CPG 2002 – Oral Presentations – Friday, June 7th

Track 1: Clinical Practice and CPGs

CPGs – Helpful aids or paradigm shift?

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Introduction
Guideline-mania has been spreading rapidly from initial cases in the USA and UK to a global epidemic affecting the health care systems of industrialized and less industrialized countries. To understand the root-causes and the actual impact of CPGs a systematic analysis from different disciplinary perspectives is warranted. The analysis in this paper will focus on two questions: What are CPG's and who wants CPG's when and why?

Method
The first answer will be provided by looking at the definitions and formats of documents (a series of recommendations expressed in words and data) called clinical practice guidelines. It will be demonstrated that over the past twenty years at least 3 generations of CPG's have emerged from methodologies based on consensus development, evidence-based medicine and cost-effectiveness analyses.

The second question will be answered by taking the perspective of the clinicians (professionalization), managers (planning and control), financiers (efficiency, cost control),
government (accountability, priority setting, regulated markets) and patients (patient empowerment, accountability, consumerism). Experiences with the development and use of CPG's will be discussed from the perspective of engineering (standardization of working processes), economics (efficient resource allocation through medical decision making), sociology (instrument for or against professionalization), bio-medical research (instrument for evidence-based decision making), law/ethics (legal and normative aspects of guidelines). It will be stated that rationalization strategies such as CPG's do not necessarily lead to more rational health care delivery given the in essence social nature with varying objectives of the care delivery process and the context surrounding it.

Discussion
To contain the epidemic and minimize unwanted side effects it should be recognized that CPG's are only one of the many technologies to improve the quality of care. CPG's should be considered in relation to care-process re-engineering, medical-decision making, indicator-development, accreditation/certification and overall knowledge-management strategies in health care delivery.

Conclusion
It is concluded that CPG's can potentially be helpful aids but often also represent a paradigm shift in the way individual patient/physician interactions are increasingly becoming subject of scientization and societalization.

Clinical Judgement and CPGs

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In daily clinical practice, physicians and other health care professionals make numerous decisions for the many steps that constitute patient care. These myriads of decisions are based on long-established habit, experience, intuition, consulting colleagues, books, journals, the Internet, clinical practice guidelines, etc. Most decisions are based on or influenced by clinical judgement, which constitutes the central momentum that governs decisions made at the individual patient level in health care. Although clinical judgement plays a key role in the delivery of high quality care it is usually not considered as a scientific activity and is rarely the object of appropriate scientific research. Clinical judgement is also

intimately associated with freedom of practice – within accepted limits. However, in these times of rapidly evolving health care systems and when freedom of clinical decisions is perceived as severely challenged, attempts at intervening to influence clinical decisions, by means of guidelines for instance, may not always be well received.

Given the many factors that intervene in the construction of clinical judgement, it is therefore not surprising that large variations in health care decisions and delivery have been observed within and between systems of care, small areas, countries or physicians. The problem is that variations in practice is sometimes also linked with arbitrariness and with substandard quality of care, largely independent of the amount of resources available in the health care system.

One aim of clinical practice guidelines is to improve quality of care. Guidelines should therefore also reduce variations in health care. Some studies have shown that guidelines may indeed modify health care practice and increase quality of delivered care. However, in many studies that report on the impact of a guideline no effects or only small effects have been observed. Large variations between the recommendations made in various guidelines tackling the same topic have been observed, some of which may be due to the poor quality of guidelines. In addition, knowledge and skills in effective implementation of guidelines is still insufficient.

Given the complexity in the building of clinical judgement, the insufficient knowledge and research devoted to better understanding how clinical judgement is made and may vary, and the variations in the recommendations that exist among guidelines, it is not surprising that, until now, clinical practice guidelines infrequently have had a large impact in improving health care.

Attitudinal Barriers to CPGs

Perceptions of Guidelines by Oncologists: A New Tool to Measure Clinicians' Attitudes Towards Practice Guidelines

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Objective:
Research has demonstrated that uptake of innovations, such as practice guidelines, is influenced by adopters' perceptions of the innovation itself and by the process by which the innovation is developed. To date, no tool has been developed to assess the range of practitioners' perceptions that enhance and impede their uptake of guideline messages. The purpose of this presentation is to describe the development of one such instrument used as part of the practice guideline external review process of Cancer Care Ontario's Practice Guidelines Initiative (CCOPGI).

Method:
Using the diffusion of innovation model as a conceptual framework, a 21-item Perceptions of Guidelines by Oncologists questionnaire was generated. Each item is answered using a 5-point Likert response scale or a combined continuous-categorical response scale. The instrument was pilot-tested and refined over the course of 2-years; principle components analysis, internal consistency and sources of variation were calculated.

Results:
One thousand twenty completed surveys regarding 26 cancer practice guidelines were returned during this time.
Structure
A principle components analysis yielded a three-factor solution: factor one (38.8% of the variance) focused on oncologists' perceptions of guideline quality issues; factor two (13.0% of the variance) focused on perceptions of the acceptability of the recommendations, and factor 3 (7.2% of variance) focused on perceptions of the applicability of recommendations and barriers to their application. Two items using the different scaling system composed the fourth dimension, comparative value.

Internal consistency
Alpha coefficients for the factors were acceptable, ranging between 0.73 (comparative value dimension) and 0.84 (quality dimension).
Sources of variation
The intent of the new instrument is to assess features of the practitioners' attitudes that may enhance or impede their uptake of guideline recommendations. Thus, measures of inter-rater reliability are not relevant as we do not expect (or desire) consistency in attitudes among Ontario clinicians. This was indeed borne out with this instrument; across each of the 4 dimensions, a greater proportion of variance in dimension scores was accounted for by differences in the practitioners who provided the external review than by the practice guidelines they reviewed.

Conclusions:
The POGBO is a methodologically rigorous tool to assess clinicians' attitudes towards guidelines. Next steps are to use data from the POGBO instrument to predict clinicians' intentions to use recommendations and to model actual clinical practice.

Effectiveness of CPGs in everyday practice – a critical review

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Objective: report from literature and research data on the outcome of guidelines implementation

Methods / Context / Project: using literature data and data from our personal current research, we attempted to classify the factors that facilitate and limit the effectiveness of clinical practice guidelines (CPG) in everyday practice. The analysis concerned therefore guidelines in general and more specifically guidelines for the prescription of blood tests and for the management of cancer patients.

Results: Barriers to guideline implementation have been identified by other authors. The typology proposed is the following: lack of awareness, lack of familiarity, disagreement, doubtful self efficacy, poor outcome expectancy, inability to overcome inertia and habits, external barriers, both financial and organisational. In our experience with test order forms, we found that external barriers were the major limiting factors: these barriers were organisational. One aspect was related to the computerisation of the process in the biochemistry lab and was dealt with. Another was related to the transmission of order between physicians and nursed during the rounds and could not be overcome. Other authors reported financial disincentives in relation with the financing system for hospitals in France. These difficulties were addressed at the national level by identifying a special budget for chemotherapy drugs. CPGs in oncology have been shown to lead to changes in practice when dissemination and implementation are conceptualised from the beginning of the guideline development process. Our experience in a regional cancer network showed that local participation in the guideline development process is crucial for local acceptance of CPG and successful implementation. In addition, evidence-based patient information and seeking patients' views in treatment decisions may represent a potential incentive for change in the delivery of cancer care.

Conclusions: although the current typology is useful in identifying barriers to guideline implementation and effective operation, each barriers requires its own analysis and removal procedures. From our experience, some barriers to effective use of guidelines can be removed at the hospital level while other require a national program or has to be taken into account from the beginning of the guideline development process. The evolution of the doctor-patient relationship and the patients' role in treatment decisions represent a challenge for implementation of good clinical practice.

The history of clinical effectiveness

Downs and ups of the quality approach

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The current debates about evidence-based-medicine and other ways to "the truth" are not new. There exist indeed three basic traditions of evidence in therapeutics, viz. (i) the pathophysiological, (ii) the clinico-observational (case reports, case series) and (iii) the tradition of critical evaluation of aggregated data.

The first, associated to-day with experimental laboratory science, goes back to the medical systems of the natural philosophers of Antiquity - and such comprehensive pathophysiological systems are also still en vogue (e.g., homeopathy, anthroposophy). Provided one moves within the system, it yields certain and objective knowledge. This also holds for clinical observations made on individual patients, yet this knowledge is subjective. In both traditions, knowledge is arrived at through the rather vague procedure of "medical judgement". The third tradition, i.e. the analysis of aggregated data obtained on groups of patients according to a set of fixed external rules, yields objective, yet probable, results. Various alliances and enmities among these three approaches have indeed been historically relevant.

As long as certainty of knowledge, in accordance with the wisdom of the ancients was essential, evidence of therapeutic effectiveness was not an issue. A physician knew and failures could always be explained away within a system. Own experience and the empirical approach by trial and error were therefore a matter for craftsman surgeons and mountebanks, i.e. men considered to be of lower standing.

This changed in the 18th century when new therapies, both in medicine and surgery, challenged traditional ones. Empirical assessment became a feature, particularly in Britain. Strong cases were made for clinical observation and the analysis of experiments conducted patient groups. To-day's evidence-based medicine is a legitimate, albeit late-born, child of their 18th century British achievement of clinical "arithmetic observation and experimentation".

If what we can learn from history is the reaction to history, we must realize that the true innovation for the future search for evidence in therapeutics would consist in integrating the three hitherto inimical and hierarchically ordered traditional approaches on the same level. Indeed, since each of these traditions has contributed to the success of medicine, they must also contribute together toward our coping with ensuing problems. Examples show that this is possible. Effectiveness thus has its (social) history.