Implementing the 1998 Canadian Asthma Guidelines

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An English professor of general practice was quoted as saying, "The problem is not with acquisition of new knowledge, but with the application of that knowledge." Such seems to be the problem with guidelines—knowing guidelines' recommendations does not mean family physicians will follow them. We know that lecture-style CME events are ineffective in changing FPs' performance.[1] But before trying to change performance, we need to know what influences FPs to adopt guidelines.

When Lockyer[2] looked at factors that affect implementing guidelines, she made four recommendations:

1. Develop a profile of physician practices relative to the guideline.
2. Determine the key messages in the guideline.
3. Consider barriers to adoption.
4. Assess resources available.

Results of the Physician Asthma Management Survey by the Laboratory Centre for Disease Control[3] showed that FPs need to improve how they manage asthma in the office. The report's final recommendation was to improve and evaluate clinicians' knowledge *and application* of recommended practice guidelines. (Emphasis added.)

With respect to Lockyer's[2] second recommendation, the Canadian Thoracic Society's (CTS) guideline implementation subcommittee has agreed to produce a 1-page summary card for FPs, listing the five or six most important guideline recommendations. These will also be communicated to FPs in other ways, which I address later.

Potential barriers to adoption

Factors that both favour and prevent FPs from adopting guidelines have been determined by a Dutch group.[4] Any recommendation that requires substantial reorganization of the practice and its staff was less likely to be adopted, as were vague, nonspecific, or controversial recommendations.

Lockyer[2] noted several potential barriers. The first was having many guidelines for the same condition. Many countries produce their own guidelines for asthma, and I have been unable to compare them all, but, for example, the asthma guidelines from the CTS[5] and the British Thoracic Society (BTS)[6] were mostly similar but had enough differences to generate uncertainty. The most obvious difference was in graphic presentation. The BTS guidelines used stepped care, and the CTS guidelines used the asthma continuum concept. Family physicians in Canada are expected to follow Canadian guidelines.

The next barrier was an inadequate scientific basis for the guidelines. Fortunately the Canadian guidelines have been evidence-based since 1995; consensus opinion is resorted to only when insufficient evidence exists in the literature.

Complex guidelines will not be adopted if they cannot be quickly and easily understood or if major practice reorganization is required even if they are understood.[4] The Canadian guidelines are straightforward and can be incorporated into daily practice with very little change in practice style.

Finally, both physician and patient barriers might need to be addressed. Physicians' knowledge and skill, age (younger physicians seem to adopt guidelines more readily[3]), and work environment all have an effect. For patients, poor compliance, lack of interest and information, and physicians' perception of patient barriers can all impede adoption of guidelines.

Assessing and using resources available

Lockyer's[2] fourth recommendation for successful implementation, assessing resources available, has been done by the CTS's implementation subcommittee. They have recognized that both national and local approaches are needed. A three-phase plan (**Table 1**) has been devised, which addresses not only physicians and (other) asthma educators, but also information for patients.

Table 1. Proposed schedule for implementing the 1998 update of the Canadian Asthma Guidelines

PHASE 1: DEVELOPMENT AND PUBLICATION
• Publication of full version in medical press
• Publication of a 4- to 6-page synopsis in various professional journals
• One-page summary mailed to all Canadian physicians and published in interdisciplinary journals
• National Guidelines Launch conferences (two) for those invited to help promote the guidelines
PHASE 2: INTENSIVE NATIONAL DISTRIBUTION
• National workshop program for family physicians
• Posting on the Internet of all three guideline versions
• "Op-ed" pieces and case-based discussions in professional journals and articles in the medical press, eg, *Medical Post*, *Family Practice*, and French-language equivalents
• Five to six "short reminders" distributed at intervals to family physicians
PHASE 3: PUBLIC DISSEMINATION
• Promotion of a lay version of the guidelines, for integration into an aggressive national distribution campaign

A British group[7] took a similar approach with the 1998 update of the BTS guidelines. A copy of the guidelines and information about local guideline meetings were mailed to all general practitioners, who could also request a series of charts summarizing the main points of the guidelines. The local meetings comprised presentations on the guidelines followed by discussion about local implementation. Both medical and lay press were notified of the release of the guidelines, and news releases were prepared for the lay press (including the names of local spokespersons for the guidelines). Their evaluation showed that 60% of general practitioners were aware of the revised guidelines and their recommendations.

Overall, the program was successful, but the level of success varied. For example, use of high-dose inhaled corticosteroids to gain control of asthma improved to 82% from 68%, but one third of FPs still did not provide patients with written action plans.

Different versions of the updated CTS guidelines will be made available for different populations. In particular, a 1-page summary of the guidelines will be produced for FPs, but a lay version will also be produced (a few months after the guidelines have been presented to health professionals) for promoting the guidelines through the mass media.

Successful strategy for change

The most successful strategy for bringing about change in the way physicians practice is a multifaceted CME approach.[1] In addition to providing summary cards for FPs, a series of workshops will also be organized, and regional focus groups will be held for FPs, asthma educators, and pharmacists. Following the guideline mailings, up to six different reminder cards will be sent to FPs regularly. Each card will succinctly highlight an aspect of the guidelines.

The CTS has produced a practical document that is relevant to family practice. If the strategies for implementing its recommendations are successful, the standard of asthma care in family practice will improve.

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