

Clinical guidelines — are they of any use?

Over the past decade, the *SAMJ* has published many clinical guidelines for the management of a variety of common chronic conditions such as hypertension and diabetes. The *SAMJ* has sought to ensure that such guidelines as it published were authoritative by accepting only those that were formulated by appropriate medical specialty interest groups.

Clinical guidelines are not an exclusively South African phenomenon. They are undoubtedly more common in countries such as the UK, the USA, New Zealand and others, often driven by medical insurance and national health systems as a means of controlling costs. Writing in the *BMJ*, Woolf and colleagues observe that 'the broad interest in clinical guidelines that is stretching across Europe, North America, Australia, New Zealand and Africa has its origin in issues that most healthcare systems face: rising healthcare costs, fuelled by increased demand for care, more expensive technologies, and an ageing population; variations in service delivery among providers, hospitals, and geographic regions and the presumption that at least some of this variation stems from inappropriate care, either overuse or underuse of services; and the intrinsic desire of healthcare professionals to offer, and of patients to receive, the best care possible. Clinicians, policy makers, and payers see guidelines as a tool for making care more consistent and efficient and for closing the gap between what clinicians do and what scientific evidence supports'.¹

But questions are frequently asked about the purpose, value and impact of clinical guidelines. For whom are they written? What assurance is there that they are scientifically sound and up to date, and that they are not inspired in some subtle way by the interests of the pharmaceutical industry, or of the medical insurer? What about the autonomy of the medical practitioner to determine for himself or herself what treatment is appropriate in given circumstances? After all, patients with the same basic medical condition often present in radically different ways, requiring the practitioner to offer individualised treatment for which the guidelines may or may not provide. Then there is the problem of possible lack of consensus among the specialists themselves regarding the appropriate approach in the treatment of a given condition: the *SAMJ* has a recent example in which the guideline it published on the use of hormone replacement therapy has been challenged by a parallel international menopause interest group on the basis of what appears to be an equally sound but different interpretation of the studies that ignited the controversy on this subject.²

Woolf and colleagues, themselves protagonists of clinical guidelines, nonetheless point out that such guidelines have potential limitations and harms. 'The most important limitation to guidelines is that the recommendations may be wrong (or at least wrong for individual patients)'.¹ The recommendations may be wrong for a variety of reasons, including the fact that the evidence may be lacking or controversial. Secondly, they can be influenced by the biased opinions or the particular composition of the group putting them together. Thirdly, the recommended choices may attach greater importance to controlling costs than to the needs of patients.

These authors further identify as a potential flaw the fact that

recommendations may fail to take due account of the available evidence, resulting in the promotion of sub-optimal, ineffective or even harmful practices. 'Guidelines that are inflexible can harm by leaving insufficient room for clinicians to tailor care to patients.' For this and other reasons, the *BMJ* currently requires that, to be accepted for publication, clinical guidelines be founded on evidence-based practice that relies on systematic reviews of randomised clinical trials — something the *SAMJ* is considering.

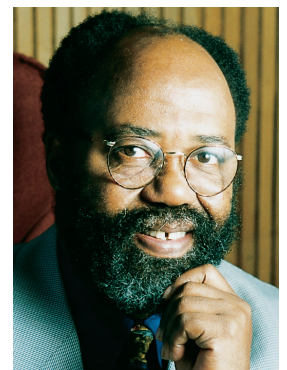
Anecdotal evidence in South Africa suggests that clinical guidelines are unevenly or even infrequently adopted by practitioners. Certainly, the guidelines to improve obstetric care and reduce maternal mortality in South African public hospitals are all too frequently ignored, according to the recent findings of the 'Saving Mothers' task team. In the Netherlands, Grol and colleagues³ found that the recommendations of clinical guidelines were followed in 61% of clinical decisions. Controversial decisions were followed in 35% of decisions, and recommendations that demanded a change in existing practice routines were followed in 44% of decisions.

Feder and colleagues⁴ observe that 'the development of good guidelines does not ensure their use in practice', and that research shows that 'relatively passive methods of disseminating and implementing guidelines — by publication in professional journals or mailing to targeted healthcare professionals — rarely leads to changes in professional behaviour'.

The Netherlands group recommends that, in order to improve the adoption of guidelines by the practitioner, the compilers of clinical guidelines should employ evidence-based support, use precise definitions of recommended practice, and test the feasibility and acceptance of recommended guidelines on focus groups of the targeted users. New Zealand's Jackson and St Bartholomew's Feder⁵ emphasise the need for guidelines to be simple, patient-specific and user-friendly. 'One of the cornerstones of evidence-based practice (and evidence-based guidelines) is the requirement that the evidence is relevant to individual patients', and is presented in a concise, accessible format.

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