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## Editorial

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# Clinical guidelines: acceptance and promotion

"Approximately 85% of all prescriptions written by senior physicians who graduated from medical school in 1960 will be for a drug about which they have received no formal education." This estimate was made by the American College of Physicians in 1988<sup>1</sup>; five years on the percentage is undoubtedly higher. Use of the new is not confined to drugs. Clinicians eagerly adopt technical innovations – the rapid growth in laparoscopic surgery provides one recent example. Unfortunately, new knowledge is not adopted as enthusiastically as new products. There is a gap between what the scientific evidence shows to be best patient management and actual clinical practice.

Manufacturers of drugs and medical equipment invest heavily in product promotion. They sell a popular message to a responsive audience – innovation is a valued aspect of health care for both practitioners and public.<sup>2,3</sup> In contrast, the results of research are not always positive about the worth of particular interventions. Health care researchers do not have the advantages of organised, aggressive commercial marketing to sell their findings. And clinicians cannot evaluate all available evidence on optimal management of the vast range of problems they see in their everyday practice.

### Translating research evidence into daily practice

What can be done to ensure that the daily practice of individual clinicians reflects research evidence on appropriate and effective health care? One strategy receiving an increasing amount of international attention is the use of evidence based clinical practice guidelines. Guidelines are nothing new: a multitude of guidelines covering most conceivable aspects of health care have been produced by various organisations. In the United States alone over 1200 guidelines produced by 45 different bodies are currently thought to be circulating<sup>4</sup>; not all are underpinned by sound research and most are not followed in any consistent fashion. In the past few years this previously sporadic and uncoordinated activity has been transformed into a growth industry now labelled the "guidelines movement."<sup>5</sup> Significant features of this movement are the emphasis on comprehensive assessment of research findings as a basis for guidelines; a focus on a systematic approach to developing and disseminating guidelines; and close attention to ways of ensuring guidelines are used by clinicians.

The aim of practice guidelines is to improve the outcomes of care by reducing unintended or unjustified variations in clinical practice. Everyone would agree that improving the outcomes of care should be a central preoccupation of health professionals. The difficulties relate to the underlying reasons for practice variation. It is widely held that variations in practice patterns reflect uncertainty in clinical decision making. However uncertainty at a collective level does not indicate that individual clinicians are uncertain about appropriate practice. As Evans says: "Deep and intense

disagreement, on the basis of strongly held views, will also yield a diversity of behaviour."<sup>6</sup> Disagreements on what constitutes appropriate care will always occur where there is no good research evidence. But even when such evidence is available individual clinicians come to different conclusions about appropriate practice policies. The reasons range from misinterpretation or lack of skills in data analysis through to placing greater value on personal experience than on research findings. The development of techniques for gathering and combining the strongest available scientific evidence on effectiveness<sup>7</sup> and the use of this information in developing practice guidelines should help to resolve some of the disagreements and narrow the range of intended but unjustified variation. This is the strength of evidence based guidelines rather than guidelines produced in some other way.

Ensuring clinicians have accurate and up to date information about effectiveness of various interventions will be a major step forward; ensuring they use this information is a greater challenge. One problem is that it is not always easy to apply collective evidence on what is best practice for a group of patients as a whole to decisions about individual patients. People differ in their experience of illness and their expectations and preferences for care. For this reason official practice guidelines, no matter how well grounded in research, cannot be uniformly applied. The question is whether clinicians should have to base their practice on established guidelines and justify any departure from these guidelines in individual cases. Practice guidelines which specify certain standards of care inevitably raise professional hackles about clinical freedom. The ability to exercise individual judgement is a core aspect of professional behaviour. While clinicians live with physical constraints – for example, waiting lists or inability of patients to pay for private care – they find it much more difficult to accept guidelines which have been described aptly as "cerebral constraints."<sup>8</sup>

Other difficulties arise when effective care (as defined scientifically) is not affordable care (as defined politically). Clinicians are trained to believe that they should provide ideal, rather than reasonable, care to the people they have identified as needing it. Prescribing resource-realistic care is something that can be done comfortably only when unaware of the personal realities of that decision for those with a particular clinical condition. It may be possible to persuade clinicians to balance the interests of one group of patients against those of another, but it will be much more difficult to persuade them to compromise clinical care when it is unclear where the money saved will be spent.

### Encouraging use of guidelines

Different approaches to promoting use of guidelines are emerging. At a major workshop on clinical practice guidelines held in Canada in 1992 it was agreed that adoption of guidelines must be voluntary. The summary

of proceedings states: "Compulsory compliance, through recertification, resource allocation, regulation or other means, fails to recognize the individualised nature of the physician-patient interaction."<sup>9</sup> Across the Atlantic, health care purchasers in the United Kingdom are considering using contracting as a means to encourage service providers to follow agreed clinical guidelines.<sup>10</sup> This is a direct challenge to clinical freedom which shifts power from individual clinicians to the academics producing the guidelines and the managers promoting their use.<sup>11</sup>

Patients and the public generally may be receptive to this shift of power, particularly if they have a voice in producing the guidelines. There have been well publicised instances in many countries in which clinical freedom has clearly not been in the best interests of patients. Pharmaceutical companies and other product retailers manage to shape clinical behaviour without compulsory compliance, but not all of their methods will be acceptable to health care funders. There are dangers in an approach which gives guidelines contractual force<sup>11</sup>; the benefits may be in clearer public accountability of health professionals.

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