Practice guidelines for clinical prevention: Do patients, physicians and experts share common ground?

Evidence

Études

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Abstract

Background: Clinical practice guidelines, such as those of the Canadian Task Force on Preventive Health Care, although based on sound evidence, may conflict with the perceived needs and expectations of patients and physicians. This may jeopardize the implementation of such guidelines. This study was undertaken to explore patients' and family physicians' acceptance of the task force's recommendations and the values and criteria upon which the opinions of these 2 groups are based.

Methods: Focus groups were used to collect study data. In total, 35 physicians (in 7 groups) and 75 patient representatives (in 9 groups) participated in the focus groups. An inductive approach was used to develop coding grids and to generate themes from the transcripts of the interviews.

Results: Physicians expressed resistance to discontinuing the annual check-up, which they viewed as an organizational strategy to counteract the many barriers to preventive care that they encounter. They reported difficulties in explaining to their patients the recommendations of the Canadian Task Force on Preventive Health Care, which they found complex and inconsistent with popular wisdom. Both patients and physicians attributed high value to the detection of insidious diseases, even in the absence of proof of the effectiveness of such activity.

Interpretation: The patients and family physicians who participated in this study shared many opinions on the value of preventive activities that depart from the values used by "prevention experts" such as the Canadian Task Force on Preventive Health Care in establishing their recommendations. A better understanding of the values of patients and physicians would help guideline developers to create better targeted communication strategies to take these discrepancies into account.

In 1980 the Canadian Task Force on the Periodic Health Examination, now the Canadian Task Force on Preventive Health Care, produced the first evidence-based clinical practice guidelines.[1,2] It recommended that "the routine annual physical examination should be discarded in favor of a selective plan of health protection packages appropriate to the various health needs at the different stages of human life," to be administered in the scope of day-to-day care.[1] It suggested that many tests, such as chest radiography and, more recently, screening for prostate cancer with prostate-specific antigen,[2] were useless, and it recommended breast cancer screening for the first time. Many of the task force's recommendations produced an uproar within the medical profession, being regarded as contrary to good medical practice and patients' expectations.[3]

Canadian studies have shown that many recommendations for preventive health are still not being optimally implemented, in spite of strong efforts at dissemination.[4–7] Research on factors that favour implementation of such recommendations has focused on practice organization and has yielded variable results.[8–10] Although

the importance of organizational factors is undeniable, medical practice depends on the interactions between a physician and a patient. Practice guidelines may not conform with patients' expectations and may even appear contrary to a specific personal need. In addition, health care professionals themselves may not agree with the norms proposed by experts. These problems present barriers to implementing recommendations.

Given that the research data available provide only a superficial understanding of the issues at stake, we planned a focus-group study to explore what patients and family physicians think of the recommendations of the Canadian Task Force on Preventive Health Care and how they make their decisions on the effectiveness of preventive interventions.

Methods

In accordance with published methods[11] we planned to run sessions for 6 groups of 6 to 8 physician participants and 8 groups of 6 to 8 patients, having observed from 2 pilot focus groups that we would attain saturation in terms of the opinions expressed more rapidly with physicians than with patients.

Aiming for a 50% response rate, we contacted 96 physicians, randomly selected from the list of family physicians working in Montreal and the Montérégie provided by the Fédération des médecins omnipraticiens du Québec. (The Montérégie is a region 20–40 km south of Montreal, on the south shore of the St. Lawrence River). All received a letter, cosigned by the investigators and the chair of the regional medical association, followed by a telephone call from one of the investigators, inviting them to participate in a study to explore family physicians' perceptions of guidelines for preventive care and of the difficulties in implementing prevention in daily practice. Patients were recruited through advertisements in the largest Montreal daily newspaper and in community-based weekly newspapers in the Montéregie. To be eligible, physicians could not have restricted their practice (e.g., to emergency medicine or to geriatrics), and patients had to be over 18 years of age and had to have sought the services of a general practitioner at least once. Physician participants were offered continuing medical education credits, and patient participants received $25 each. The groups were arranged to ensure balanced representation in terms of sex, age, socioeconomic background (for patients), and years of experience and practice setting (for physicians).

During the first part of each 2-hour focus group, participants explored their perceptions about prevention. We then presented a vignette inspired by the recommendations of the Canadian Task Force on Preventive Health Care to trigger discussion of their acceptability. The groups were led by a sociologist experienced in focus groups (J.L.) in the presence of one researcher (M.-D.B., É.H. or D.R.) and the research assistant (D.F.).

Our analysis was based on the transcripts of the group discussions, the notes of the 2 observers and the group leader for each focus group, and the transcripts of the debriefing sessions.[11] Two coding grids, one for physicians and one for patients, were developed. All transcripts were coded by one person (D.F.). The researchers analysed the transcripts independently to identify themes within the different coding categories and then shared their evaluations. We used the QSR NUD.IST software package (distributed by Scolari, Sage Publications Software, Thousand Oaks, Calif.) for data management.

Different techniques were used to ensure internal validity. The results of independent coding among the researchers were compared for 5% of the material from the physician sessions and 15% of that from the patient sessions. One of the researchers (R.P.), who had not participated in any focus group, analysed excerpts of the material. We also analysed and compared the content of the 14 group discussions and of the 2 pilot groups. The study was approved by the Ethics Committee of the Centre de recherche du Centre hospitalier de l'Université de Montréal.

Results

Of the 96 physicians approached, 74 were eligible to participate. Of these, 44 (59%) accepted our invitation but only 25 (34%) were able to attend one of the focus groups. We completed the groups with 10 physicians from a convenience sample made up of physicians approached by 2 investigators (M.-D.B. and É.H.), to balance for sex and location and type of practice setting. There were 7 physician groups, including the pilot group. The differences between physician participants and nonparticipants were not statistically significant for sex, location and type of practice, or number of years of experience. The 75 patient participants were divided into 9 focus groups (including the pilot group). Tables 1 and 2 summarize the characteristics of the physicians and the patients respectively.

The annual examination as an organizational strategy

Most of the participants favoured the "annual check-up," for a variety of reasons. Both patients and physicians felt that a check-up permits a more thorough evaluation than regular medical visits and that it also builds trust. Indeed, many physicians said that they advise their patients to have a general physical examination annually to make sure that "everything is done."

To quote one physician, "I just can't see how you can do prevention without the annual check-up. Once a year, I do a thorough examination.… Are there any new things to add to [the patient's] medical history? Even if I've seen the person once a month [over the year], there are times when I have not necessarily done preventive care."

The value of screening tests

We observed that tests play an important role for patients in their personal preventive routine, giving them access to information they could not obtain otherwise. In view of this perception, such tests seem empowering.

One patient expressed it this way: "The way I see it, a test is a tool. It can be good; it can be bad. The fact is that there is no other way, if I want to know what I have. That's why I prefer to have preventive tests done on a regular basis."

Patients considered test results more accurate than the history and the results of the physical examination. Very

few identified disadvantages to screening tests. The fact that early diagnosis does not necessarily translate into better chances of survival appeared contrary to popular wisdom. Indeed, some patients found the idea that prevention can do more harm than good very disquieting.

Physicians valued the history and the results of the physical examination much more than test results. Indeed, they agreed that there are very few truly effective screening tests but considered the downgrading of the physical examination by the task force unacceptable. Physicians were sensitive to the dangers of false-positive test results. However, they felt a strong responsibility to not miss a diagnosis when a patient specifically requested a "check-up." The issue of guilt seemed very important. All of the physicians who participated indicated that it was easier to live with not following guidelines than with having missed a diagnosis.

Table 1: Characteristics of the 35 physicians participating in focus groups

Characteristic	No. (and %)*
Sex	
Women	20 (57)
Men	15 (43)
Age, yr	
29–34	5 (14)
35–44	21 (60)
45–54	7 (20)
55–64	2 (6)
Country of birth	
Canada	31 (89)
Other	4 (11)
Primary language	
French	32 (91)
English	3 (9)
Location of practice	
Montreal	20 (57)
Montérégie	15 (43)
No. of yrs in practice	
5–10	9 (26)
11–20	18 (51)
> 20	8 (23)
Type of pratice	
Group	21 (60)
CLSC	10 (29)
Solo	4 (11)
Method of remuneration	
Mainly fixed honoraria	6 (17)
Mainly fee-for-service	23 (66)
Mixed	6 (17)
Residency in family medicine	
Yes	13 (37)
No	22 (63)
Participation in a university teaching program	
Yes	7 (20)
No	28 (80)

*Percentages may not sum to 100 because of rounding.

Making judgements about preventive guidelines

Physicians reported that the approval of their peers, the approval of local experts and the absence of controversy were the 3 main factors that determined the acceptability of recommendations. Groups composed exclusively of "researchers" did not have as much credibility as groups that included clinicians. For both categories of respondents, groups supported by governments or the pharmaceutical industry were suspect. Patients who had developed a trusting relationship with a family physician gave a lot of credence to his or her recommendations.

Some physicians questioned the "scientific" nature of the process followed by the groups that formulate recommendations, including the Canadian Task Force on Preventive Health Care. Many thought that experts do not

Table 2: Characteristics of the 75 patients participating in focus groups

Characteristic	No. (and %)*
Sex	
Women	49 (65)
Men	26 (35)
Age, yr	
18–34	24 (32)
35–54	25 (33)
≥ 55	26 (35)
Country of birth	
Canada	66 (88)
Other	9 (12)
Primary language	
French	71 (95)
English	4 (5)
Level of education completed	
Primary school	6 (8)
Secondary school	17 (23)
CEGEP	21 (28)
University	31 (41)
Occupation	
Employed	29 (39)
Unemployed	19 (25)
Student	8 (11)
At home, retired	16 (21)
No response	3 (4)
Household income, $	
< 12 000	16 (21)
12 000 – 19 999	12 (16)
20 000 – 29 999	8 (11)
30 000 – 39 999	15 (20)
40 000 – 49 999	8 (11)
≥ 50 000	9 (12)
No response	7 (9)
Regular family physician	
Yes	55 (73)
No	16 (21)
No response	4 (5)

*Percentages may not sum to 100 because of rounding.

consider all of the positive repercussions of a screening test, such as discovering abnormalities other than those specifically targeted by the test or creating an opportunity for counselling. The cornerstone criterion for prevention is that a screening or diagnostic manoeuvre must have some effect on morbidity, but many physicians, mostly those with more experience, disagreed that the value of a test should be determined only on this basis.

As one physician commented, "My goal is to find out if there is prostate cancer. Maybe we want to turn physicians into less social beings and get them to say that they will only keep those interventions that will change morbidity.… If that's the case, then when an 80-year-old man comes to the emergency room, you will say: "No way, [treating the elderly is] not worth the trouble."

Both physicians and patients expressed the opinion that experts place economic considerations ahead of scientific concerns when they judge the value of screening activities. Many felt that experts do not take into account the limits of current knowledge and that they may recommend not performing a test that might prove effective in the future. Physicians and patients also recognized that a particular intervention might be useless for the general population but useful to an individual.

Interpretation

The results of this exploratory study suggest that, on the whole, patients and family physicians share common ground in terms of their values and expectations regarding clinical prevention. The annual physical examination is seen by physicians as an organizational strategy. This consideration was dismissed by the Canadian Task Force on Preventive Health Care, even though some studies have suggested that physicians are more successful in meeting the task force recommendations in the context of a regular check-up.[6] Diagnosing disease was perceived by both groups of respondents as the physician's responsibility and a legitimate end in and of itself. Screening tests were seen by patients as tools for empowerment.

We applied the rules of qualitative research design to ensure the internal validity of our results. However, there are some limitations inherent to focus-group methodology. Exploration of opinions may be more superficial than in other designs because of the number of participants. Focus-group methods are also sensitive to group dynamics, which may lead to a phenomenon known as "group censoring."[11] We tried to avoid this phenomenon by regularly asking all respondents to give their opinions. Getting busy physicians together for the focus groups proved difficult. We completed the groups with a convenience sample, but this did not jeopardize the study in terms of qualitative research standards.[12] We do not think that the views of these physicians were related to their francophone background. Indeed, surveys conducted elsewhere in Canada and in the United States support our findings, suggesting that physicians do not necessarily subscribe to preventive guidelines.[13,14]

We know from surveys[15] that patients expect screening tests to a greater extent than is recommended. Our results suggest that the public is unaware of many important facts about the risks and costs of screening and entertains wishful thinking about the effectiveness of prevention. The scientific rationale for prevention often runs counter to popular wisdom. Hence, family physicians are left to explain these sophisticated concepts in the emotionally charged context of the consultation.

Our results shed some light on the issues surrounding so-called evidence-based prevention. The values used by experts, such as the members of the Canadian Task Force on Preventive Health Care, to determine what constitutes sufficient evidence were not shared by most of the patients and many of the physicians in our focus groups. In contrast, patients and physicians attribute high value to early diagnosis, regardless of whether this affects outcome. Such observations raise fundamental ethical questions in a society that values individual autonomy in medical decision-making while it is grappling with the rationing of resources.[16] Proponents of evidence-based medicine must also realize that people are sensitive to the limits of scientific knowledge and that many physicians and patients regard science with suspicion.

The National Forum on Health correctly stated that to succeed in creating a culture of evidence-based decision-making, we must have a better understanding of the meaning of "evidence" to different people and its place in the decision-making process.[17] Models such as the Health Belief Model[18,19] or the social-cognitive theory of Ajzen and Fishbein[20] can be useful in explaining the behaviour of physicians and of patients. In addition, studies aimed at understanding physicians' and patients' acceptance of state-of-the-art preventive guidelines must be replicated in different health care settings with a variety of participants and research methods.

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