Laws, Guidelines and professional choice

My wife runs a family business in the Lake District of England and regularly interviews people for a variety of jobs. Her business includes a visitor attraction centre, and she recently interviewed a very nice 42-year-old gentleman who wanted the job of handing out leaflets to local shops and hotels. All was going well and, as they got to the end of the interview, she asked him if he had any questions. He replied that he just wanted to clarify that the previous experience he had in canteens and workshops was actually gained while serving for 22 years in Durham prison for murder.

It struck me that we do not meet people like this very often. As a rule we all seem to follow our national laws that state that we should not commit murder, robbery or fraud, and society seems to work quite well because of this. However, all this breaks down when we get into a motor vehicle. I am yet to meet someone who has not broken the speed limit in his or her car, and I count myself as one of those who blame the speed camera when I get a ticket. So what is it that makes one law beyond question and another acceptable to flout?

In our own specialty, we have many guidelines produced by leaders in the field after meticulous systematic reviews that set the standards for our clinical practice. Who would question that prophylactic antibiotics are indicated for patients undergoing cardiac surgery or that aspirin should be given to all patients to improve vein graft patency (grade A evidence: American Heart Association 2004, [1])?

In contrast, Nowell et al. [2] have provided us with comprehensive account of the evidence for and against warfarin therapy after an aortic bioprosthesis, together with current guideline recommendations. The dichotomies between the evidence, guidelines and current practice are striking in this paper. The ACCP [3] and the ESC [4] guidelines all recommend 3 months of warfarin, the ACC/AHA [5] disagrees, and surveys of current practice [6,7] show us that while 80% of us are aware of guidelines indicating warfarinisation, over half of us do not anticoagulate after bioprostheses.

So, what is the role of a guideline in the modern era if we do not follow their recommendations? I regard guidelines to be excellent resources for summarising the evidence on a large range of topics in a way that I would be unable to do myself. The publication of the guideline from a respected professional body together with an expert panel gives me further confidence that I can believe the recommendations being given, so that I do not have to find and read the original papers myself. I can then follow their guidelines in the knowledge that I am likely to be following best practice.

However, we must consider ourselves fortunate that we are not bound by these guidelines. If I disagree with any of the guidelines, I can look up the evidence myself and come to my own conclusion, and this practice will be supported at my institution as my own professional choice.

In 1999, the UK government set up an 'independent' national body called the 'National Institute for Health and Clinical Excellence (NICE)' to produce guidance for clinicians in all specialties with a well-funded ongoing process of guideline development. However, often funding and benchmarking becomes linked to NICE guidance in the UK, and in many situations clinicians are unable to dissent from NICE guidance and their professional choice has been eroded. Examples of this include Herceptin for Breast Cancer which could not be prescribed until NICE published its final guidance document in August 2006 [8], cholinesterase inhibitors for Alzheimer's [9] and the recommendation against the use of autologous cartilage implantation for arthritis of the knee [10].

Thus guidelines from professional bodies may now have a second important role, namely to support their members in their clinical decision making by providing a document that can support their clinical practice. However, for this to be successful, the guideline development process must be brought as close to the clinical practice of its members as possible, so that the people for whom the document is intended, can actually influence its recommendations.

Last year, we commenced a process of guideline development for the European Association for Cardio-thoracic Surgery. Our first guideline on Atrial Fibrillation was published in December 2006 [11], and the next guideline is entitled 'Perioperative management of anticoagulation and anti-platelet therapy in cardiac surgery'. Where our guideline development process differs from other professional bodies is that all our individual recommendations are first published in the ICVTS as a Best Evidence Topic. This allows any surgeon in Europe to read the evidence online and then post a comment if they wish. This comment will then be published together with the ICVTS publication and subsequently quoted when the full guideline is published. The paper on warfarin for bioprosthetic valves has already been...
published [12] and a recommendation based on this paper will appear in the final guideline document. This process is in its early stages, but if successful the European association will be able to use the whole of its membership as its ‘expert group’ when deriving guidelines. These guidelines will reflect the range of best practice seen amongst its members, and allow clinicians to support their decision making against a range of external benchmarking and financial pressures. Thus, we have the opportunity to set our own speed limits before external guideline development agencies supported by their governmental sponsors turn their own guidelines into ‘law’. We now have an interactive guideline development process in place for EACTS and with the support and comments of its membership, we will ensure that these guidelines reflect the full range of best practice across Europe.

References


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