A guide to guidelines

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Clinical governance, evidence-based practice, research into practice, clinical effectiveness (and its very own national institute), audit and clinical performance indicators are all relatively recent developments in the British NHS. To a greater or lesser extent, all of these jargonistic phrases are served by the use of guidelines in patient management.

New guidelines are sent out to me every month from one organisation or another; most are read briefly and then end up gathering dust on my office bookshelf. I have asked many of my colleagues and they do the same. Do we all have a Luddite-like reluctance to change potentially outmoded and ineffective practice? Are we arrogant individuals who know it all and do not need a guideline to tell us how to manage something we have looked after perfectly well (in our eyes) for years? Or is there something inherently wrong with sending out a book of instructions to independent practitioners and telling them that is how they are going to practise from now on? The obvious tone of the last sentence indicates that I believe the latter to be true.

View from both sides

I have been involved in writing guidelines on the management of the diabetic foot and have acted as an external assessor for guidelines from other parts of the country. I am also fortunate in having worked in one of the leading centres for diabetic foot care and research, producing a considerable body of scientific work which is often quoted in guidelines. I am now trying to develop my own centre using the best possible principles of care. I therefore feel I can write from experience of guideline development as well as from the perspective of the guideline recipient and potential implementor.

In modern times our practice is meant to live or die by evidence. The evidence for most of our practice with diabetic feet does not exist in a robust form. It has been decided that the randomised double-blind placebo-controlled trial is the pinnacle of evidence. Such trials do not exist in the complexity and size required to answer even some of the most basic questions about diabetic foot ulceration. One example of this would be the statement that patients with diabetic neuropathy benefit from the provision of appropriate footwear. This is supported by a number of observational studies and a couple of randomised trials and is therefore a highly rated recommendation. Yet it says very little. What kind of shoes? How often should they be changed? Should different shoes be used for different lesions? Should custom insoles or flat insoles be used? All have a bearing on the care of an individual patient, and on these questions the practitioner is on his/her own.

Guidelines: good science?

Guidelines that try to give evidence levels are often full of recommendations rated at level C. These are only a little better than the 'men in suits sitting around tables' approach which we are supposed to eschew. For this reason it is often hard to follow recommendations that go against your own instincts without hard scientific proof to force you to change.

A recommendation that all diabetic foot ulcers should be treated in hospital clinics might be eminently sensible, but there is no randomised trial evidence for it and therefore it does not get a top rating in a guideline. If a guideline were to say that all diabetic foot ulcers should be treated by podiatrists, this would immediately invalidate all of the nurse-led diabetic foot clinics in many prestigious centres. However, some in the podiatry profession would regard this as a good recommendation.

Antibiotics are another classic example of where guidelines run into problems. Lack of convincing clinical trials has not stopped me, or others, from prescribing long-term antibiotic therapy for the majority of my patients. Fortunately, evidence has recently been emerging that this policy was probably right all along. However, local formularies and microbiology guidelines often meant a long hard struggle to assert my clinical judgment in the face of others who, like me, were equally expressing an opinion based upon no scientific evidence.

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Despite this, guidelines have often taken on a life of their own in the courts, where deviation from a guideline might be seen as indefensible if the deviant is unable to provide hard evidence that he/she was acting in a responsible manner for which there is a body of opinion in support. In the absence of true scientific proof on both sides, argument will come down to the balance of probabilities, and an official guideline might carry more weight than a single expert opinion.

Ownership of guidelines is also important. The more remote the guideline from the recipient, or the more comprehensive the guideline tries to be, the less it is relevant to the care of an individual patient in the everyday practice of the clinician.

Recent international guidelines, for example, have to allow for the fact that there are no podiatry services in many countries or that gross domestic products in poorer countries do not allow for the provision of footwear to patients. Scotland has its own guidelines committee that is separate from England and Wales, and Northern Ireland has its own diabetic foot guideline that is separate from the UK mainland. In each case the guideline committee has tried to look at factors that might influence the use of the guideline in the intended community, but in truth all guidelines are a compromise. The broader the user base for the guideline, the weaker the recommendations that can be made and the more guidelines should stick to suggesting systems of care, structures and organisation.

Local treatment protocols should be adapted from all generic guidelines, and implementation in individual units should be based upon local service differences. Where clear deficiencies in service provision are highlighted it should be possible to use a guideline to improve service and lobby for more resources. However, this is often likely to be unsuccessful as most guideline creators have no statutory power to enforce the guideline or even, in some cases, the will to ensure that they are implemented. Lone individuals may champion the cause, but without the consensus of the users no guideline can succeed in overhauling a cash-constrained health service. For this reason I feel that most of the current guidelines can be used only as a framework for practice and not the basis for everyday patient care.

Conclusion

All guidelines are generic and rarely fit the patient in front of you. A guideline should be adapted for local use as far as possible in order to increase the uptake of its message.

All guidelines on the diabetic foot have to contain as much subjective opinion as true evidence-based fact, because the evidence is often missing on many of the key subjects on which an answer is sought. This editorial has contained a considerable amount of subjective opinion, but I stand alone and do not claim the additional kudos of being part of a governmental task force on guidelines, or a committee, no matter how highly regarded, internationally renowned and scientifically respected they might be.

You are therefore free to ignore all that I have written in this polemic. However, if you have received guidelines, and your practice falls short of the so-called 'gold standard' practice therein, be ready to defend yourself if the auditors call. ■