‘Guidelines are systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances’ [1]. Their development began in the 1970s and there has been a huge proliferation of guidelines for the management of medical conditions over recent years. This has been fuelled by The National Institute for Clinical Excellence (NICE), who produce clinical guidelines and recommendations on the appropriate treatment and care of people with specific diseases and conditions within the NHS in England and Wales. NICE suggest four ways in which clinical guidelines should be helpful: (i) they should improve patient care by making recommendations for the treatment and care of people by health professionals; (ii) they should be used to develop standards to assess the clinical practice of health professionals; (iii) they should be used in the education and training of health professionals; and (iv) they should help patients to make informed decisions, and improve communication between the patient and health professional [2]. We will consider these four aspects in turn.

There is some evidence from rigorous evaluations of guideline implementation that guidelines can improve patient care, although whether they do this in routine clinical practice is unclear [3]. Evidence shows that guidelines improve the consistency of patient care and they are felt to play an important role in making our cash-limited system more equitable [4]. Guidelines can be used to influence public policy and highlight potentially neglected areas of medicine. They certainly provide a basis for auditing practice and may form part of a doctors’ assessment if referred to the National Clinical Assessment Service (an advisory body for doctors and dentists in difficulty) [5]. These are only valid if following the guidelines produces a better clinical outcome and, as already mentioned, evidence for this occurring in clinical practice needs to be collected.

The reduction in junior doctors’ hours, driven by the European working time directive and the shortening of training programmes, has made the training aspect of guidelines more important [6]. There is a fear that guidelines are being made to act as a short cut to experience. For example, guidelines could allow individuals with inadequate clinical exposure or experience to act independently, simply referring their decisions to a flow chart. It is essential that guidelines are not used in this way or as a substitute for education. They should only be seen as one of many strategies that can help improve the quality of care of patients.

Evidence that patients are using guidelines in order to inform discussions with their health care professionals is also lacking. Guidelines are not generally of assistance to experts as they themselves know their field well and can interpret the evidence base applicable to a given clinical situation, ignoring the guideline when appropriate. Guidelines can be helpful for experts straying outside their particular area of expertise and for juniors who lack experience. Most important numerically is primary care, where the situations dealt with are confusing messes, compared with consultants working on the high, hard ground, where problems may be better defined [8]. Unfortunately, published guidelines tend to be disease-orientated, which is not the manner in which patients present and also demand that an appropriate diagnosis is made first.

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The evidence used in the construction of guidelines has major limitations. The results of a study apply only to the population and the disease studied. A decision needs to be made as to what extent it applies to the person and the presenting disease. In what ways was the study population different from this patient? How certain and how variable is the diagnostic category you are using and was that encompassed by the study? The answers to these questions will indicate levels of uncertainty that need interpretation, and make dogmatic advice invalid. Naive doctors who follow guidelines without questioning their advice may run into problems, as was highlighted in a recent case report in the Lancet in which strict adherence to chest pain guidelines would have resulted in a patient with an aortic dissection receiving thrombolysis [9, 10].

Grade A evidence is collected in randomized controlled trials which are conducted on highly selected patients. Other coexisting diseases are commonly excluded, as are other medications. In some guidelines, grade A evidence is found only for drug interventions where the regulatory procedures demand such evidence. Another limitation of evidence occurs when the study has not been done either because of the difficulty of recruitment, such as in a rare disease, or difficulty in performing the study because of methodological problems, such as inadequate outcome measures. There are also biases in relation to what gets published.

There needs to be some leeway in the guidance to allow clinical judgement to be used. This is often based on unspecified criteria, including past experience, and will include features of the patient and the impact in their personal circumstances, their values and their preferences. There will be many other clues that make us think a patient is ill or not and these are not yet well enough understood to be included in guidance. Guidelines, as currently written, tend to ignore the patient and their priorities and concerns.

Usually, guidelines are written by ‘experts’ who may see a different spectrum of disease from the target audience, e.g. primary care, and have fewer problems with diagnostic uncertainty as these are excluded from their practice or the guideline. To generalists, these guidelines may seem self-serving, biased and threatening [4], which would reduce the possibility of them being used. It is therefore important that guidelines are written by those who would use them [11].
Guidelines also raise training issues. The current debate in relation to Modernising Medical Careers (MMC) and the foundation programmes is that junior doctors should be competent. The General Medical Council defines a competent doctor as one who recognizes and works within the limits of their professional competence [12]. Epstein and Hundert [13] define this as 'the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values and reflection in daily practice for the benefit of the individual and the community'. It could be argued that clinical guidelines do not allow this to happen, by being prescriptive.

There is debate about whether outcome models tend to limit the reflection, intuition, experience and higher-order functions that are required for expert and holistic practice. Competency models may not produce better results in terms of professional understanding and performance [14–16]. Narrowing down a skill-set too much risks reducing professionalism to a jobsworth trade [17]. We suggest that there is a direct extension into the world of the clinical guideline, where there is less opportunity for reflective practice.

The proliferation of guidelines also requires innovative ways of making them available. GPs are overwhelmed by the number and size of the guidelines they receive [18], and the recommendations from different sources for the same condition often differ [19–21], which reduces the likelihood of them being used. The GP needs to have it in their mind that there is a useful guideline and to know where to find it. It has been suggested that there should be a ‘chief knowledge officer’ within an organization (e.g. a primary care trust) taking responsibility for ensuring that helpful information is collated and disseminated appropriately to overcome these problems [22].

We have some suggestions. Despite these concerns regarding guidelines, we accept that they are important and have a significant role in patient management. Therefore, solutions to address these issues should be sought.

We suggest that guidelines, especially if they are for primary care, should start with a symptomatic clinical presentation, as there is evidence to show that GPs prefer their teaching to start with a clinical presentation rather than with a disease [23]. Thus, there would be a guideline for multiple joint pain rather than rheumatoid arthritis or generalized osteoarthritis.

The guide would follow the usual medical practice of advising on taking a history followed by examination. It would make suggestions as to what history was important in differentiating diagnosis and treatment options, presenting available evidence with an indication of its strengths and limitations. The same would then be done for examination. This would provide a great learning opportunity, with information given on the frequency of symptoms and the sensitivity and specificity of the clinical tests (as available). It would also help identify gaps in the evidence that would indicate where future research could be directed. By advising rather than dictating, it would also allow the doctor to take account of the patients’ priorities and circumstances, and of gut feelings and clinical experience.

As in clinical practice, this would lead either to a differential diagnosis or a diagnosis and management plan. This is where the current guidelines usually start, but this way we have included a much greater proportion of patients. At this point the current guidelines are likely to be satisfactory. Investigations directed at helping to define diagnosis or treatment would then be recommended, again with the evidence, including strengths and limitations, presented in support. This would also provide a good learning opportunity.

For primary care, the end result will either be the appropriate treatment of the patient or onward referral to secondary care. If the patient is sent to secondary care, there should be secondary care guidelines in which the history and examination are revisited, leading to appropriate investigation. The result of this may either be to pursue further management in secondary care or to refer back to primary care with advice and reassurance. In a situation where the diagnosis is not clear and the need for referral is not established, the guideline may recommend review on a suitable time scale.

In order for this system to work well it will be necessary for decisions to be made about what should be managed, both in primary and secondary care. This may well be subject to local variation depending on factors such as the experience of the GP and service availability. The guideline would need to reflect this. The primary care guideline would take the patient from presentation to the GP through to treatment and follow-up or waiting for developments, or referral to secondary care. Referral guidelines could therefore be incorporated into the local guideline for symptom presentation.

If guidelines are to be written for primary care they need to be written in primary care, taking advice from specialists as appropriate.

Making guidelines available also presents many challenges. Making them more useable will help. Starting with symptoms and working them into a computer-based algorithm that helps the GP to manage the patient would be a logical development.

Finally, it should be remembered that guidelines should inform the decision-making process, not replace it. Guidelines are guidelines, not rules!

References

12. General Medical Council (www.gmc-uk.org).