EDITORIAL

Guiding guidelines into practice

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Index words: evidence-based medicine, clinical governance, quality assurance, standards.

(Aust Prescr 2001;24:50–1)

Introduction

Guidelines have been defined as 'systemised statements designed to assist clinicians in managing patients'. However, their use is not always straightforward. They can be used for assisting clinicians with clinical decisions, as standards for determining the quality of care, and as part of wider processes for improving the quality of care. In a perfect world guidelines would be unnecessary, clinicians would obtain the best available evidence relevant to each patient's problems at each point in time, and use it in their practice.

There are disadvantages to the use of guidelines as well as advantages. Before deciding to what extent we should embrace or repel them – let alone how we should do so – it is important first to look at the context in which guidelines are used.

Guidelines and evidence-based medicine

Guidelines are designed to help clinicians do the right thing. However, this means we have to define what 'the right thing' is.

In this issue...

Nine new drugs are discussed in this issue. It will be difficult to assess what role some of them will have in therapy until more information is available. This is where clinical practice guidelines can be helpful, but Chris Del Mar reminds us of some of the problems with guidelines.

It is not only new drugs which can change practice. Con Aroney informs us how new laboratory tests are helping to change the management of acute coronary syndromes.

While there have been no dramatic changes in the management of vaginitis and vulvitis, Gayle Fischer and Graeme Dennerstein stress the importance of an accurate diagnosis in successful treatment. Excluding a serious illness is also important in the management of irritable bowel syndrome, but Rob Fraser tells us that the exact cause of the condition is still unknown.

Depression is another condition which can be misdiagnosed, particularly in the elderly where it may co-exist with other conditions such as dementia. Although depression is common in older age, John Snowdon tells us that the prognosis may be as good as it is in younger patients.

Evidence-based medicine, the process of obtaining and using the best available evidence from research, clearly has a central role although evidence is lacking for many areas of clinical practice. Originally developed as a process to provide the clinician with the information with which to make decisions, it has been seized upon by the makers of guidelines to ensure that their guidelines are optimal. Guidelines are not necessarily evidence-based (in the past, they were often only 'consensus-based'), but the best ones are evidence-based.

Guidelines as standards

What about clinicians who do not adhere to a guideline? Guidelines have changed their function from being something designed to assist clinicians in managing patients, to become a standard. For example, the National Breast Cancer Centre commissioned guidelines for the management of women with a new symptom in the breast. These guidelines were studied not only to decide if they changed doctors' behaviour (they did when the education was combined with an audit), but also as benchmarks to make judgements about the doctors' standard of care.[1] The National Prescribing Service has also encouraged audits of antibiotic prescribing in which guidelines have been used as the standard against which judgements can be made.

Standards can be set at several levels: minimal, normative and exemplary.[2] Each has its own uses. Minimal standards can be used to identify health professionals who perhaps require remedial or even punitive action. Exemplary standards aim to encourage the whole profession to improve. It is clearly important to recognise which level should be applied to any guidelines that will be used as a standard.

Guidelines and quality of care

Guidelines can be used to improve the quality of care. They can help clinicians who want to know what to do. This can be amplified into a wider process such as 'quality assurance', 'quality improvement' and more recently 'clinical governance'. These all involve a cycle of selecting an area of care, measuring this against guidelines as a standard, and then changing management to address any discovered shortcomings. However, the notion of 'guidelines-as-standards' as a means of reducing 'clinical variation' may be flawed.

First, variations in care do not necessarily imply variations in quality. There are many situations in which one form of care is as good as another. A good example comes from the use of antibiotics for acute otitis media.[3] The benefits of antibiotics are marginal and may be counterbalanced by the adverse effects. In other words, symptomatic treatment with or without

a prescription for antibiotics may be equally good quality care.

Secondly, guidelines imply that one size should fit all. In some situations this is likely to be correct. For example, a breast lump in a woman 65 years old needs to be properly investigated in a specialist clinic until malignancy has been excluded. However, there will always be some people who do not fit the guidelines. General practitioners are experts at finding the right treatment for their patients. This involves taking account of their psychosocial factors and welding different pieces of information together to make a decision.[4] A woman might have a phobia of needles that would make fine-needle aspiration of her breast a serious problem; she may also have other more pressing and urgent medical or non-medical problems that assume a greater priority. Being sensitive to these issues may actually be a sign of very good quality care. Patients' views (if well informed) may be as important a factor in deciding what to do as the evidence on which guidelines are based.

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3. Glasziou PP, Hayem M, Del Mar CB. Antibiotics for acute otitis media in children [review]. In: The Cochrane Library. Oxford: Update Software; Issue 2, 2000.
4. Stewart M. Healing partnerships between patients and family doctors: an aspect of quality of care. Working paper series #98-1. Ontario: Centre for Studies in Family Medicine, The University of Western Ontario; 1998.

FURTHER READING

Some guidelines can be accessed through the following web sites:

http://www.guideline.gov/ (US National Guidelines clearinghouse)

http://www.health.gov.au/ (Commonwealth Department of Health and Aged Care – a good starting point for several other sites)

http://www.nhmrc.health.gov.au/ (National Health and Medical Research Council)

http://www.healthinsite.gov.au/ (A federally-funded information site about health)

http://www.ctfphc.org/ (One of the best sites on preventive health care, from the Canadian Task Force)

http://www.tg.com.au (Therapeutic Guidelines) (available at cost)

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Letters

Letters, which may not necessarily be published in full, should be restricted to not more than 250 words. When relevant, comment on the letter is sought from the author. Due to production schedules, it is normally not possible to publish letters received in response to material appearing in a particular issue earlier than the second or third subsequent issue.

Prescribing by numbers: pharmacoeconomic consideration

Editor, – Referring to comments made by P. Neeskens (Aust Prescr 2000;23:115) on the usefulness of the number needed to treat (NNT), it is worth mentioning that the figures were misquoted. The original article by Eve Hurley (Aust Prescr 2000;23:38) stated that X = event rate control was 4.1% and that Y = event rate active (with gemfibrozil) was 2.7%. In Dr Neeskens' comments these two figures were transposed.

While it may be true that the NNT does not always give a feel of the relevance of an intervention, it certainly does provide a useful measure for comparing interventions when pharmacoeconomic evaluations are performed. From the Helsinki Heart study, it can be calculated that to treat the 71 men for 5 years with gemfibrozil just to prevent one event would cost: 220 (ZAR) x 12 (months) x 71 (men) x 5 (years) = 937 200 ZAR (South African Rands) in drug costs alone. This is equivalent to $220 000. If there is a cost-effective non-pharmacological intervention or an alternative drug that provides the same or similar relative risk reduction (of 34% as quoted) then the use of NNT will help in decision-making for policy-makers as well as clinicians.

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Medications which may lower seizure threshold

Editor, – Amongst the medications which may lower seizure threshold (Aust Prescr 2001;24:8-9) two stimulant medicines are listed, namely dexamphetamine (uncommon) and methylphenidate (anecdotal reports).

I would like to add another anecdotal report regarding caffeine, a self-medication or perhaps a recreational drug. I have seen two patients within a year or two of each other, both middle-aged women, who gave me almost identical histories. They had each been investigated for the cause of major seizures, including inpatient EEG monitoring, without a cause being found or effective relief obtained. On questioning, they each admitted to being heavy drinkers of instant coffee, to the order of 40 cups a day. I advised both women to reduce their coffee consumption to normal levels, and neither of them has had any further seizures over 10 years.

Michael Grounds
General Practitioner
Bendigo, Vic.

Editor, – I found Professor Neil Buchanan's article 'Medications which may lower seizure threshold' (Aust Prescr 2001;24:8-9) very timely and useful. Over the last month, the Acute Pain Service at my hospital has come across three patients taking pethidine (for patient controlled