Clinical Practice Guidelines?

Many of the readers have written me regarding the Clinical Practice Guidelines that have been recently published in the Journal of Foot and Ankle Surgery. Although the inquiries have been varied, the common thread is, “Are these supposed to guide the way I practice?” I would like to take this opportunity to recall the process and the history of the project. The answer to that question should then become evident. In particular, I will attempt to parallel the inception of practice guidelines in general with that of the College.

Practice guidelines can play a key role in efforts to improve the value of health care—that is, patient outcomes for resources spent. The identification of both beneficial and excessive services can help patients get the care they need. The guidelines can also help patients, physicians, payers, and others make appropriate choices in an environment of limited resources.

In 1989, the federal government confirmed that practice guidelines were an integral component for health care reform. In fact, to facilitate the development of practice guidelines, the Agency for Health Care Policy and Research was created. The agency was funded by the government and directed to sponsor guideline development and to provide research data for the development of future guidelines. Well, you might think that the government was being quite generous to the medical profession, which most would welcome. The kicker was that the system was set up to encourage the medical profession at large to escalate efforts to reduce “inappropriate” services. How many physicians would volunteer that some of the services they provide are “inappropriate?” Well, what was the incentive then for any organization, including ACFAS, to develop these guidelines? The answer to that question is fundamental. . . . The system collectively placed physicians at financial risk of the volume of services provided to Medicare beneficiaries through a mechanism known as volume performance standards. The creation of such guidelines was thought to be a compelling tool for doctors to respond to the “need” to control costs.

Well, now you say this was just another ploy by the payers to reduce the amount that they paid. To a certain extent, that was true, and you just had to accept it. The questions really become, “Do these guidelines improve the ‘quality’ of care?” and “Do these guidelines really reduce costs?” Ideally, these guidelines are designed to help address costs without requiring value-laden decisions on the trade-offs between costs and benefits of services to patients. Unfortunately, there is no consensus as to whether guidelines do either. . . . Do they really improve care and reduce costs? Is this concept an oxymoron?

In 1991, ACFAS set forth to participate in this growing trend of practice guidelines. Many of you will recall the first document, a Preferred Practice Guideline, “The Ingrown Toenail.” Although a seemingly mundane topic, that entity was chosen, like subsequent conditions, based on the prevalence of the condition in our practices. Prevalence translates into global cost to the payers. ACFAS past-president Alan Shaw heralded this entire effort, which led to other documents such as “Hallux Valgus in the Healthy Adult,” “Hallux Rigidus in the Healthy Adult,” “Hammertoe Syndrome,” and many others.

Over the years, these documents have been updated and improved to reflect the changing therapeutic modalities in our specialty. Currently, the College has provided several contemporary publications entitled “Clinical Practice Guidelines,” which have been published in your Journal as recently as the last issue. Take a look. . . .

You’ll find a concise, well-researched, amply referenced
guideline for the treatment of the adult flatfoot. The newer documents reflect a more streamlined, easier to read effort which leads to increased utilization. Now how exactly do you use it? I am not quite sure that the average practitioner will rummage through the bookcase to determine the “optimal” treatment for the next patient that enters the office with stage 3 posterior tibial tendon dysfunction. Rather, the usefulness of the document is to guide treatment decisions over a large cohort of patients, a more national approach so to speak. In no way are these guidelines intended to restrict your capacity to do what you really think is best for a particular patient. If you read the piece carefully, it is quite liberal with regard to the indications for many procedures and techniques. Yet we have to balance that liberal sentiment with a “best practice” philosophy. To put it another way, if you saw 100 patients with the same diagnosis, the overwhelming majority of patients can be treated without deviation from the published algorithms.

Guidelines mean just that and are not meant to stifle the zeal for improvement. The College has put forth tremendous financial and intellectual resources so that each patient can receive the optimal care at a reasonable price. Although an unpalatable notion, these guidelines may actually deter some us from performing experiments. Experiments are best left to those in a laboratory. Take pride in these guidelines, and just to assess your own practice habits, take an informal compliance test . . . you might be surprised just how helpful these things can be!

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