Guidelines not the be-all and end-all of better healthcare

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There is much more to the doctor–patient consultation, and to quality healthcare, than clinical guidelines can ever cover.

Consider this: 97 per cent of quality improvement is not measurable; we measure only that which can be measured.

This argument was espoused in 2009 by surgeon, scholar and the then British health minister Lord Darzi, who said: “We can only be sure to improve what we can actually measure, and that’s only 3 per cent in terms of quality,” ie, the bits we can measure are only a tiny fraction of what’s important. And these bits then feed into guidelines. And guidelines feed into shared decision making.

However, often the good consultation is one in which guidelines are not adhered to, because of the other 97 per cent that reflects the realities of everyday consultations.

At the RNZCGP Quality Symposium in Christchurch recently, much of the discussion centred on the value of measuring quality.

Tim Stokes, keynote speaker, was most recently with the University of Birmingham as a senior lecturer in primary healthcare. Through his work with national agency NICE, he gained a profile in healthcare quality improvement research and development, with a focus on clinical practice guidelines, quality standards and performance measures.

Dr Stokes identified a number of problems with guidelines. First, there are issues with the evidence-based medicine model. These include:
- conflicts of interest that may be pecuniary, related to specialist societies, or governmental (particularly politically driven health policy)
- the volume of evidence available to support evidence-based medicine
- statistically significant benefits may be marginal in clinical practice, and
- evidence-based guidelines map poorly to complex morbidity.

Are guidelines a means to an end or an end in themselves? Therein lies the challenge of changing clinical practice.

Another issue with guidelines is the limited focus on implementation approaches, which include:
- collegiate approaches
- changing the behaviour of individuals and practice teams, and
- the variable success of implementation models.

Dr Stokes advocates a “third age” of guidelines and suggests three key features. The first is refocusing on guidelines as a means to an end. We need to be aiming for efficiencies in guideline production; their development needs to be sustainable; and we need to be sharing the methodology.
The second is that any guideline needs to be fully integrated into the practice management system. For guidelines to be useful, the information they contain has to be instantly available to the clinician, so that the right thing to do is also the easy thing to do.

Third, any guidelines need to be embedded at all layers of the health system, from individuals, to healthcare teams, to PHOs and networks commissioning for services, to DHBs and the Government.

At the individual and healthcare team level, these would be clinical guidelines involving audit and feedback at an individual level. At the DHB and government level, this may involve financial incentives and pay for performance. Guideline-based performance measures raise issues that need to be debated:

- It is unclear how or where they should be used in the health system.
- They reflect a disease-focused approach. Is this, in fact, appropriate?
- They are inherently reductionist, reducing a pathway-to-process markers. Is this appropriate?
- They need rigorous evaluation. Do they work? What are the unintended consequences?

It would seem guidelines are good, but one must qualify that view and acknowledge they can guide only that which can be measured, a tiny percentage of what we do. Guidelines have a role in evidence-based medical practice, but aspects of the patient–doctor interaction lie outside evidence-based medicine. The relational aspects of care are equally important.

Our role is in assisting to alleviate fear, for instance, and in supporting the emotional aspects of care.

Time and again, patient surveys reflect on the relational components as the ones they value the most.

So, do not let us forget that guidelines are not the best, the only, or the major determinants of quality care.

Evidence-based practice (including guidelines), and the experience of both clinician and patient, all contribute to the shared decision making that improves quality of care.

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