Evidence-based guideline development can be seen as one of the major achievements in efforts to improve patient care in the last decade. Well developed clinical guidelines provide professionals, patients, and policy makers with information on how to manage health problems appropriately within day-to-day practice. The development of guidelines has made an enormous progress in the last 10–15 years with many guideline development programmes, such as those of NICE, SIGN, and medical colleges, using established methods and procedures, according to AGREE Collaboration criteria.1

New developments related to searching and grading evidence (SEARCH, GRADE), and adapting guidelines to local context (ADAPTE) aim at making guideline development better and more effective. Guidelines have had a major impact on care in general practice in some countries; for instance, in the Netherlands most problems seen in general practice are covered by national evidence-based guidelines developed by the scientific body with over 70 national evidence-based guidelines.2

Guideline development is time consuming and expensive, about €100 000–200 000 per guideline, and the question is, if this is cost-effective. It may be, if guidelines were valid and had a wide impact on health care.


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Getting a grip on guidelines: how to make them more relevant for practice

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However, even well developed evidence-based guidelines are often not used in day-to-day care (estimations range from 25–50%). There are different causes for clinical guidelines not being used, partly related to the health problem well, as outlined by Hegarty et al.³

In a large study (yet unpublished) on the implementation of chronic obstructive pulmonary disease (COPD) guidelines in the Netherlands, we found that improvement failed, largely because patients did not follow the advice of their GPs. The guidelines on COPD do not address this problem of non-adherence sufficiently. Many guidelines also lack the tools that should help to make them work in real practice, such as well-structured care pathways and well-developed indicators to measure performance and change, and focused programmes to support their implementation.

Clinical guidelines are potentially very valuable tools to support decision making in general practice, but some improvements are required in current guidelines and guideline development processes to make them more relevant. They should, for instance, be focused more on key-issues in patient care, with direct relevance for both practitioners and patients; they should take real (comorbid) patients as a starting point; they should be developed in less time-intensive procedures to keep them updated, presented in more concise formats, and be combined with quality indicators and support tools for practice. A priority is better collaboration between all stakeholders — clinicians, scientists, patients, policymakers, and others — to identify jointly the most important questions, assess the available evidence, and draw recommendations that can work under prevailing practice conditions.¹ The limitations and importance of drawing guidelines for highly different circumstances under which practitioners encounter their patients should be acknowledged. This is even more important when financial incentives are linked to the evidence-based guidelines. Such improvements should lead to guidelines being able to deliver what they intend: better care for patients in response to their needs.

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Direct access to diagnostic services

Under conventional systems of care, outpatient clinics see patients referred by a GP for clinical assessment by a hospital specialist. Subsequent hospital visits are arranged to undertake any specialist diagnostic tests that may be required and to initiate treatment where necessary. In other words, the specialist in the outpatient clinic acts as a gatekeeper to other hospital resources. Allowing the GP to bypass this gatekeeper and gain ‘direct access’ to tests can enable GPs to make more efficient use of hospital resources and reduce waiting times for patients.

Direct access to diagnostic services should reduce outpatient attendance in that GPs may refer patients for diagnostic testing without prior consultant assessment. Waiting time from presentation to testing is accordingly reduced. If the patient can be managed by the GP without subsequent referral to a consultant, waiting time from presentation to treatment is also reduced and further outpatient attendance avoided. However, direct access may increase demand for testing and lead to less appropriate referrals with a consequent reduction in diagnostic yield. It is also possible that the quality of care will decline if GPs fail to take appropriate clinical action in response to test results. All other factors being equal, the direct cost to hospitals may be reduced if savings from reduced referral rates to outpatient clinics are greater than the costs of providing the direct access service.