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Clinical Guidelines

Barriers to Adoption

This briefing was prepared as part of a primary health care research collaboration between Griffith University and General Practice Queensland.

Background

This briefing provides a summary of key issues affecting the uptake of clinical guidelines by general practitioners in Australia and internationally. This briefing is part of a research review paper, which identifies considerations and strategies for improving the adoption of chronic disease clinical guideline evidence by General Practitioners. The full article (in review) can be found at www.gpqld.com.au/Programs/Collaborative_Research_Hub

Barriers to Adoption

Practitioners have been overloaded with information available in decision-making around the development of guidelines and pathways to support the management of chronic conditions. The adoption of guidelines in practice varies considerably and dissemination alone does not guarantee uptake.

Guidelines do not always meet the clinical realities experienced by practitioners who need accessible, on demand knowledge at the point of care. Guidelines aim to provide access to evidenced-based information, to improve the benefits to the patient by standardisation of good practice across practitioners. However, the research suggests that there are a significant number of barriers and issues, which need to be addressed to improve the adoption and uptake in practice. It is an important first step in identifying the key elements which impact on adoption, to inform potential solutions in addressing these barriers, and how best to improve dissemination and communication processes (see summary table on page 2).

In a systematic review, Majumdar et al. (2004) identified four clusters of barriers, namely the evidence, the clinician, the consumer and the context. They concluded that the nature of evidence is often uncertain, inconsistent, limited and complex, leading to an unwillingness or inability to apply it. Practitioners can also lack motivation, awareness or self-efficacy to apply evidence, irrespective of its quality. Further, there are often competing influences (i.e., pharmaceutical incentives and promotions) that take precedence over evidence-based knowledge. Consumer demand or preference can also take precedence over evidence-based knowledge, particularly in this era when practitioners are encouraged to develop treatment regimes in conjunction with consumers. Practitioners must also take into account the context of the consumer (i.e., ability to afford treatments, access to healthcare). Other features of the context that were found to influence adoption of guidelines included lack of time, resources and incentives, an emphasis on acute symptoms and the absence of opinion leaders to influence change.

Practitioners regard access to quality, reliable and credible information in a useable form as essential aspects to support the adoption and uptake of guidelines and pathways in practice. They need to be practical in their application and from a trustworthy source. Flexibility in decision-making is regarded as critical, in combination with clinical judgement, being able to adapt to the patient needs, case knowledge, advice from other health professionals and experience to make the complex clinical decisions.

The following table summarises the key barriers to the adoption of evidence around clinical guidelines (part of a systematic review, Majumdar et al. (2003)¹

Summary of Barriers to the Adoption of Evidence

1. Evidence is uncertain or inconclusive in some areas (i.e., not enough evidence is available)
2. Evidence is often inconsistent (i.e., contradictory evidence)
3. Evidence has a limited scope or focus (i.e., focus on only one condition)
4. Evidence is limited to particular populations (e.g., lacking in relation to young people with multiple chronic conditions)
5. Evidence has not been synthesized into useable form (i.e., clear summaries are absent)
6. Evidence-based interventions are often too costly or complex
7. Practitioners may lack the necessary motivation to use evidence
8. Practitioners may lack the skills to use or critically review evidence
9. Practitioners may lack awareness of the evidence
10. Practitioners may disagree with the evidence as a result of their practical knowledge and experience
11. Practitioners may lack self-efficacy (i.e., a belief in their ability to implement treatments)
12. Practitioners may be over cautious about or over-emphasize the potential negative side effects of an evidence-based treatment
13. Consumer preferences, expectations and knowledge can take precedence even if they contradict evidence
14. Consumer may fail to comply with evidence-based recommendations
15. There is a lack of resources to support patients and practitioners to adopt evidence-based treatments
16. Limited access to healthcare restricts the ability to apply evidence (i.e., limited likelihood of follow-up visits)
17. Evidence-based treatments are often unaffordable (i.e., due to patients' lack of private health insurance, need for expensive diagnostic tests)
18. Evidence usually focuses on acute rather than ongoing management
19. There is a lack of time to implement evidence
20. There is a lack of incentives to change practice
21. There is a lack of opinion leaders among physicians to lead change
22. Evidence fails to address broader issues (i.e., how to treat a particular patient in a particular situation in a way that is efficient and equitable).

Adapted from Majumdar et al. (2003)¹

Briefing number 2 in the series explores dissemination practices and provides options for consideration in improving the processes to support the uptake of evidence in future practice.

Acknowledgments

This briefing is a summary of a research paper (in journal publication review)

Paper Title: **When guidelines need guidance: Considerations and strategies for improving the adoption of chronic disease evidence by General Practitioners**

Available at: www.gpqld.com.au/Programs/Collaborative_Research_Hub

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1 - Majumdar, S., McAlister, F. & Furberg, C. (2003). From knowledge to practice in chronic cardiovascular disease: a long and winding road. *Journal of the American College of Cardiology*, 43(10), 1738-42.