Guidelines and Avoiding Meltdown

The provision of medical care has become more complex and correspondingly more stressful. Patients' expectations of doctors are high. Poor medical outcomes are in many cases likely to be perceived as physician or surgeon failure rather than the inevitable consequences of the underlying disease. Both the substance and the process of individual cases are closely scrutinised. It is about how you do it as well as what you do. Guidelines, protocols and clinical care pathways are now widely employed in the provision of patient care. They developed out of two requirements. The need to bring uniformity to the management of patients and the need to practice evidence based medicine. The principal is a sound one and has widespread acceptance. Medicine should be administered to a uniform acceptable standard. Evidence based medicine integrates the latest research evidence with the expertise of the clinician. It is a means to improve patient care. Despite these positives they continue to receive a lukewarm reception in some quarters. The lack of universal acceptance is worthwhile considering and exploring.

Properly constructed guidelines that are reviewed at frequent intervals can be very helpful. They fill an important gap in the knowledge industry. Busy doctors do not have time to read all the papers and articles in their specialty. It has previously been calculated that a doctor would have to read 19 articles every day of the year in order to remain fully up to date in his specialty. On the other hand it has been estimated that consultants spend only 1 hour per week reading medical journals. The two sides of the equation simply do not add up. Doctors need a reliable new information source.

However there are difficulties. There is a disconnect between writing protocols and putting steps in place to ensure their implementation. The validation process to ensure that the protocol is effective and safe in clinical practice is deficient. We don't know if guidelines reach the right people and we are unsure whether they are working. These and other considerations may lead a doctor to be non-compliant. This can have serious consequences. Failure to operate within a guideline can leave the physician or surgeon exposed to criticism at a number of levels. The Medical Council has a section on poor professional performance which is defined as a failure by the doctor to meet the standards of competence (whether in knowledge and skill, the application of knowledge and skill or both) that can reasonably be expected of doctors practising the kind of medicine practised by the doctor. This is clearly in the domain of evidence based medicine and how it is administered to patients. Doctors fear that they could get caught in the crossfire of conflicting guidelines.

McCarthy et al point out that non-compliance is a real possibility due to the vast numbers of guidelines that have been generated. Over 3,000 guidelines have been produced by the UK health department and a further 1000 from NICE. Sub-speciality groups also produce guidelines. There are 21 organisations producing anaesthesia guidelines. In addition to the large volume of guidelines that are produced, the computer sites are full of boxes, arrows and difficult to read. If it is subsequently placed in a 'difficult to access' computer location, the staff may be totally unaware of its existence. There may be a number of versions of the guideline from a variety of professional bodies. It is uncertain which version would be accepted in the event of a medicolegal complaint.

The competency and expertise of the groups producing guidelines should be reviewed. A common concern is that some of the individuals involved in writing up acute medical or surgical guidelines may not have personally been in a similar situation in the recent past. A guideline may have an inherent flaw or deficiency which makes it difficult to understand and execute. For example there are US and UK directives in addition to local policies. Doctors are frequently unsure about which guideline to follow. The information is frequently located on the hospital's intranet and is poorly indexed. Obscure wording of a policy increases the users difficulty in accessing it. When a new version of a guideline is written the older version is sometimes not removed. Fear of litigation encourages guideline writers to be excessively wordy and to produce over-detailed communications. There is a danger that the key message may be lost. Trainees frequently complain 'I've read the guideline but I still don't know what I'm supposed to be doing'. The introduction of trivial knee jerk policies in response to a minor one off incidents should be resisted. For example how staff should meet and greet patients or how to answer the phone. Guidelines should be reserved for serious and important medical issues, otherwise the message may be lost. Trainees frequently complain 'I've read the guideline but I still don't know what I'm supposed to be doing'.

The lack of universal acceptance is worthwhile considering and exploring.

The process needs to be rationalised. In other organisations, such as air traffic control, the number of bodies that produce protocols is curtailed. When a protocol is produced and circulated there are systems in place to ensure that it is both read and understood. Multiple policies often exist for the same condition giving rise to conflicting recommendations. For example there are US and UK directives in addition to local policies. Doctors are frequently unsure about which guideline to follow. The information is frequently located on the hospital's intranet and is poorly indexed. Obscure wording of a policy increases the users difficulty in accessing it. When a new version of a guideline is written the older version is sometimes not removed. Fear of litigation encourages guideline writers to be excessively wordy and to produce over-detailed communications. There is a danger that the key message may be lost. Trainees frequently complain 'I've read the guideline but I still don't know what I'm supposed to be doing'. The introduction of trivial knee jerk policies in response to a minor one off incidents should be resisted. For example how staff should meet and greet patients or how to answer the phone. Guidelines should be reserved for serious and important medical issues, otherwise the collaborative will become trivialised. Another criticism is the production of multiple overlapping guidelines. In one specific example an elderly patient admitted for emergency hip surgery generated 75 guidelines.

Guideline writing groups need to understand why staff may fail to comply with their deliberations and instructions. The policy may be long, full of boxes, arrows and difficult to read. If it is subsequently placed in a difficult to access computer location, the staff may be totally unaware of its existence. Multiple policies often exist for the same condition giving rise to conflicting recommendations. For example there are US and UK directives in addition to local policies. Doctors are frequently unsure about which guideline to follow. The information is frequently located on the hospital's intranet and is poorly indexed. Obscure wording of a policy increases the users difficulty in accessing it. When a new version of a guideline is written the older version is sometimes not removed. Fear of litigation encourages guideline writers to be excessively wordy and to produce over-detailed communications. There is a danger that the key message may be lost. Trainees frequently complain 'I've read the guideline but I still don't know what I'm supposed to be doing'. The introduction of trivial knee jerk policies in response to a minor one off incidents should be resisted. For example how staff should meet and greet patients or how to answer the phone. Guidelines should be reserved for serious and important medical issues, otherwise the message may be lost. Trainees frequently complain 'I've read the guideline but I still don't know what I'm supposed to be doing'.