidelines have been defined as "systematically developed statements to assist practitioner and patient decisions about appropriate health care."[2] Clinical practice guidelines have been seen as the remedy to at least 3 problems facing healthcare systems[3]: wide variation in the health care people receive[4]; rising health care costs[5]; and health

professionals' difficulty in keeping abreast of research evidence.[6] Despite increasing numbers of clinical practice guidelines, clinicians often do not change their practice accordingly.[7] The reasons for this have not been fully explained.[1]

At least 45 different depression guidelines have been published for use in primary care since 1991. However, a review concluded that they all make essentially the same recommendations.[8] Thus, whichever guidelines GPs used, the recommendations were similar and were based on the 1992 joint consensus statement,[9] which advises that that 4 depressive symptoms must have been present for at least 2 weeks before prescribing antidepressants. In this study, in-depth interviews explored GPs' views on guidelines for the management of depression, how they used these in practice, barriers to using the guidelines, and how best to implement guidelines.

BARRIERS TO EFFECTIVE TREATMENT

Successful implementation of a depression guideline (by the US Agency for Healthcare Research and Quality) increases the quality of care and improves clinical outcomes.[10] However, a widely acknowledged gap exists between research findings and their clinical implementation.[11] In the UK, GPs tend to overprescribe relative to recommendations[12]—antidepressant prescribing has increased for all age and sex groups over the last 20 years[13]; prescribing no drugs is rare.[14] Nevertheless, depressed persons are often underdiagnosed and undertreated[13,15]; only about 10% receive appropriate treatment.[16]

Barriers preventing effective treatment for depression include service provision[17]; patients' attitudes and beliefs about depression and its care[18]; lack of access to care; treatment preference; and concerns about confidentiality and stigma.[19–21] Physicians have sometimes overruled guidelines when patients have complex illness patterns.[18] Physician factors, including lack of time[22] and poor awareness of guidelines,[22,23] may also contribute.

Asking questions about guidelines in practice

This study sought GPs' views about the gap between depression guideline recommendations and practice, and examined how best to implement clinical guidelines from the GPs' perspective. Specifically, the following research questions were addressed:

1. Do GPs agree with the recommendations made by depression guidelines?
2. Do GPs feel that guidelines are flexible enough to manage depression in all patients?
3. What barriers do GPs perceive to following the recommendations?
4. What do GPs perceive to be the most fruitful method to promote guideline use?

METHODS

Participants' characteristics

GPs eligible for this study (n=102) participated in 1 of 2 postal questionnaires, wherein they were asked to make treatment decisions in 20 systematically varied case vignettes of patients with symptoms that might indicate depression. Fifteen GPs were invited to participate, of whom 11 (73%) agreed to be interviewed.

Potential participants were sampled to reflect the range of compliance in response to the previous study's vignettes (5 exhibited high levels of compliance, 3 medium, and 3 low), and to ensure the sample included GPs from different-sized practices (5 GPs worked in small practices, 5 in medium, and 1 in a large practice) and different locations (7 from the Scottish Grampian region, 4 from the Northeast of England). Eight GPs were male, 3 were female. GPs were interviewed during April 2002 at their practice premises by LS. Previous questionnaires did not reveal that analyses took guideline compliance into account; thus it was deemed that participants would not be affected by social desirability characteristics.

Interview procedure

A topic guide was designed to guide interviews and included the research design showing who

was to be interviewed and key questions to be addressed. Questions were open-ended, semi-structured, and followed research questions. GPs' permission was sought to record interviews, and confidentiality was assured. GPs were encouraged to talk freely. Interviews lasted between 45 and 75 minutes; they were tape-recorded and transcribed with all identifying text removed.

Data analysis

Two researchers (LS & AW) analyzed transcripts using the Framework Technique,[24] chosen because it is grounded in and driven by participating GPs' original accounts and observations. Abstraction began after the full data set was reviewed. Emergent themes and issues were noted and given a code, and an index was constructed. This was revised several times as new issues emerged and was systematically reapplied to all the interview transcripts. Interviews were analyzed independently and any differences of interpretation were resolved through discussion.

RESULTS

Of the 7 GPs who knew which was their latest depression guideline, 2 had no problems with recommendations. However, several GPs disagreed with some recommendations, possibly explaining variable compliance.[12]

Disagreements

One area of disagreement was the recommendation to refer patients, as specialists were not always available or waiting times were too long. Criteria for referring patients to secondary care include diagnostic uncertainty, treatment failure, suicidal tendencies, and psychotic or disturbed behavior. (This recurring issue of referral is discussed below.)

Another area of disagreement was the duration-of-symptoms criterion, as heard in the following observation:

> It stipulates they have to have these features and for at least 2 weeks … and if they only have them for a week why should I wait … why should they be miserable for a week, when I am pretty certain they are depressed? (GP3)

Guidelines' flexibility

Evidence-based recommendations are usually expressed in terms of typical clinical situations. Perhaps such recommendations are particularly difficult to apply to individuals who can present with varying combinations of pre-existing illness, beliefs about depression, treatment preferences, concerns about confidentiality and stigma, as well as varying degrees of access to care. We therefore asked GPs whether they believed the available depression guidelines are sufficiently flexible to use with all their patients in managing depression.

Many of the GPs thought the guidelines were not flexible. For instance, GP4 said he worried about lawyers becoming involved in guideline compliance, which could result in defensive practice rather than the best treatment for patients. Similarly GP2 said that guidelines should not be used in all situations because they vary so much. GP7 reported that depression guidelines made invalid assumptions about patients presenting with only one illness (and GPs having plenty of time), resulting in the guidelines not being useful for some patients with certain illness combinations.

BARRIERS TO FOLLOWING GUIDELINES

Number of guidelines. The most common perceived barrier preventing these GPs from following guidelines was the volume of guidelines they receive. They thought they received too many guidelines and had too little time to read them all. The GPs sometimes felt confused about which one to follow. Although they could not quantify how many new guidelines they received in a month, or from how many sources, GPs appeared to feel overwhelmed and despondent.

> …There's a bit of numbing as well: oh no, not another guideline. (GP11)

> We get flooded with stuff.… With a lot of stuff I bin it or file it. (GP5)

Time constraints. Lack of time was consistently viewed by participating GPs as a major barrier to guideline use. This is not surprising considering patients are booked in every 5–10 minutes,[25] with GPs seeing around 140 patients a week.[26] Furthermore, GPs viewed guideline accessibility, style, and presentation as barriers.

> SIGN guidelines are always very good because they come on clear to follow laminated cards which are kind of summary versions of them. Many other guidelines are not so good ... much longer and difficult to follow.… (GP6)

Lack of resources. Lack of resources reemerged as a major barrier to following guideline recommendations. Problems of patient referral included having no specialist to refer them to, patients being misled about specialists' qualifications, and patient confidentiality issues. Several GPs reported that by the time patients received appointments, they reported their problems had disappeared and they no longer wanted appointments.

> …a guideline might come through and I've followed the protocol … and arranged a referral … then the reply has come back from the hospital that they don't have the resources for this at the moment. So it [the guideline] has fallen flat on its face and that is extremely disappointing when we in primary care are trying our best. (GP2)

Waiting times reported were between 2 to 26 weeks for psychiatrists or community psychiatric nurses and 9 to 12 months for psychologists. Perceived delays or deficiencies in specialist services may partially explain GPs' tendency to over prescribe relative to recommendations.[12]

Increasing guideline use

For guideline use to increase, GPs in this study thought that more resources needed to be put in place (particularly mental health professionals); the number of guidelines issued should be reduced; and guidelines should be produced and sent from a central body with a multidisciplinary team including some GPs, to reduce problems of perceived unrealistic assumptions. Incorporation of guideline recommendations onto computer systems with prompts and flow charts was also suggested by several GPs as method to promote guideline use. The majority of interviewed GPs also said they would like some form of audit and feedback.

> We really need some kind of measure.… We're all meant to audit our work, but again its time and we audit what we have to. If someone could demonstrate that I'm not managing depression well, then I might sit up and think I need that guideline there. We need all the feedback we can get really. (GP9)

DISCUSSION

In this study, GPs perceived barriers to implementation of current depression guidelines matched other research findings on this subject—eg, lack of time,[22] lack of resources,[17] variability among patients,[19–21] lack of awareness,[22,23,27] lack of agreement with guideline recommendations,[28] and poor accessibility to guidelines.[11]

The relatively small group of participants in this study cannot be generalized to all GPs. Additionally, there are always difficulties with self-reporting—participants may not do what they say they do. However, "purposive" sampling is consistent with qualitative approaches and allows a wide range of GPs' views to be explored in depth. This study could be replicated elsewhere to assess how representative these views are.

Interviewed GPs did not always agree with depression guidelines. To address disagreement, some sort of educational intervention may be useful. Previous research has shown educational interventions to enable guideline implementation: an educational program was reportedly one of the most important elements in the successful implementation of cervical screening guidelines[28]; and large group meetings were effective in modifying drug use in coronary artery disease.[29]

An important theme in this study was the issue of referring patients and the availability of specialist services. GPs disagreed with the recommendations about referring, and saw lack of mental

health professionals as a main barrier to following depression guidelines. This problem needs to be addressed, and interviewed GPs believed certain recommendations would be followed if resources were put into place. Their views have important implications for clinical guideline development. Resources must be considered before recommendations are made. Alternatively, those involved in guideline production may be demonstrating the case for more mental health professionals.

The volume of guidelines and lack of time and accessibility to guidelines were also perceived barriers. Both barriers could be addressed by introducing computerized decision support systems. Indeed, several GPs suggested the incorporation of guidelines onto computer systems as a way of promoting guideline use. However, the effect of computerized evidence-based guidelines has been variable,[1,30] and further study is needed.

The GPs thought depression guidelines were insufficiently flexible to use with the spectrum of depressed patients they see. However, some expected this, believing there would always be certain patients to whom guidelines do not apply. Greater involvement of GPs in guideline development was seen as a means to addressing this problem as well as reducing unrealistic assumptions made about general practice.

Audit and feedback emerged as a potential method for assessing and improving compliance. This matches the evidence. A review of 12 studies using audit and feedback as implementation strategies concluded these activities change behavior modestly, but all studies reported improvements in the process of care.[1]

If we are serious about closing the gap between research evidence and practice, possibly a new system of guideline development is needed, with a national clearinghouse for guidelines. Here a multidisciplinary team including some GPs would be responsible for evaluating guidelines, incorporating them onto computer systems, auditing performance, and giving feedback to GPs. This study has opened up possibilities for further exploration.

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