

Positive experiences with a specialist as facilitator in general practice

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ABSTRACT

INTRODUCTION: The use of facilitators for quality improvement in general practice has accelerated during the past decade. As general practitioners (GPs) or pharmacists have typically been used as facilitators, there is a lack of knowledge of how other professionals function as facilitators. This article explores the experiences and assessments of GPs and nurses participating in a project in which a medical specialist (endocrinologist) acted as a facilitator for quality improvement.

MATERIAL AND METHODS: This study is based on observations of facilitation sessions and interviews with the health professionals (13 GPs, four nurses, one endocrinologist) participating in a facilitation project in the Capital Region of Denmark.

RESULTS: The facilitator sessions primarily focused on pharmacological issues related to diabetes treatment. The respondents described the facilitation sessions as a positive and motivating learning experience, and the majority of them were able to point to specific learning outcomes.

CONCLUSIONS: The results suggest that for selected medical issues, a trained medical specialist can act as a facilitator in general practice to the satisfaction of GPs and staff. Future studies should assess the clinical effects of such facilitation programmes.

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Educational interventions for quality improvement in general practice have been carried out for more than 20 years [1]. While effects have varied across studies and contexts, active intervention strategies have generally been more effective than strategies relying exclusively on passive information transfer [1, 2]. Hence, the employment of facilitators in various kinds of outreach visit projects has accelerated during the past decade, and this has increased the need for studies that focus on the experiences of health professionals participating in such programs [3, 4]. Also, since general practitioners (GPs) (or pharmacists) have typically been used as facilitators in such interventions [3, 5-8], there is a lack of knowledge of how other professionals function as facilitators [3]. In fact, some studies can be taken to suggest that

other professionals will have problems occupying this role since they do not have sufficient legitimacy and experience from general practice [3, 4, 6].

This article focuses on a facilitator project (see **Table 1**) in which a medical specialist (endocrinologist) acted as a facilitator for quality improvement in general practice on the basis of standardized data on clinical quality. The issue of medical specialists acting as facilitators in general practice is important to explore for at least two reasons. Firstly, the transfer of knowledge between secondary and primary care is usually considered an important means to improve the quality of chronic care, and in many health care systems there is a growing interest in supporting collaborative arrangements between hospitals and general practice [10-12]. Secondly, educational interaction between hospital-based specialists and GPs has traditionally been sparsely researched [13], and only few studies have been published in which medical specialists attempt to facilitate learning from quality data. An exception to this is Smith et al 2008 [14], who report on a telemedicine intervention where endocrinologists provided e-mail feedback on patient data to GPs. In the present article, we present the findings from a qualitative study of the above-mentioned facilitation project which was carried out in 2010. The purpose of the article is to articulate the experiences and assessments of the GPs and nurses participating in the facilitation sessions.

MATERIAL AND METHODS

The article is based on a qualitative study employing observations and interviews. First, we observed (and audio-recorded) the seven learning sessions between the facilitator and the professionals from the nine participating clinics (**Table 2**). The telephone sessions were observed from the facilitator's office. The participants had been informed beforehand that a passive observer would be present during the sessions, and the observer presented himself briefly at the beginning of each session. Second, semi-structured interviews [15] were carried out in all participating clinics 1-2 weeks after each session. GPs and nurses were interviewed separately in order to let the nurses express themselves more freely (considering the employer-employee relationship characteristic of general practice as well as the traditional

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TABLE 1

The facilitation project.

Background	The facilitation project under study was set up by a group of GPs (from the Capital Region of Denmark) and endocrinologists (from the Steno Diabetes Center) aspiring to conduct a clinical randomized trial on the effects of employing medical specialists as facilitators (using various interactive techniques) However, it was decided to carry out a pilot project first and then (based on the experiences) to decide if and how a randomized controlled trial should be carried out The authors were asked to perform a qualitative study of the pilot-project sessions focusing on the experiences of the involved professionals
Defining facilitation in the project	In relation to the various definitions found in the literature, in this project the notion of facilitation primarily referred to the task of providing "expertise in the clinical area addressed by the intervention" and less to the act of providing advice on "techniques for structuring and driving a process of change" [9, p. 38] In this study, facilitation is closely related to the concept of outreach visiting [3], except that the facilitator did not visit all the participating clinics in person, cf. below
Training of facilitator	To prepare the endocrinologist for the role as a facilitator, the specialist participated in a two-day course conducted by a professional coach with prior experience from facilitation projects in general practice
Recruitment	24 GP clinics from the Capital Region of Denmark were invited to join the project Clinics were invited if they had reported type 2 diabetes data for more than one year to the national database for general practice This was the only selection criteria, i.e. the clinics were not selected on the basis of self-reported needs/-problems or an external assessment of quality indicators The clinics received a letter of invitation followed by communication via fax or/and phone Nurses were invited to participate in the sessions together with the GPs Lastly, the nine clinics who responded positively within the deadline were randomly selected to one of three types of interaction with the facilitator
The three interaction forms	1) Face-to-face meeting in general practice (duration: 60-80 min.) 2) Group meeting between the facilitator and participants from three GP clinics at the office of the specialist (duration: 150 min.) 3) Telephone 'meeting' between the facilitator and GPs (duration: 45-60 min.) Generally, no major differences in the contents and assessments of the sessions were found across the three communicative techniques in the project, and comparing these techniques is not the subject of this article Rather, we focus on the participants' experiences with receiving feedback from a trained specialist facilitator/supervisor

GP = general practitioner.

TABLE 2

Participants in the facilitation sessions and the subsequent interviews.

Clinic	General practitioner	Nurse	Type of facilitation session
C1	GP1	—	Telephone
C2	GP2 a	—	Telephone
C3	GP3, GP13 ^a	—	Telephone
C4	GP4	N2, N3	Personal visit
C5	GP5	—	Personal visit
C6	GP6	—	Group
C7	GP7	—	Group
C8	GP8, GP9, GP10	N4	Personal visit
C9	GP11, GP12	N1	Group

GP = general practitioner.

a) GP13 was unable to participate in the interview.

professional hierarchy between nurses and doctors) in a situation where opinions might differ. Observation notes and recordings from the sessions were used to adjust the interview guide prior to each interview (adding specific questions in light of the specific contents of each session). The interview guide addressed the overall experience of the sessions, reflections on the topics covered during the sessions, the usefulness of advice given, perceived learning outcomes and an assessment of the facilitator. The interviews had a duration of 30-45

minutes. Having completed these interviews, a one-hour interview was carried out with the facilitator in order to explore her perceptions of – and reflections on – the sessions. This provided an additional perspective on the sessions serving to enhance the credibility of the study [16]. All interviews were recorded and transcribed for analysis of the central themes of the study (i.e. thematic re-ordering of interview passages and comparison of statements within and across the interviews) [17].

Trial registration: not relevant.

RESULTS

Taking departure in the indicator-based data set from general practice, the facilitator sessions primarily focused on pharmacological issues related to diabetes treatment (see **Table 3**). Issues of local collaboration and referral, often associated with arrangements for improving chronic care across sectors, played no prominent role in the sessions of the present study as the participating clinics did not belong to the uptake area of the hospital at which the facilitator was employed.

Overall experiences and perceived learning outcomes

Generally, the professionals described their participation in the facilitation sessions as a very positive and motivat-



TABLE 3

The facilitation sessions: preparation, contents and facilitation approach.

Preparation	<p>Before each session, the facilitator received a standardized data set, which each clinic receives regularly from the national database for general practice</p> <p>The data set contains demographic and clinical information on diabetes patients affiliated to the clinic (gender, age, smoking status, blood sugar levels, blood pressure, microalbuminuria, cholesterol, type of medication prescribed and date of latest control visit)</p> <p>Reviewing the data looking for areas of possible improvement, the specialist made a (flexible) agenda for each session so that the data set constituted a starting point for discussions</p>
Contents of the sessions	<p>Talking about these data – and asking the clinics about their treatment goals – the facilitator focused on the possibilities for optimizing medical treatment, e.g. by increasing attention on specific indicators (such as cholesterol and blood pressure) or through the introduction of GLP-1s</p> <p>Also, the GPs and nurses were encouraged to ask any questions they might have in regards to diabetes treatment in general or specific patient cases</p> <p>This gave rise to several questions and talks about the treatment options for specific patients, the pros and cons of various pharmaceutical products, and the dosage and combinations of drugs</p>
Facilitation approach	<p>Generally, the specialist adopted an appreciative approach which consisted in:</p> <ol style="list-style-type: none"> 1) Commending the clinics on their work, e.g. “you seem to be good at using ACE inhibitors”, “these blood pressures looks really fine” 2) Acknowledging that some patients may be very difficult to treat ‘by the book’ due to issues of compliance and co-morbidity 3) Recognizing that the clinics’ distinctive knowledge of their patients made them best qualified to take decisions on what advice to implement and how

ACE = angiotensin-converting-enzyme.

GP = general practioner.



TABLE 4

Illustrative interview quotes referred to in the results section.

Question no.	Quotation
1	It was a very pleasant conversation which gave me an overview of things and it met my needs in regards to exploring blind spots in my practice. I also had some useful feedback on specific patients (GP3)
2	... the fact that she came to visit us made us talk about these data, all of us together [...] I think this is something I have been missing [...]. And just to experience that we had plenty of time and that it was okay to sit down and talk about this [diabetes treatment] which I put so much effort into, without being interrupted by a telephone or someone knocking on the door (N4)
3	Regarding diabetes, we know that all the other things we can do [e.g. motivate to dietary changes] are next to nothing compared to the effects of medical treatment (GP8)
4	We had some tips, e.g. that it is good to intensify the use of lipid-lowering drugs for several of our patients, but it was also fine that she stated that you do not necessarily give those drugs to patients who are really low on cholesterol. I mean, there is this popular idea that all diabetics should have lipid-lowering drugs, but if this was so, we might as well pour it into the drinking water. However, that was not her opinion and it is not my opinion either (GP7)
5	... I like to see the patients next week or the week after, so I can watch the patients more closely than they can at the hospitals. And I get confused in regards to side-effects if I treat them with several different things at once (GP3, referring to a session in which the endocrinologist had recommended combining several drugs at an earlier stage of treatment than usually preferred by the GP)
6	On the matter of albuminuria, she [the specialist] was in favour of a more aggressive approach. That was not so surprising but, I guess, we prefer more of a “wait and see” approach because sometimes it is persistent, and sometimes it is gone the next time we perform a test (GP6)
7	I feel quite competent in this area and I generally have good knowledge on which drugs to choose, but as for practical experience [...] I mean, I don't have that many complicated diabetes patients compared to an endocrinologist, so I had some good advice based on her experiences at a specialized department (GP7)
8	I don't mind having someone checking on me as long as it is done in a good spirit, as I experienced it at that meeting. I did not feel like I was facing the chairman of the Diabetes Association [an endocrinologist] who was trying to crush me, but that I was facing a colleague who tried to give me some professional input (GP7)
9	I don't mind being challenged a little bit more because that helps get you on your toes. Because she is sitting in an ivory tower in which they only see patients with diabetes [as their primary diagnosis] and the patients that we see are also depressed, overweight, getting divorced, forced into job activation and so on – all those things which the specialists are not interested in, because when you are an endocrinologist you look at hemoglobin AC and cholesterol, and in the ideal world you should do so and so [...] And in our world, we have to get these things to work with the patient and his situation. So, I would like to discuss more patient cases in which she acted more expert-like (GP 9)
10	I realize that she should not be very aggressive the first time, since it is not easy to come here as an expert and look at our things because this is our life blood and thousands of hours have been put into this. So, if someone comes here and tells us that “this is really awful, what the ... do you think you are doing?” then we would have a mental block and say: “We can't use this at all” (GP9)

GP = general practioner.

N = nurse.

ing experience. In all clinics, the respondents perceived that their time was well spent on the sessions, and they expressed an interest in participating in future sessions with a medical specialist. The GPs appreciated the opportunity to review their quality data with a specialist

and to discuss difficult patient cases along with the pros and cons of specific drugs and combinations hereof (Table 4, Quotation #1 (Q1)). The nurses, who spend much of their time handling diabetes patients, were even more enthusiastic since the sessions afforded them

Dialogue between doctors in the clinic.



with an occasion to take time to evaluate the procedures and the results of the clinic together with the GPs (Table 4, Q2).

For several of the professionals, it was also gratifying to have their efforts recognized by an expert in the field. While no radical changes in clinical practice resulted from the sessions, most participants could point to specific learning outcomes in the form of planned or implemented changes resulting from the sessions:

- Intensification of pharmacological treatment concerning cholesterol, blood pressure or microalbuminuria (C2, C4, C8, C9).
- Introduction of immediate prescription of anti-diabetics (metformin) when diagnosing a patient with type 2 diabetes (C6, C9).
- Introduction of glucagon-like peptide-1 (GLP-1) drugs, e.g. Victoza (C6, C7).
- Drug replacement (Insulatard for Levemir) (C6).
- Combining angiotensin-converting-enzyme (ACE) inhibitors with thiazid (C3).
- Increased attention to specific patients at particular risk (e.g. impaired renal function) (C1).
- Reduction of anti-diabetic medication for co-morbid patient on multiple medications (C3).
- Motivation of patients to measure blood sugar at home (C9).
- Nurse-led initiation of more systematic follow-up on patients based on indicator data (C8).

Apart from these specific points, most participants also reported increased motivation to review feedback data from the national indicator database. For two of the GPs (GP4, GP5), most of the knowledge relayed by the specialist was known in advance, and the learning outcome mainly consisted in making a few adjustments in the balancing of known options and concerns in relation to difficult patient cases. These two sessions were the only ones in which the facilitator experienced that she had

not quite succeeded in conveying her message of intensified pharmacological treatment. In another clinic (C1), located in a relatively affluent area, the session had not given rise to much change, since the patients in this clinic were quite well-motivated, compliant and well-regulated.

During the learning sessions, very few explicit disagreements arose between the facilitator and the professionals from general practice. The interviews subsequently confirmed that the GPs and nurses had mostly agreed with the specialist concerning the goals and means of diabetes treatment (Table 4, Q3, Q4). The few differences noted by the participants were primarily attributed to the different contexts of care of the (hospital-based) facilitator and the participants from general practice. Particularly, in some cases, the continuity of care in general practice seemed to promote a less “aggressive” pharmacological approach than that generally favoured by the specialist (Table 4, Q5, Q6).

Assessments of the endocrinologist as facilitator

All participants commended the endocrinologists’ way of engaging with them and their data (see Table 3). The participants perceived that the specialist found a good balance between listening, asking questions, pointing to areas of improvement and giving specific advice. They also appreciated that the specialist had recognized the various challenges of diabetes treatment and acknowledged that it may not be possible to reach the ideal indicator targets for all patients. Although the specialist could not draw on working experience from general practice, her extensive knowledge of existing research evidence combined with years of clinical experience in an out-patient clinic helped strengthen her standing with the GPs (Table 4, Q7). None of the participants expressed that they had felt uncomfortable or threatened by the situation in which a specialist could access and comment on indicator data from their clinics (Table 4, Q8). One GP would actually prefer the endocrinologist to take a more aggressive approach since this might not only serve to challenge and inspire his own professional practice, but also the world view of the endocrinologist (Table 4, Q9). However, this GP also recognized the dangers of a more aggressive approach, especially at the first session (Table 4, Q10).

DISCUSSION

Both the GPs and nurses described the facilitation sessions as a very positive experience; and in most clinics, the professionals could point to specific learning outcomes primarily related to pharmacological questions. Compared to existing studies on outreach visits and academic detailing in general practice, the findings of this study are notable for three reasons. First, the facilitation

sessions evolved around a unidirectional transfer of knowledge from the specialist to the generalists. Theoretically, this unidirectional learning approach might be viewed as problematic in an era in which the traditional hierarchical relationship between specialists and generalists is challenged as general practice asserts its own particular identity [13]. Second, some studies have shown that GPs can have doubts over the objectivity and independence of external facilitators [6]. Third, recent studies have suggested that sharing a common experience as GPs is an advantage when acting as facilitator in general practice [4], and this may call into question whether other health professionals than GPs are able to "convey the necessary tacit knowledge to general practitioners concerning medical topics" [3, p. 273]. However, the facilitation sessions and the subsequent reflections by the respondents do not suggest that the facilitator was disadvantaged by the fact that she was an external specialist. In fact, the facilitator was well-received in all clinics, and the GPs and nurses experienced that the specialist succeeded in inspiring them to reflect on their treatment regimes as well as in providing them with useful professional knowledge and advice. Also, on issues of pharmacological treatment, most respondents preferred the facilitator to be a medical specialist rather than a GP (although it should be kept in mind that the study was not designed to compare hospital-based specialists with GPs as facilitators). These findings may be ascribed to several factors:

1. During the past 5-10 years several steps have been taken to standardize and improve diabetes treatment in general practice in Denmark through the development of clinical guidelines and a national database for quality monitoring. In clinics using such tools, knowledge and attitudes may have been affected in a way which is favourable to interventions promoting new medical evidence.
2. The selection process (cf. Table 1) may have produced a group of participants who were particularly interested in diabetes and/or particularly positive to this kind of intervention. Other clinics, less interested or experienced in diabetes treatment, may have more need for a facilitator with specific knowledge of how to systematically organize diabetes treatment in a general practice.
3. The distinctive personality and pre-established skills of the specialist (as acquired through prior teaching tasks and a two-day training course in facilitation) may have produced a particularly positive learning experience.
4. The facilitator combined research-based knowledge with clinical experience. This earned her an important amount of professional credit in the learning

situation and made it possible for her to discuss medical issues at the population level as well as in relation to specific patients. This interpretation is in line with previous research emphasizing the importance of pragmatically relating expert knowledge to clinical experience when communicating in a GP context [18].

In terms of the transferability of the findings in this study, the first point raises awareness to the national health care context in which the programme was carried out. Here, it may be noted that similar developments in terms of guidelines and indicators are taking place in several other countries. The second and third points relate directly to the specific design and setting of this study and suggest other possible limits of transferability. However, these points do not fundamentally disturb the basic conclusion of the study, namely that the combination of specialized knowledge and hands-on clinical experience seems to be an important advantage when using a medical specialist as facilitator in quality improvement efforts directed at pharmacological issues in general practice. Having said this, it should, of course, be noted that a high degree of acceptance and satisfaction with outreach visits does not guarantee significant improvements in clinical performance [19, 20]. Hence, further studies may evaluate the effectiveness of this kind of intervention in terms of clinical quality and costs.

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