Guidelines for dyspepsia management in general practice using focus groups

A PALI S HUNGIN

GREG P RUBIN

ANDREW J RUSSELL

BERNADETTE CONVERY

SUMMARY

Background. *There is a paucity of published guidelines on managing dyspepsia in general practice. Existing guidelines emphasize the role of investigations and drugs rather than management approaches. Focus groups are a means of uncovering the way in which the participants think and work in the pragmatic setting, and have not previously been formally used in creating guidelines.*

Aim. *To develop guidelines for the management of dyspepsia and to assess the use of focus groups of general practitioners (GPs) in order to do so.*

Method. *Initial evidence-based guidelines were proposed by a group of four GPs with an audit facilitator, and used for discussion in three focus groups using a standard format. An anthropological analysis of the proceedings led to modifications of the original guidelines, based on knowledge, perceptions and attitudes. The study was set in three distinct locations involving 30 GPs. The outcome measures consisted of feedback, categorized by types of responses, from the analysis of the focus groups and the creation of guidelines.*

Results. *The resulting guidelines were patient centred and based on the principles of good consultation. They encompassed patients' fears and doctors' clinical uncertainties, and allowed flexibility in the individual patient's management. The focus group methodology exposed a substantial number of GPs to guideline development, and had the added benefits of dissemination, peer review and educational challenge.*

Conclusion. *It was possible to develop guidelines for dyspepsia using focus groups. The methodology had the added benefits of ownership, peer review, exposure of educational gaps and locality factors, and dissemination of good practice. It included steps from evidence review to implementation strategies. The development of this technique could lead to a strategy towards the creation and application of evidence-based and professionally acceptable clinical guidelines and practice on a locality basis nationally.*

Keywords: guidelines; dyspepsia.

APS Hungin, MD, FRCGP, DRCOG, general practitioner, director, Northern Primary Care Research Network (NoReN), The Health Centre, Eaglescliffe, Stockton on Tees; GP Rubin, MRCGP, general practitioner, research fellow, Northern Primary Care Research Network, The Health Centre, Thornaby, Stockton on Tees; AJ Russell, MSc, DPhil, Department of Anthropology, University of Durham; B Convery, MSc, facilitator, Cleveland Medical Audit Advisory Group.

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Introduction

THERE is a paucity of clinical trials and published guidelines for the management of dyspepsia in general practice,[1] despite guidelines for using endoscopy.[2] Many of those available tend to be from outside general practice, e.g. from gastroenterologists or pharmaceutical companies, and despite sometimes representing consensus from mixed groups, they risk interpretation as products of self-interest or unsolicited advice.

Part of the difficulty of developing dyspepsia guidelines is a problem with its definition.[3,4] 'Dyspepsia' overlaps with other gastrointestinal problems, e.g. irritable bowel syndrome,[5-7] and engenders uncertainty over non-gastrointestinal problems such as angina. Also, many existing approaches omit the consultation as the starting point and use dyspepsia as an implicitly defined entity with which management begins. As algorithms, such guidelines delineate pathways,[8,9] but, because they focus on a defined presenting entity, they exclude the more diffuse constellation with which many patients present in general practice. Misdirected management can ensue if the initial symptoms are not interpreted within the context of the patient's perceptions.

Basic general practice teaching stresses the need to explore the patient's fears and perceptions and the importance of unmasking the factors leading to the consultation.[10] For dyspepsia, research has reiterated that differences between consulters and non-consulters are more likely to be related to perceptions and fears (e.g. of cancer or heart disease) than characteristics such as duration or intensity of the symptoms.[11] A seemingly excellent management plan based on probable endoscopic appearances may thus miss the mark if the patients' concerns are ignored.

GPs' own involvement in guidelines creation is crucial to ensure representativeness and 'ownership', and to increase the chances of their uptake.[12] Although specialists have specific expertise, their vantage point differs from those in primary care, and factors relating to service provision, e.g. waiting times, may influence their initiatives. Clinical goals may differ: in hospital practice, the emphasis may be on discovering pathology, whereas in general practice it is often more important to establish normality[13] and to provide symptom relief.

The purpose of this project was to develop guidelines for managing dyspepsia in general practice using focus groups. The process was based on recommendations in the published literature,[12] commencing with a literature review, initial consensus and modification with objectively analysed feedback. Instead of drawing up a prescriptive pathway, the guidelines aimed to describe good management and incorporate GPs' own uncertainties during the consultation. The study describes the process of developing guidelines using the inherent characteristics of focus groups to educate, disseminate and implement, but does not undertake their formal analysis in practice.

Focus groups

Focus groups have been described as an important research tool.[14,15] Kitzinger[14] describes them as a form of group interview that capitalizes on communication to generate data. They are particularly useful for exploring knowledge and experiences and for examining people's thoughts and the processes behind them.[16]

They allow the participants to become actively involved in the process of analysing the concepts under consideration.[14] Where the aim of the research is to improve services, the facilitation of criticism and the generation of solutions is especially useful,[14] as participants are able to offer critical feedback without feeling that shortcomings in services or patient management are a result of their own inadequacies.[17] The importance of maintaining context in the topic being evaluated[18] is an important attribute, allowing local conditions to be considered and enabling a study of how consensus and conflict are handled.[16,19] Challenging theoretically perfect concepts with accounts of what people actually do,[12] and uncovering insights and educational gaps, are important steps in initiating change.

Focus groups are ideal for exploring a subject such as dyspepsia, for which clinical definitions are open to interpretation and practice-based management often does not follow conventional advice, such as restricting gastroscopy to older patients in whom pathology is more likely. Also, despite being part of a large professional community, most doctors' support bases are in small local subgroups.[21] Focus groups share this advantage and have the power to influence attitudes. Developing guidelines using this mechanism thus touches upon education and implementation.

Method

The process of guideline creation consisted of three phases: (1) evidence review and draft guidelines creation by a project group; (2) focus group discussions with GPs, within a standardized format; and (3) analysis of discussions leading to suggestions for modifications of the original guidelines.

Evidence review and guidelines creation by project group

A group of four GPs and a non-medical audit facilitator, convened by the Cleveland Medical Audit Advisory Group (CMAAG), met at the first stage to develop guidelines. The GPs were a non-fundholding hospital practitioner in gastroenterology, a fundholder, a trainer, and the chairman of the CMAAG.

The group reviewed published information on the management of dyspepsia from the point of first contact with the patient. Recognizing the complexities of decision-making during patient care, it was agreed that: (i) matters relating to the consultation itself were as important as those covering epidemiological and pathological factors; (ii) uncertainty about the definition of dyspepsia should be recognized, rather than assuming that it was a clear-cut entity; and (iii) drug therapy was not necessarily central to the initial decision processes and that, to avoid controversies, therapy decisions would be left to individual clinical situations. The guidelines were to be patient-centred management and pragmatic.

The literature search used MedLine, under keywords linked to dyspepsia, guidelines and general practice, and reference to review articles with attendant references. Key clinical management points were identified by consensus after four group meetings and reduced to those considered salient to managing dyspepsia in general practice.[6,10-12,22-38] Draft guidelines for a patient-centred approach were developed on this basis for the focus groups.

Focus group discussions with general practitioners

Three independent focus groups of 6–11 GPs in the Teesside and Hartlepool Health Districts in Cleveland met to consider the guidelines. Each group was drawn from a pre-existing local audit group. They were facilitated by the CMAAG coordinator and resourced by a member of the original consensus group. Each group followed a standard procedure. The facilitator introduced the topic with a copy of the draft guidelines. The discussion was handled non-directively and the session closed with mutual consent, the average discussion time being 55 minutes. The proceedings were audiotaped.

Analysis of focus group discussions

The transcripts were analysed by the Department of Anthropology, University of Durham, using the grounded theory approach. Themes were selected on the commonality of the discussions and an attempt was made to represent all the voices in order to cater for 'muted groups'. Themes that appeared 'muted' might have represented potentially dominant arguments in another locale and all the ideas expressed were therefore represented in the analysis, albeit with due regard for the frequency and vehemence of expression. Themes and counterthemes were highlighted where argument occurred as 'nodes of concern', points of contention surrounding medical practice, which could feasibly be expected anywhere in the UK and which might make the implementation of such guidelines problematic.

Results

Positive comments

The guidelines seemed to capture the participants' intellectual imaginations: 'It is an interesting way of doing a flow chart', said one, 'patient centred — I like that'; 'it's the way we think', reinforcing the argument that the guidelines were 'general practice-based ('reality'), rather than putting people into disease titles… because you don't really end up at that stage until quite a way down the line'. Concerns were raised about the management of dyspepsia, some of local relevance and others involving general uncertainty about how best to treat patients. The discussions revealed various decision nodes of concern, points of conflict and uncertainty, which were generally outwith the immediate concern of the guidelines, but which were likely to influence their uptake by GPs.

Table 1. Points identified by consensus group as a basis for developing guidelines.

1. Fewer than 50% of individuals with dyspepsia consult their GP. The difference between consulters and non-consulters is likely to be related to their beliefs and concerns about their symptoms. Duration, severity and patterns of symptoms, sex and socioeconomic factors are not overall determinants for consultation. A fear of a fatal or serious condition, particularly heart disease and cancer, are important determinants.[6,11,22,23]
2. Early investigation, regardless of a patient's age (and even if expected to produce a normal result), may have the advantage of: (a) directing clinical management more effectively; (b) altering the consultation and prescribing rates positively; (c) responding to the patient's needs more directly; (d) having positive economic consequences; and (e) being linked to the detection of early gastric cancer.[10,24-33]
3. Lower prescribing in terms of quantity and efficacy (also indirectly related to cost) may be more likely if a specific problem is being treated.[34-37]
4. Serious lesions, such as gastric cancer and peptic ulcer disease, are relatively rare in patients under the age of 40 years.[38]
5. Guidelines, created with pragmatic management focusing on a specific clinical area with the active participation of the potential users, are more likely to contribute to patient care than flow charts based on investigations and drug regimens.[12]

Nodes of contention

Patient-centred versus doctor-centred approaches. There were long-running arguments between patient-centred and doctor-centred approaches. Not all GPs were happy to accept the patient-centred aspects. 'I think it is too much from the patient perspective rather than the clinician's or even a combination of the two,' said one. 'I am not really so concerned with why a patient comes to see me,' said another, 'I think of that as being a little irrelevant — what the patient fears. You know, I think that patient has to be guided by us to some extent.' This reflected an underlying anxiety about patient-centred approaches and the extent to which doctors feel that their position is being undermined. Said one GP, 'You have got to listen to patients and help them interpret what they're experiencing because…they have a lot of funny ideas; often they're right, but often they're not — what about the doctor's fears?' One group suggested that the guidelines may have bias in assuming that all patients would be able to articulate what was wrong and what their fears were. A concern was the extent to which patients themselves would subscribe to the patient-centred approach.

Non-ulcer dyspepsia also raised concerns, particularly as to how a normal endoscopy would affect lifestyle. 'Do they feel that if they drink heavily, smoke and they have a normal endoscopy, that they can carry on?' Counselling about lifestyle was considered appropriate, but of limited effectiveness.

Recent developments in the investigation and treatment of dyspepsia.

The discussions highlighted the fact that GPs were still accommodating recent developments in the diagnosis and treatment of dyspepsia, and that a great deal of uncertainty still existed. The main points concerned open-access endoscopy, 'which, 10 years ago would only have been offered if gastric cancer was suspected, but can now be used even to establish normality'. Waiting times were crucial and all agreed that it had an impact on their prescribing behaviour, e.g. the 'blind' use of anti-*Helicobacter* therapy or PPIs.

Uncertainty about when to treat *Helicobacter pylori* and the need for a specific diagnosis before treatment, was a common discussion point. Perhaps surprisingly, there was palpable scepticism about the link between *Helicobacter pylori* and duodenal ulcer disease: 'Why do so many people who are *Helicobacter pylori* positive not have demonstrable ulcers? Should we not treat them as well?' This showed a belief model at variance with that of most gastroenterologists.

Treatment with PPIs raised much contentious discussion. 'Magically effective', commented one GP, while acknowledging the high cost of purely symptomatic treatment for a non-life-threatening condition (presumably gastro-oesophageal reflux). Some stated that they had avoided using PPIs altogether, regardless of clinical indications, because of this uncertainty. Several GPs in the focus groups were, nonetheless, stimulated to audit their PPI prescribing.

Increasing emphasis on cost-effectiveness.

The transcripts revealed GPs trying to come to terms with the principle of cost-effectiveness in primary care. 'I don't think anybody is interested in cost-effectiveness, only in cost reduction,' highlighting the Family Health Service Authority (FHSA) for particular opprobrium. Discussion also focused on whether patients might be encouraged to accept cheaper medicines if they were told the cost of their drugs. The tone of the discussion around economic issues reflected the GPs' attempts to grapple with the principles of a market economy, which are new and in many ways alien to their training.

The guidelines

Table 2 gives practical suggestions and modifications to the draft guidelines.

Figure 1 shows the revised guidelines after incorporation of the points raised by the focus groups. This is shorter than the draft version and incorporates doctors' own fears and concerns.

Discussion

Most would acknowledge that the purpose of clinical guidelines is not to impose medical judgement or to imply that there is no other way to manage a particular problem. They do need to incorporate evidence and to reflect the views of clinicians, especially in a fast-moving field.[39] These guidelines fulfil these conditions in a local situation and, in principle, are of national validity. Their strength lies in tackling a clinical field that lacks randomized studies, and for which a formal hierarchically categorized search would have provided little definitive guidance for GPs.

The main difference between these guidelines and others was their patient-centred approach, with the nature and quality of the consultation seen as a fundamental part of the overall management. While accepting this patient-centredness, the GPs also wanted their own uncertainties recognized, and the final result attempts to reconcile the two. The guidelines reflected pragmatic practice and tried to optimize quality of care, rather than defining expedient routes for treatment, e.g. by recommending tests only for older patients or by supporting particular drug combinations. They illustrated dilemmas and discrepancies in approaches, rather than marking out a singular pathway. Developing them indicated that there has been an underestimate of the newer influences upon GPs — the shifting proposition of new treatments, dealing with cost conflicts and with uncertainties about the meaning and interpretation of dyspepsia. The exercise also identified gaps in the understanding of the management of dyspepsia and facilitated peer education.

There is a paucity of guidelines from GPs for many clinical conditions they encounter frequently. This may be a reflection of difficulties in acknowledging and studying the qualitative aspects of managing physical conditions, possibly because conventional medical training is along disease-oriented models. Guidelines rooted in general practice need to overcome the discomfiture of deviating from consultant-espoused approaches, and focus groups

Table 2. Practical suggestions and modifications to the draft guidelines.

1. The guidelines needed to be simpler — 'You can follow it but it is not easy on the eye.' If the guidelines were too complex to be retained mentally, they were unlikely to be adopted.
2. While agreeing that the guidelines should be patient-centred, it was felt that more emphasis should be placed on doctors' suspicions and fears.
3. In the section establishing the reasons for the consultation, some suggested highlighting a specific question, e.g. 'Do you have any idea what might be causing your problem?'
4. Lifestyle counselling should be included.
5. Acknowledgement that delays to endoscopy may determine the management plan.
6. Acknowledgement that the guidelines could not necessarily be relied upon to promote cheaper management.
7. That good communication between the GP and the specialist was necessary to respond to the patients' and the GPs' requirements.

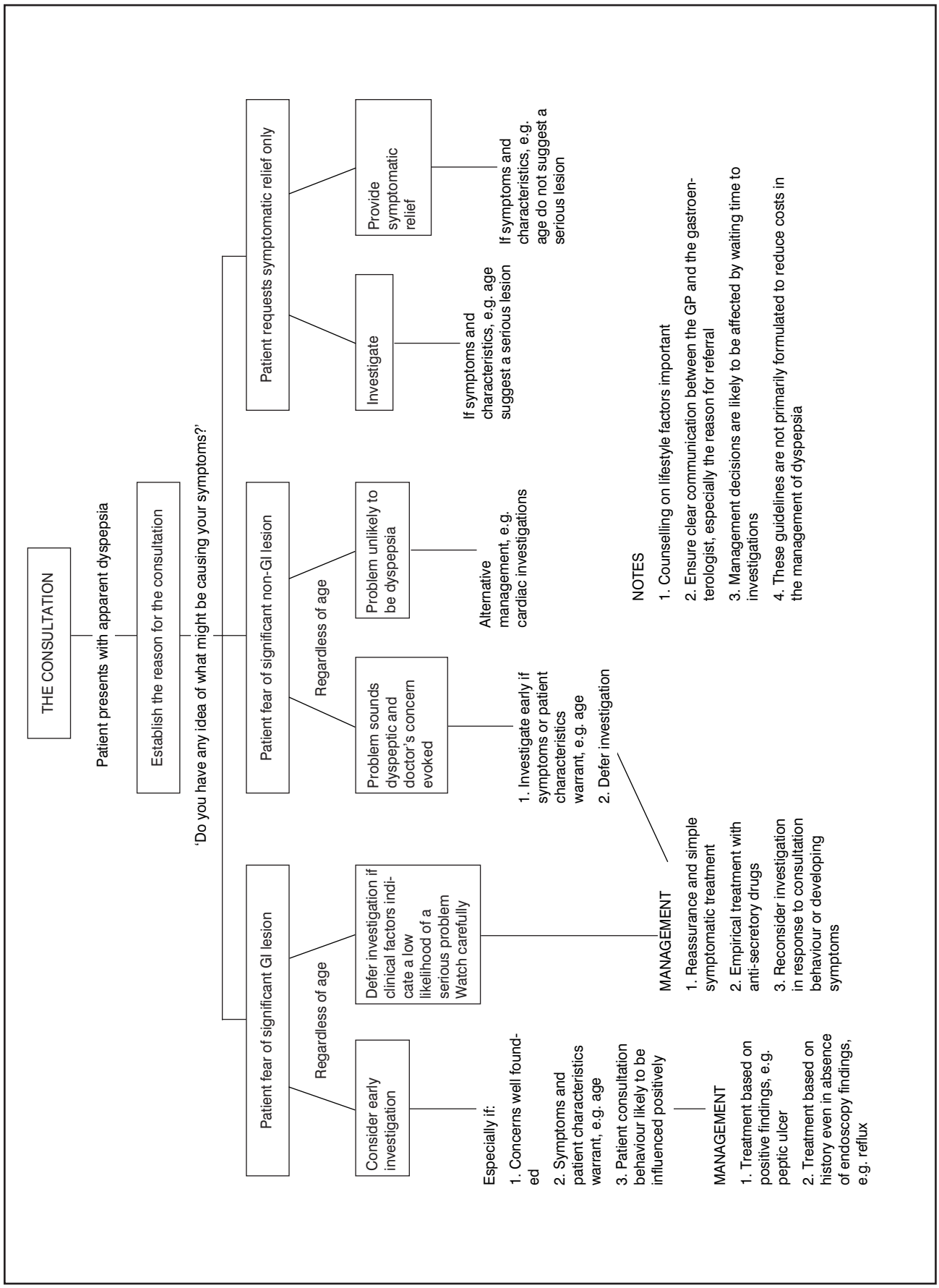

Figure 1. Guidelines for the management of dyspepsia in general practice described by focus groups.

provided a safe environment to do so.

A benefit of the focus groups was the incorporation of local conditions into the guidelines, enhancing their relevance. A potential problem was that they were likely to have been drawn from existing enthusiasts, thus limiting their value. However, the study demonstrated that the participants, representing 15% of local practitioners, consisted of those likely to be innovative and influential as opinion leaders, and that the effect of the groups is likely to have extended beyond the groups.[40-42] Another potential problem of this approach is that clinical areas, for which systematic literature surveys are unavailable nationally, will need to be reviewed locally with varying levels of expertise and resources, although, paradoxically, this may also strengthen their acceptability.

Steps recommended in the evolution of guidelines include implementation and assessment. Focus groups have the inherent characteristic of involving participants in implementing new ideas and modifying those at variance with peer values. As evidence, several GPs were led to audit their prescribing. However, the extent to which uptake and 'implementation' occurred was not measurable. Formal evaluation has problems in clinical topics beset with definition difficulties, latent patient needs, and changing management propositions. In dyspepsia, lack of unanimity about treatment represents a pitfall, as does pressure to prescribe powerful and expensive drugs for symptom relief alone. Arguments about empirical treatment before endoscopy are unlikely to be resolved immediately. There is a risk that attempts to produce tight guidelines will be hampered because they will not reflect pragmatic practice and keep pace with rapid clinical advances.

While recognizing the limitations of these guidelines, created but not tested in the practice setting, we suggest that focus groups are an important adjuvant in their development and dissemination. Defining wider goals and problems before tackling the details of specific clinical actions seems a logical approach, and this methodology represents a new way of describing and promoting quality in the face of rapidly shifting clinical propositions. The potential of focus groups to modify attitudes and to educate could be harnessed on a national scale. Together with their inherent advantages of ownership and local relevance, this also makes them tools for facilitating dissemination and implementation.

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Address for correspondence

Dr APS Hungin, The Health Centre, Eaglescliffe, Stockton on Tees, Cleveland TS16 9EA.