Clinical Practice Guidelines: Praise and Problems

Gary S. Sachs, M.D., and Sara Gaughan

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System, or as I term it method, is the harness without which only the horses of genius can travel.
—William Osler, *Aphorisms*

Published in this issue of the *Journal* is the article "Clinical Practice Guidelines for Bipolar Disorder From the Department of Veterans Affairs."[1] The particulars of the described pathways are the result of a rigorous process consisting of multiple reviews and revisions that brought forth guidelines in broad agreement with those produced by other experts and different methods.[2–4] While prior guidelines have often seemed impractical by virtue of their length or complexity, the hard work of Bauer and colleagues presents us with a system of practice guidelines that is comprehensive, flexible, and concise enough for use by clinicians in routine psychiatric practice. The accessibility of the guidelines presented in this article raises serious issues worthy of our consideration.

Are practice guidelines good or bad for psychiatry? Some distinguished psychiatrists may dismiss practice guidelines like those formulated by Bauer et al. as evidence of the "cookbook therapeutics" best avoided by our field. While there are clearly some legitimate concerns about possible negative consequences of guidelines, the weight of potential benefits builds a compelling case for development and adoption of clinical guidelines. Medical societies, government, and health care insurers have acknowledged the above quoted wisdom of William Osler and now clearly recognize the desirability of method in clinical practice. Guidelines for psychiatric conditions are published with increasing frequency.

Does psychiatry need clinical practice guidelines for bipolar disorder? Practitioners, who confidently initiate the most appropriate available treatment plans for their carefully evaluated patients, may answer no. Bipolar disorder is a common, severe, and not infrequently deadly mental disorder for which effective treatments are available. Yet the widespread ignorance regarding bipolar illness and its treatment challenges even our most dedicated compassionate colleagues to maintain the fund of knowledge necessary to confidently manage their bipolar patients. Guidelines based on the best available evidence bring to every patient the benefit of clinical data and clinical judgment beyond that which can be rendered on the basis of a single clinician's experience. For instance, the guideline for managing patients with hypomanic, manic, or mixed episodes informs the clinician that if an antidepressant is part of the medical treatment, it should be discontinued. If every physician follows this simple advice, treatment outcomes must improve.

Is there potential for misuse of clinical guidelines? Certainly there is potential for legal and economic misuse of treatment guidelines. Even where authors expressly state that guidelines are not intended to be used to define the standard of care in legal proceedings, it seems likely that lawyers will introduce published guidelines where favorable to their arguments. Health care payers may embrace guidelines as defining the limits of reimbursable care. In both cases, the existence of guidelines is not the source of a new problem for psychiatrists. It is therefore difficult to

discourage development and dissemination of guidelines since thoughtful use or deliberate nonuse of a known guideline appears at least as likely to aid psychiatrists and their patients as to be used against them.

Perhaps the most worrisome negative consequence would be for guidelines to fail in achieving their primary purpose—improving the well-being of patients. In fact, it is quite difficult to demonstrate that current published treatment guidelines have any impact on health care outcomes. Over the past 2 decades, increasing recognition of unexplainable large variations in local medical and surgical practice prompted Congress to create the Agency for Health Care Policy and Research (AHCPR). The work of the AHCPR, in addition to that of related governmental agencies and medical societies, has produced impressive scholarship. For many common medical conditions, it seems relatively easy to assemble credible experts and marshal the available medical evidence in order to produce broad consensus on both the need for practice guidelines and the specific guidelines themselves. The National Institute of Mental Health (NIMH) consensus conference reports and the proliferation of published guidelines demonstrate that, even in psychiatry, there exist sufficient databased evidence and concurrence of expert opinion to produce reasonable practice guidelines for common severe mental disorders. Unfortunately, the small amount of evidence available regarding adherence to treatment guidelines suggests that the guidelines are not in themselves sufficient to alter physician behavior and improve the quality of care.[5] Among the most distressing findings in the discouraging data on adherence is that a sizable number of physicians who believe they follow the guidelines established by their medical specialty association do not comply with the actual guidelines.

How can guidelines be made more useful? Practitioners are likely to follow guidelines when they are involved in writing those guidelines or have a close affiliation with the organization that sponsors the guidelines. Therefore, as many clinicians as possible should participate in the basic 3-step process used to develop clinical guidelines: (1) assemble the pertinent evidence (data and expert opinion), (2) develop clinical policy, and (3) apply clinical policy.[2] Large organizations could aid this process on a local level by facilitating efforts to draw on the existing scholarship and methodology needed to produce guidelines. The existence of a number of separate guidelines for the same disorder is not problematic since it offers the opportunity to compare the utility of various treatment approaches.

Development of guidelines should proceed as an iterative process with continuous improvement based on results harvested from ongoing use. Regular evaluation and revision of guidelines require not just systematic clinical assessment and treatment, but also standardization of clinical outcome measures. Health care systems must provide training and incentives for clinicians to use simple standardized outcome measures in their routine practice. Routine quality assurance programs can inform psychiatrists how their practice compares to relevant guidelines. Government funds are required to implement the large-scale outcome studies that are necessary to evaluate alternative treatment guidelines.

Today as we treat our bipolar patients, it is important to remember that the Veterans Affairs treatment guidelines are posted on the *Journal* web site (http://www.psychiatrist.com). While waiting for results from large studies, psychiatrists can immediately improve the care for thousands of patients by adopting the guidelines, which seem to represent a genuine gift from the government to our patients as well as our profession.

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REFERENCES

1. Bauer MS, Callahan AM, Jampala C, et al. Clinical Practice Guidelines for Bipolar Disorder from the Department of Veterans Affairs. J Clin Psychiatry 1999;60:9–21
2. Haynes RB. Some problems in applying evidence in clinical practice. Ann N Y Acad Sci 1993;703:210–224
3. Leape LL. Practice guidelines and standards: an overview. QRB Qual Rev Bull 1990;16:42–49
4. Battista RN, Hodge MJ. Clinical practice guidelines: between science and art. CMAJ 1993;148:385–389
5. Kosecoff J, Kanouse DE, Rogers WH, et al. Effects of the National Institutes of Health Consensus Development Program on physician practice. JAMA 1987;258:2708–2713

See the accompanying article beginning on page 9, and visit our Web site at http://www.psychiatrist.com *for the Bipolar Guidelines.*