A Report on Results of a Qualitative Study on the Factors affecting the Implementation of Clinical Back Pain Guide

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Abstract

Introduction: Today, the use of clinical guidelines is increasing. Unfortunately, their use in therapeutic clinics is facing barriers. The purpose of this study is to investigate the barriers to the use of clinical guidelines to try to resolve them. **Methods and Materials:** Qualitative study method was used to study the barriers of using clinical guidelines. 15 physiotherapists from the private and public centers of Tehran participated in the study. In one interview, all of their comments were recorded in relation to the clinical management of back pain. **Results:** After interviewing each other, their views were summarized and eventually classified into five groups. **Conclusions:** Despite the positive attitude of interviewed people towards using clinical guidelines, the results showed that there are significant barriers in this regard. Some of the most important barriers are: Content validity of the guide , Individual attitudes , Authorities influencing the implementation process , Financial factors and Publishing and implementation strategy

Keyword : Guideline Implementation, Impliments Barriers, Low Back Pain Guideline

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Introduction

In recent years, several clinical guidelines have been developed to diagnose and treat low back pain in different parts of the world (1, 2). Despite the increasing spread of clinical guidelines and their importance in diagnosis and treatment, but as expected, it has not been used in clinics (3). Researchers are trying to look for the causes of lesser therapists' use of guidelines. Examining the obstacles to implementing clinical guidelines in clinics can provide a clearer perspective on this and help bridge barriers (4, 5). The aim of this study was to investigate the qualitative aspects of a number of physiotherapists in Tehran based on the clinical management of back pain and their implementation barriers in their clinics.

Material and Methods

For this study, invitations were sent by mail to physiotherapists working in private and public centers of Tehran, and, in explanation of the purpose of the study, they were invited to conduct the interview. Finally, 15 physiotherapists were interviewed and each interview was conducted individually, and their comments regarding the level of knowledge with the clinical management of back pain and the reasons for not doing so in their clinics were asked.

Results

The results of the interviews are reported in 5 general topics.

1- Content validity of the guide

2- Individual attitudes

3. Authorities influencing the implementation process

4. Financial factors

5. Publishing and implementation strategy

1. *Content validity of the guide*

-Evidence-based

-Flexibility

Evidence-based guide

Interviewees had different and sometimes contradictory opinions about the scientific validity and evidence-based nature of the guide. One of them believed that since there is insufficient evidence for some of the issues discussed in the guide, there shouldn't be definite recommendations about them in the guide. One of the interviewees believed that, in some cases, the guide contents are contradictory to the existing evidence, and undermine the scientific validity of the guide. On the other hand, two individuals believed that the guide contents were completely match with the existing evidence and it was designed based on available guides and valid scientific resources. Overall, there may be doubts regarding the scientific validity of this guide that prevents it from being implemented. One person noted that in order to overcome this impediment, as one of the stages of intervention in this study, we can introduce the design and development course of this guide and the resources used so that they can be assured of its scientific authenticity. On the other hand, the interviewees believed that guide recommendations were not so consistent with academic education, and this would be one of the reasons justifying physiotherapists' resistance to implementing the guide. "Basically, the current educational system is formed in all levels on the basis of a biomedical perspective, and therefore some aspects of this guide are unknown for people; however, it doesn't mean that they have not heard of it, they may not believe it," and "guide recommendations are inconsistent with the training given. Basically, it makes no sense to act based on the evidence within the framework of the training given".

The comprehensiveness and applicability of the guide for a full range of patients with back pain

From the perspective of the interviewees, this guide is not applicable to all patients with back pain. They believed that the patients' classification is very general in this guide: "I think that acute and chronic classification does not work. At present, the use of subgroups is not taken into consideration too much. There should be a more distinct distinction between back pain patients and then we'll see it works for some subgroups and doesn't for the rest. "And" Not all pains are of the same degree. In some cases, these recommendations work well, that is, the patient gets well with two relaxation exercises, but when the pain is severe, I believe that exercise alone is not enough, the patient does not accept and agrees and it does not make sense to him. It is first necessary to use pain reduction methods to relieve pain and then exercise recommendations are applied ". "The type of injury and the onset of the problem starts is very important on the type of the treatment. I also believe that we shouldn't make the patient depend on the device. For example, a pregnant woman refers and has partial pain, and she wants her pain to be relieved and her muscles strengthened; here exercise works well and the client does not need to go back to the clinic and can do it at home ".

One of the interviewees believed that the classification presented in the guide was based on the bio-medical perspective, while today the world moves toward other perspectives in explaining the causes of diseases: "For example, according to a global study, some causes (back pain) are behavioral, some physical, and some others are psychosocial. The acute and chronic classification according to the biomedical perspective only takes into account the time criterion for classifying the types of back pain, which is very general. "On the other hand, one of the individuals believed that, despite the generality of the classification, this guide is applicable for all things. He believed that this classification is used in all the clinical guide in the world, because there is no specific definition of the back pain subgroups based on the current knowledge of humans. Overall, this guide does not seem to be comprehensive enough, and the recommendations cannot be used for all patients.

2-Individual attitudes

Individuals believed that therapists' attitudes play a crucial role in the implementation of the guide. They believed that if the therapists themselves were convinced that the guide was a useful tool that they could achieve the desired result by following its recommendations, they could overcome other obstacles to a large extent. It seems that the root of negative attitudes toward guide is related to its inconsistency with academic education. "I must first eliminate the inflammation, that is to say, to create peace. I cannot accept to discard the previous methods which yield positive results. I cannot accept a laser-free work." There are evidence-based. "

One person believed that use of special interventions, such as referral for MRI, or lack of advice to exercise and staying active (as stated in the guide) in many cases, is attributed to the fact that therapists fear from possible consequences and as well as lack of patient's revisits; therefore, they prefer to act with extra caution.

3. Authorities influencing the implementation

From the point of view of patients (clients), colleagues working in other specialties, academic individuals, and insurance organizations were the most influential authorities. People believed that the patient's desire and preference are decisive as other medical interventions: "Unfortunately, when a patient who goes to the clinic in Iran, if we advise him exercises for an hour, but do not use the device, he would tell us why you did not do anything for me, that is, the patient imposes what we do for him/her" and" If we do not use the device for the patient, the patient would say: I can do the exercise at my home, I came here for the device ". On the other hand, one of the interviewees, while expressing the influence of patients, believed: "if I am convinced, I will certainly spend time and justify the patient. The place where I work is very traditional, but, in the same environment, if I explain to patients they will accept it, however, it's time consuming. "One of the individuals believed that the response and feedback of the patient was very decisive." When I get good result on 10 patients, I will do the same for the eleventh one, which means patient satisfaction and feedback is very important."

Contrary to these views, one person believed that he did not request a particular method because patients did not have much information about the treatment methods. Although he believed that the patient might compare therapist's work with other clinics and therapists and raise some requests, he does not act based on the patient's request and does the procedure that is good for the patient. One of the individuals believed that if the therapists' attitudes were corrected, one could change the patient's preferences: "Many of the views and attitudes of patients originate from the therapists' views that (consequences) are now coming back to ourselves." Another influential authority was the specialists of other fields. Since most patients referring to physiotherapy clinics are referred by other specialties such as orthopedists, neurologists, and even general practitioners, as long as these colleagues have no belief in the recommendations given in the guide, they (recommendations) cannot be implemented. "For example, if we say MRI or riboksin is not beneficial, a neurologist would take offence and (s) he may still recommend the above things." "This guide is not just about physiotherapists, it's multidimensional. There is a medical and diagnostic discussions as well. It's a team work, perhaps a patient with back pain should be visited by a team consisting of a physiotherapist, a psychologist, a neurologist or orthopedist because this is a multidimensional guide that requires at least the presence of higher-level individuals working in different specializations who decide on how to properly deal with patients. If there is a difference between the views of these people; for example a neurologist believes that the patient should have two weeks of absolute rest, but the physiotherapist induces a different view, it will be hard work; but if everyone is in harmony, the patient will not be confused and will undergo surgery more effectively".

Other important authorities were insurance organizations. Interviewees believed it would be problematic for therapists who have contracts with insurance like government centers, to follow the recommendations of the guide, including using exercise and not using other interventions like lasers: "The insurance has a specific instruction, based on which the insurance inspector checks and says: we will consider, for example, 20k for this type of the back pain, which consists of 4 interventions, why only one (exercise) is carried out, that is, if we do not act on this basis, we will face a legal problem. We are under the compulsion of high-level institutions. In these circumstances, if the patient complains that the work is incomplete, we are convicted. "

According to the interviewees, among the cases referred to above, overcoming the compulsion of insurance organizations was the most difficult thing because they had no control over it. "It's not possible to overcome insurance standards and it's a factor that is beyond our control." Contrary to this view, one interviewee believed that the insurance instruction was not so effective and he does what the patient needs: "I do not care what the insurance says. For example, if it tell us to do anything for the patient, we have only 15K, and take money from the patient if you work harder. If I find out more work is needed, I will do more and charge no more money. "

One of the individuals believed despite regarding the recommendations of the guide as inappropriate, these recommendations can be trusted only when they are provided by an academic individual with treatment experience (and not only based on academic texts and articles), and thus change in our performance.

4. Financial factors

From the perspective of the interviewees, the recommendations of the guide is against with earning more money, which can act as a major obstacle to the implementation of the guide. In addition to the issue of insurance standards that are problematic in government centers and insurance contracting parties, people believed that such recommendations ignored a significant part of their capabilities and tools in more effective treatment and money-making: "This guide may remove 60-70% of our workload and actually disarm us. When this (guide) prevents us from doing what we know, it limits our financial resources. "

Another factor contradicting more money-making based on the implementation of the guide was the time-consuming nature of recommendations: "The financial issue is very important. Everyone may not be ready to spend an hour and advise exercise to the patient, the tariff is very low. Bearing in mind that the therapist occupies a bed and takes time, but does not earn a lot. "Although he believed that he would follow this method, if he gets good result from it, he would use compensatory remedies to overcome the problem of time-consuming procedure:" If I get good results, I can reduce exercise time and train the patient how to do exercises at home. "Contrary to these views, one interviewee believed that promoting evidence-based perspective and implementation of guide recommendations could have a positive impact on the money-making of the therapists: Now the labor market is saturated and is moving towards becoming more specialization), people like to attract more patients. What they are doing now is to bring the latest equipment, but if we move towards evidence-based performance, that aspect of costly equipment will be reduced, and good results will be gained in addition to lower expenditures. "

5. Publishing and implementation strategy

Individuals believed that the use of two strategies could be helpful in the implementation of the guide. The first one, which was emphasized by all interviewees, is education and information. They believed that it would be possible to effectively educate the beneficiaries even without making structural changes in the university education system: "We shouldn't expect much for such topics to be included in university books, we can provide sufficient awareness to relevant groups in a variety of ways, such as seminars, workshops, and retraining programs". However, they believed that if these trainings have specific features, they would be welcomed

more frequently. "We do not have good classrooms and retraining programs. Most colleagues are pursuing retraining programs that are less costly and certificates are issued for the participation." And "only theories are not taught in these trainings, and if skills are needed, for example, they will be taught in these trainings."

The second case was the supervised and compulsory participation by the higher-level authorities: "If there is no management requirement in our country, we will achieve nothing ". One of the individuals believed that even individuals should be forced to receive the trainings so that that they welcome them (trainings): "Now, retraining scores have no advantages, although they are said to be important, but we have not seen anything so far, if it is required that, for example, I have to obtain a certain score every 2 years, I've got to receive these trainings to keep my clinic open".

Individuals believed that in addition to holding classes and seminars, training can be presented through mass media, pamphlets, multimedia, and e-mails. They have given a special importance to the role of mass media: "Mass media are very important, the feedback given by patients on the effect of television programs is very interesting; for example, an 80-year old woman explained that all the information she received from the Hello, doctor program".

Individuals believed that in addition to providing education to the public, the media could also be used to inform specialized groups: "For example, it could be explained in a television program about the source of the clinical guide so that they are convinced that this guide has a solid scientific foundation."

Regarding the use of educational pamphlets, one of the individuals believed: "Pamphlets are better than other things like CDs and movies, because I think individuals can spend time and study at different time periods such as the interval between visiting two patients or while commuting, but they always have no access to laptop or PC to watch CDs. " Contrary to this view, one of the interviewees believed that multimedia could be more useful considering the possibility of creating more attractiveness.

Regarding the content of the training, individuals believed that they should be able to convince people during these trainings that the guide has a scientific foundation. To this end, one person believed that the guide concept should be clarified for the beneficiary groups: "The concept of a clinical guide is too vague for many individuals." Many people think the guide is the same brochures given to patients. "One of the people believed that "if one knows the meaning of existing evidence is, (s) he can make him/herself adaptable; for example, if (s) he overcomes /her his fear on the basis of existing information and supports, (s) he will come and advise on exercise." One of the people believed that to persuade people to follow the guide, a table can be designed in the training package in which all the recommendations contained in the global clinical guide s are presented so that people can compare it with the guide designed and then trust it. One of the individuals said that the first step in promoting the use of the guide is to let groups involved know about at a large scale: ""If there is no legal prohibition, the first step is to have a copy of the guide available to all relevant individuals. In addition to the guide, attempts should be made to present the preparation steps and resources used. "In his view, this will reduce the resistance of other relevant groups, including specialists. Afterwards, it is necessary to run the program in a pilot so that its implementation problems are identified. He believed that "the pilot program should be implemented where there are no insurance requirements".

Conclusions

Despite the positive attitude of interviewed people towards using clinical guidelines, the results showed that there are significant barriers in this regard. Some of the most important barriers are: Content validity of the guide, Individual attitudes, Authorities influencing the implementation process, financial factors and Publishing and implementation strategy

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References

1- Clinical Guidelines for the Management of Low Back Pain in Primary Care: An International Comparison. Koes, Bart W.,; van Tulder, Maurits W., *et al.* Spine: November 15, 2001 - Volume 26 - Issue 22 - p 2504-2513.
2- An updated overview of clinical guidelines for the management of non-specific low back pain in primary care. Bart W. Koes *et al.* European spine journal. December 2010, Volume 19, Issue 12, pp 2075–2094.
3- Effect on the process of care of an active strategy to implement clinical guidelines on physiotherapy for low back pain: a cluster randomised controlled trial. G.E Bekering *et al.* Qual Saf Health Care 2005;14:107–112
4- Barriers and Strategies in Guideline Implementation-A Scoping Review. Florian Ficsher *et al.* Healthcare 2016, 4(3), 36.
5- Development of an implementation strategy for physiotherapy guidelines on low back pain. Geertruida Bekkering *et al.* Australian journal of physiotherapy. Volume 43. 2003, Pages 208-214.