Recipes or roadmaps?

Instead of rejecting clinical practice guidelines as “cookbook” solutions, could physicians use them as roadmaps for the journey of patient care?

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Résumé

Pourquoi y a-t-il un gouffre qui persiste entre l’élaboration de guides de pratique clinique (GPC) et leur application à la pratique? Dans ce numéro, Dr. David Davis et Mme. Anne Taylor-Vaisey (page 408) décrivent toutes sortes d’obstacles, y compris les aptitudes des praticiens. Les médecins rejettent souvent les GPC comme des «livres de recettes» qui ne tiennent pas compte de l’art de la médecine, de la variabilité de la pratique ni de son imprévisibilité. L’auteur suggère de considérer les GPC comme des cartes routières qui doivent guider les médecins dans les voyages qu’ils accomplissent avec leurs patients. Les GPC peuvent aider les médecins et les patients à choisir leur destination, tenir compte de leurs préférences et les empêcher de se fourvoyer. À cette fin, il faut toutefois appliquer les GPC à la pratique. Il reste beaucoup de travail à faire dans le domaine de la mise en oeuvre des GPC, et il faut établir à cette fin les associations entre les praticiens, les patients, les centres universitaires des sciences de la santé, les hôpitaux communautaires, le secteur public, l’industrie, les associations professionnelles et les organismes bénévoles.

Clinical practice guidelines (CPGs) have become an inescapable part of the contemporary practice environment. Rooted in the desire to reduce unwanted practice variation, the CPG “movement” has been accelerated in recent years by the pressure to minimize the cost, while maintaining or even enhancing the quality, of health care. As a result, CPGs should now be indispensable to practitioners, particularly in an era when “evidence-based medicine” has been so widely embraced and so highly touted.

Why, then, is there a continuing gulf between the generation and dissemination of CPGs and their translation into changes — and presumably improvements — in practice? Dr. David Davis and Ms. Anne Taylor-Vaisey (page 408), offer a lucid and comprehensive exposition of the multifactorial etiology of the failure of “naturalistic” CPG implementation, citing such barriers as CPG quality, patient and provider characteristics, practice setting, incentives and regulation. Looming large among these barriers are our attitudes as practitioners. To paraphrase US humorist Will Rogers, “We all approve of progress; it’s change that we don’t like.”

On a more optimistic note, Davis and Taylor-Vaisey observe that a change in attitude seems to be taking place, citing a growing receptiveness toward CPGs among the younger generation of Canadian practitioners. This openness probably reflects the growing emphasis given to information literacy and critical appraisal in today’s undergraduate and postgraduate medical curricula.

Still, rejection of CPGs as “cookbooks” that fail to take into account the art of medicine is common. As practising physicians, we have little use for simple, prescriptive “recipes” for health care, knowing, as we do, the variability and unpredictability of the “ingredients”: our access to diagnostic and therapeutic technologies, our proximity to specialists and subspecialists, and most of all, the defining characteristics of our patients (age, sex, comorbid conditions and adherence to medical therapy), which may differ significantly from those of the select few en-
rolled in randomized controlled trials. It is no wonder that there is still considerable geographic variation in the processes and outcomes of health care. The broader questions remain: How much variation is acceptable? Which benchmarks (population-based, age-adjusted rates of diagnostic and therapeutic procedures, hospital stay and so on) are appropriate?

It may be preferable to view CPGs as “roadmaps” rather than “recipes.” Our relationships with patients are like journeys that we share with them. As fellow travellers, we agree upon destinations and way-stations (long-term and intermediate outcomes of care), and we negotiate the most appropriate routes to take (processes of care) along the available roads, bridges and waterways (structures of care). Exigency usually dictates a more express route of travel; other circumstances may allow a more circuitous path. Our recent and remote experience as travellers undoubtedly determines our familiarity with the terrain and colours our choice of any given route. Whereas a few of us seem to be blessed with an almost instinctive sense of direction, most of us need maps, particularly when the landscape keeps changing.

The poet T.S. Eliot once remarked, “Where is the knowledge we have lost in information?” CPGs attempt to distil the best available scientific information into a coherent, graspable, working knowledge base for the busy practitioner. In the absence of evidence or in the presence of considerable uncertainty, CPGs attempt to achieve a consensus of opinion among leaders in the field, usually with balanced representation from generalists and specialists, epidemiologists and biomedical scientists. CPGs summarize and synthesize the science of medicine for us, allowing us to foster, with our patients, our particular brand of artistry. Finally, helpful as they are, CPGs do not absolve us of our obligation to seek out and appraise the quality and strength of the evidence on which they are based.

CPGs, like roadmaps, can guide us in our journeys with patients, pointing the way to our agreed-upon destinations, allowing leeway to accommodate individual nuances and preferences, and keeping us from getting too far off track. But, as any traveller knows, even the highest-quality map is of little use on a journey if it is left in a cabinet drawer at home. The principal challenge facing the CPG movement lies not in the production or dissemination of new guidelines — although CPGs must, and do, undergo continual revision as new evidence emerges — but in their implementation. Davis and Taylor-Vaisey have provided us with a succinct summary of current knowledge about CPG implementation, pointing out that some methods work better than others and suggesting that combinations of strategies are probably more effective than any single strategy. Nonetheless, our knowledge in this area is far from complete, and much work remains for us to do — in collaboration with our leaders in continuing medical education; our colleagues in academic health science centres, community hospitals, government, industry, professional associations and voluntary agencies; and, most of all, our patients — to realize the potential of CPGs in changing practice and improving health.

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