

Author's response to reviews

Title: Acceptance and perceived barriers of implementing a guideline for managing low back in General Practice

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Version: 2 **Date:** 15 October 2007

Author's response to reviews: see over

Dear editors, dear reviewers

Thank you for your kind consideration of our manuscript. We also want to thank the reviewers for their critical comments, which helped us to clarify the objective of our manuscript.

Here is our detailed response to the concerns raised by the reviewers. We have highlighted all changes made to the manuscript except corrections of grammar.

Please don't hesitate to contact me if you have any problems or questions regarding our manuscript.

Best wishes,

A handwritten signature in blue ink, appearing to read 'J.F. Chenot', is centered on a light blue rectangular background.

Jean-François Chenot for the authors

Reviewer: Marloes Amantia van Bokhoven

Reviewer's report:

General

Thank you for the opportunity to review this paper from this large German group. I appreciate their efforts to implement guidelines in an evidence based manner, while the position of general practice is not as strong as in some other countries. The findings seem to me valuable as they describe the perceived influence of contextual factors, regarding the health care system on guideline adherence. In my opinion the paper is sufficiently clear to read, though some improvements of structure and language would positively add to this.

Major Compulsory Revisions (that the author must respond to before a decision on publication can be reached)

1. The aim of the authors is to explore the acceptance of the LBP guideline. However, they mainly chose a quantitative method. I would expect qualitative methodology more suitable. The remarks of the discussion (table 4) are useful in this respect, but a description of data extraction and analysis according to qualitative methods is lacking in the methods section.

We agree that a qualitative approach as chosen by Schers et al. is more suitable to explore acceptance of a guideline. This small research project was embedded within a large RCT, therefore we choose a more convenient questionnaire. We state now in the abstract and the method section that we include comments from GPs derived from protocols of the sessions. We have no verbatim transcription of the sessions. We collected concerns and comments using metaplan technique from Eberhard Schnelle, which is very popular in Germany for structuring group discussions. Members of a group write down comments on cards which are grouped according to themes in groups on a board. Similar statements were summarized. These cards were the basis for the protocols of the last sessions. We only report comments made at least during two different sessions, but we did not quantify frequency. This is now described in the methods section (*page 6*)

- Schers H, Braspenning J, Drijver R, Wensing M, Grol R. Low back pain in general practice: reported management and reasons for not adhering to the guidelines in the Netherlands. Br J Gen Pract 2000; 50: 640-644.
- Schnelle E. The Metaplan Method; CommunicationTools for Planning and Learning Groups. Metaplan series No. 7, Hamburg, Quickborn 1979

2. In my opinion the timing of the study, AFTER the intervention, is not optimal. As the authors state in the introduction, interventions need to be based on the findings from the analysis of determinants. In this way the interventions may have influenced the findings of this study. No analyses was done to check for this effect. Furthermore, the intervention might have benefited from the findings from the analysis of determinants. Could the authors comment on this, especially in the limitations section of the discussion?

As stated in the first paragraph of the methods section we are only reporting results of the questionnaires and group discussions of the intervention arms of the larger RCT (*page 5*). We did not attempt a pre-post comparison. The guideline was not yet officially published when we started the educational intervention and we assumed that most GPs were unaware of alternative guidelines on low back pain. Knowledge of guideline content is a prerequisite for evaluating acceptance of a guideline and discussing perceived barriers adhering to it.

We agree that answers to questionnaire do not necessarily reflect real life behaviour; therefore we have added a caveat to the limitations section (*page 8*).

3. No information has been given on the evidence base of the chosen interventions, nor if the intervention strategies were tailored to the determinants and intervention objectives.

There is a debate and a lot of research done on how to implement guidelines effectively. We have cited relevant reviews dealing with this topic (Cabana et al.). Here we report the evaluation and acceptance of a guideline within a RCT investigating the effectiveness of quality circles for guideline implementation (*page 5*). The approach is different from other intervention to promote guideline adherence for LBP and has to our knowledge not been evaluated previously. The guideline is tailored towards helping general practitioners to manage LBP as stated in the introduction and not towards a specific intervention (*page 3*).

4. It does not become clear if the quality circles were already existing, and if so, what approach they use for quality improvement. If the quality circles were only organised as part of the intervention, they may not be comparable to regular quality circles.

The quality circles were only organised temporarily as part of the intervention. This is now clarified in the method section subsection intervention (*page 5*). We agree that they may not be comparable to regular

quality circles, however regular quality circles show large variations in activities. We rather wanted to point out that we were using techniques frequently used by quality circles and that we were not lecturing GPs on how to manage LBP. To clarify that we have changed the phrase interactive group sessions organised like QCs (*page 5*).

5. The questionnaire was self-developed. How did the authors ensure that all relevant issues were tackled? It seems to me that some questions are multifaceted which may result in agreement with one part of the question and disagreement with another. I suggest the authors compare their questionnaire with what is known from the literature and comment on this.

As described in the method section we piloted the educational intervention in an established quality circle in Kassel. The development questionnaire was influenced by the feed back of the participating GPs. We have expanded the section referring to the questionnaire (*page 6*).

Some of the questions (Table 2 and 3) are indeed multifaceted. This can unfortunately not be changed.

6. As the authors state GPs' answers regarding their change process are contradictory. However, I do not understand their explanation that this may point at the different treatment of elderly and younger patients. Furthermore I miss the possibility that GPs changed their behaviour into the wrong direction.

If GPs already treated patients guideline concordant it is surprising that they simultaneously indicated that the guideline changed their management of LBP. Traditional management of patients with bed rest and injection is hard to change in elder patients used to this approach. The feeling that they changed something refers to the younger patients where they feel it is easier to promote staying active and oral analgesics.

We have no reason to believe that we have influenced GPs into the "wrong" direction. We rather feared not to change anything at all. The aim of this paper is to report acceptance and perceived barriers of a guideline and not actual behaviour. The effects of the intervention on patients outcome compared to GPs in the control group (which is not included in our sample) has been accepted for publication in *Spine* and will appear soon. The publication on guideline concordance is still work in progress. Measurement of guideline concordance based on limited information clinical information is however delicate. We can only state that the proportion of patients receiving a specific diagnostic or therapeutic intervention indicated appropriate or inappropriate use according to guideline criteria.

7. It is known from the literature that GPs' reported behaviour may not be the same as their actual behaviour. I miss a critical reflection on this.

We have added a section emphasizing this point in the discussion subsection (strength and limitations) (*page 8*). Within the trial we observed actual behaviour. The paper reporting those results is under review elsewhere.

8. In my opinion too many results are either described for the first time or repeated in the discussion (e.g: '...concerned that patients might feel pain...'; 'GPs wanted not only...'. I think they should be in the results section. I suggest that the authors stronger adhere to their structure of the discussion: summary of main findings in the beginning and discussion of implications later on.

We have expanded the results section and provide a short summary of Table 4 (*page 7*). Additionally we erased some passages from the discussion.

9. In the discussion section authors sometimes present opinions as facts. This is most clear in the conclusion: The findings are that GPs' have certain hypotheses about the patients' opinion. Next, it is stated that the patients have certain opinions and that these opinions need to be corrected. Finally, the authors state the way in which that needs to be done, without a comment that this is their opinion.

To make clear when we where using statements, we refer to the GPs. We agree with your comment regarding the conclusion and have changed the wording to allow the reader that this is our opinion.

Minor Essential Revisions (such as missing labels on figures, or the wrong use of a term, which the author can be trusted to correct)

1. I agree with the authors that social desirability may be an issue in this study, but I am not convinced that this influenced participation in the study. I rather think it may have influenced the GPs' answers tot the questionnaires. Please comment.

We agree that this might be more relevant and rephrased that sentence (*page 8*).

2. Though the language is clear enough to read easily, I think it may improve quite a lot if a native speaker corrects the manuscript, as

there are quite some smaller language mistakes. Two spelling examples: page 10: also concerned also, archive instead of achieve

We had the manuscript revised by an native speaker.

Discretionary Revisions (which the author can choose to ignore)

What next?: Unable to decide on acceptance or rejection until the authors have

responded to the major compulsory revisions

Level of interest: An article of importance in its field

Quality of written English: Acceptable

Statistical review: No, the manuscript does not need to be seen by a statistician.

Reviewer: Carsten Oliver CO Schmidt

Reviewer's report:

General

This article gives an interesting insight into GPs reasoning about guidelines in Germany. The topic is of relevance to health policy.

Major Compulsory Revisions (that the author must respond to before a decision on publication can be reached)

Minor Essential Revisions (such as missing labels on figures, or the wrong use of a term, which the author can be trusted to correct)
Abstract methods (p. 2) In the methods paragraph they did not mention the group discussion. Please add.

We have addressed the group in the abstract

Methods – Intervention (p. 5)

There is no intervention of primary interest in this paper. Therefore the header of this paragraph seems misleading. Rather, whatever is of interest for the description of the sample should be subsumed under "General practitioners", and whatever concerns the "Data collection" should be mentioned there.

We have erased the subsection heading intervention. We agree that this heading was misleading with regard to reported results.

Results, Group discussion (p. 7)

How many groups, how many participants ? – I did not find an explanation in methods. Please add and give a short summary of the main findings in the results section.

We have clarified this in the methods section (*page 6*) and give a summary of Table 4 in result section (*page 7*).

Results, sample characteristics (p. 7)

When the authors state "basic demographic data" I suppose they mean age and sex. Please just talk about these variables explicitly - "basic demographic data" is too diffuse.

We have erased "basic demographic data" as suggested and give now the details (*page 7*).

Discussion, Strengths and limitations (p. 8)

Again: The authors may have a representative sample in terms of age and sex, but likely not in terms of "propensity to adhere to guidelines" - as the authors correctly state themselves.

Please do only state that the age/sex distribution is similar to the GP population but they may not assume "that we have a representative sample of GPs". The low participation rate needs to be mentioned (# 72 practices from a population of 818 practices).

We have expanded the strength and limitations section addressing these concerns (*page 8*). Trying to get GPs and practice nurses to participate in a trial which requires showing up regularly for educational interventions is a difficult task. Including the control group a participation rate of slightly above 10 % is not to bad.

Results, access to rehabilitation (p. 7)

The authors state that "More than half of the GPs had no local access to Multimodal rehabilitation for patients with chronic LBP.". It may be preferable to state "multimodal pain programs", as was done in the abstract, and in the discussion section, instead of "rehabilitation". The latter term may be misleading because of its different meaning in the German health system. An according change should be made in Table 3.

We have corrected this.

Discussion – traditional treatment of older patients (p. 9)

I cannot see where this result comes from. I suppose the discussion groups. Please be explicit. How many GPs stated this. Please state the underlying findings in results.

This was statement made in several groups and sometimes by several GPs in one group. However, we cannot quantify how often this was stated. This is now clearly stated in the methods section (*page 6*).

Discussion (p.9)

"Therefore colleagues giving in assumed or real patients expectations which are not guideline...". I do not understand what the authors mean. Please rephrase.

We have rephrased this sentence.

Discussion (p.10)

“Even though most GPs stated that guideline recommendations for chronic low back are helpful.” – This sentence seems to be out of context or it should be rephrased.

We have erased this sentence.

Discretionary Revisions (which the author can choose to ignore)**Abstract conclusion (p. 2)**

I think in addition to public education GPs’ training with regard to patients’ expectations should added.

In fact, a lot of GPs wished for training in communication skills, but they did not write it on metaplan cards.

What next?: Accept after minor essential revisions

Level of interest: An article of importance in its field

Quality of written English: Needs some language corrections before being published

Statistical review: No, the manuscript does not need to be seen by a statistician.