Practice Guidelines:
Micromanagement on a Broad Scale, or A Modest Proposal for Omniscience

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I cannot remember a medical world without guidelines. Algorithms and "work-ups" have permeated my reading from day one and I have grown to like them. They are a helpful kind of pre-thinking and can lead to efficiency in practice. I'm hearing more and more about guidelines and, despite my fond experience with them, I'm having an adverse reaction to what I hear. Suspicion.

Why suspicion? We have all experienced Newspeak. "Contributions" to Social Security *sound* like the kind we make to church or charities. To date, however, neither church nor charity have required employers to deduct them from our wages under heavy penalty for nonperformance, nor will we be arrested for failure to contribute. Yet, they remain "contributions." In like fashion, might practice "guidelines" become something more? Most likely. Voluntarism is rarely so heavily funded.

For clues to the future, let us take a particular set of guidelines as exemplary of what is going on.

In late 1989, the United States Congress created the Agency for Health Care Policy and Research (AHCPR).[1] "The AHCPR has been given agency status within the US Public Health Service (PHS) similar to that of the National Institutes of Health (NIH)."[2] From humble beginnings in about 1930, the NIH began to grow exponentially in the mid-1950s.[3] The AHCPR was born at a status level similar to the NIH. Why am I already not reassured? "The agency has received funding to study the effectiveness of preventive, diagnostic, and therapeutic strategies employed in health and medical care. More generally, the AHCPR funds analyses of the organization, financing, and delivery of health care services in order to enhance the quality, effectiveness, appropriateness, and access to such services. The agency is also charged with influencing health care policies through the development and dissemination of practice guidelines."[4]

One searches the U.S. Constitution in vain for the authority for another broad federal reach into the lives of private institutions and citizens. One turns aside elitist arguments that ordinary citizens cannot understand the supposedly esoteric language of the Constitution. The tenth amendment says, clearly, "those powers not delegated to the United States by the Constitution, nor prohibited by it to the states, are reserved to the states respectively, or to the people." Neither medicine, medical care, medical research, guidelines, DRGs, health security cards, nor anything like these are remotely in view for the population according to the Constitution. We can read English acceptably well without the tutelage of a government expert.

As a generalist in medicine, it also immediately occurs, if one has the health of the population in view, that living in liberty secured by a constitutionally-limited republic has health benefits in itself. It is even conceivable that these health benefits exceed anything that a Washington agency could provide, even if it functioned perfectly. In other words, does this effort for guidelines contain a lethal, genetic flaw that will actually harm the population's health?

Ah, but to believe that there is a *flaw* is to presume that one knows to what environment these guidelines were adapted. If one presumes that they were adapted to improving the health of the population, and to lowering the cost, one might be mistaken. If they are in fact evolving to increase central *control* over our lives, then the genes may be perfectly adapted.

But let us now move from generalities to specific items.

Which Guidelines?

The AHCPR guidelines appear to be the front-runners in the guideline race. There are other contenders. "Seven different federal agencies, the American Medical Association, insurers, hospitals, specialty societies, and numerous other organizations are producing them."[5] Some claim there are about *1500* practice guidelines already developed.[6] I'm sure this number does not include the algorithms regularly published in throw away journals. Can you serve two masters? Three? Four? Do you believe that they will all agree? If you think that, I have some sub-hydraulic land in coastal Carolina you might be interested in purchasing. Every developer of a guideline has an agenda. Not all agendas are congruent.

Guidelines for Physicians, or for Attorneys?

The sheer number of guidelines will perhaps assist our attorney friends with their yacht or European condominiums. Dr. Troy Brennan who is a lawyer and a physician, "...warns that physicians who don't follow guidelines will 'find themselves in court.' "[7] *Another* opportunity to be in court is certainly on the top of my list. If you cannot follow several incongruent guidelines simultaneously, then an attorney has only to choose among the ones you neglected to find you negligent. Perhaps he can put these guidelines on the television screen as shopping lists for patients. "Did your doctor order this test for you? If not, call me, toll free, at 1-800-SHARKS."

"The Clinton administration and at least two congressional committees have proposed demonstration

projects to link practice guidelines and liability protection."[8] The liberal politician's guide to enslaving physicians is already far too heavy on the punitive end. It would be nice to create guidelines and then "allow" doctors to escape malpractice excesses by remaining within them. A carrot to go along with the stick. One wonders what the trial lawyers will be offered to help them take up the slack.

Guidelines to Serve Whom?

The number of agendas that can be served by practice guidelines exceed even those served in the big fire in Waco, Texas, last year. Quoted in *American Medical News* is David M. Eddy, MD, PhD, who says that, "The first challenge for doctors working in capitated systems is learning that they can no longer offer patients any service that might make a difference. That's because capitated providers essentially have 'promised to spend money in a way that maximizes the health of the population.' ...Emerging health care report cards judge success not on individual episodes of care but on broader measures of health status."[9] That could be Newspeak for, "Mrs. Rogers, removing your gallbladder ranks 417 on a list that is only funded to number 398. It is going to have to stay in, since the population just is not going to be significantly healthier if we remove yours. You have only a few years left anyway, at best. However, we do have several pairs of these blue-colored glasses that will fit right over your bifocals — there — like that. Give them to your family and friends and they'll hardly notice that you've turned the color of a squash."

John W. Robbins, reviewing the national health care schemes of the Nazis and other totalitarians, writes:

By the time of [the] Weimar [Republic], German doctors had become accustomed to cooperating with the government in the provision of medical care. The reforms of the Weimar Republic following the medical crises of World War I included government policies to provide health care services to all citizens. Socially minded physicians placed great hope in a new health care system, calling for a single state agency to overcome the fragmentation and the lack of influence of individual practitioners and local services. The focus of medicine shifted from private practice to public health and from treating disease to preventive health care....The physician began to be transformed into a functionary of the state-initiated laws and policies. Doctors slowly began to see themselves as more responsible for the public health of the nation than the individual health of the patient....[10]

Notice the reference to "fragmentation." How controllers love to hate fragmentation! A barracuda observing fish mingling about a reef might lament their fragmentation into individual fish and solve the problem by merging them into its flesh. A bureaucrat observing physicians mingling patient idiosyncrasies with variable medical information might have the same instinct.

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Dr. Eddy, whom you would doubtlessly be astonished to learn is a "prominent cost-effectiveness analyst," explains further, "...better education is needed to help patients understand that they don't have a right to receive any care merely because they desire it."[11] Wow! America, the land of the free and the home of the brave. The place where ads for hamburgers, jeans, beers, and autos tell us that we "deserve" something. Couple Dr. Eddy's explanation with the recent barely derailed national health care system which allowed *no* exits to privately contracted care and you have a population which could choose its frivolous cars, clothes, and caviars, but not choose a health care maneuver which they were convinced would improve their health.

Just as we cannot serve two masters in the form of multiple guidelines covering the same issues, so also we cannot serve the "population" in the abstract instead of the patient before us. It is Doublespeak to maintain otherwise.

The AHCPR Guidelines

Among all the contenders for Dominant Guidelines (consider that he who writes the guidelines holds the vital parts), the AHCPR is the clear front-runner. These guidelines are backed by the full faith and credit of the United States government and are therefore as sound as a Federal Reserve fiat dollar.

Very recently, I ordered all the AHCPR guidelines that have to date been distributed. They arrived in a box, a rather large box, which raises a practical issue. Can you read all of this stuff? Are you too busy calling some other third-party for "permission" to admit a patient to a hospital, answering a challenge from the PRO, or filing CLIA paperwork? Remember that there will be revisions. You cannot read them once and absorb them. And, these are just the merest shadow of what is coming. These also are only the AHCPR guidelines. Like the Federal Register which, at over 65,000 pages, we are all responsible to obey but could not read if we lived forever, we will be accountable perhaps to such as these guidelines. The sheer *volume* is going to be ridiculous, but serviceable to those whose agenda is to control. We already live in a nation where the KGB can tell its political superiors, "Show us the man you want and we will find the crime."

Look at one guideline booklet for the goodies within — lowly "otitis media with effusion in young children." See the panel which produced it. See how these are people just like you are — ordinary practical workaday physicians taking care of patients, meeting payrolls, keeping up with their hospital charts,

and so on: Professor of Pediatrics at the University of Pittsburgh, Professor of the Department of Family Medicine at the University of Washington, Associate Professor of Otology and Laryngology at Harvard.

Of 19 panelists, I found only one practicing family physician. Eleven held an MD degree. There were four PhDs, three RNs, one consumer representative, and...a partridge in a pear tree. The politically correct balance was there with 9 men and 10 women. For relief of your anxiety, I'll tell you now that there was also racial balance. I do not know whether Baptists were balanced against atheists, the left-handed with the ambidextrous, or whether there was even one low handicap golfer. For a scientific document, one would wonder why science is such a respecter of race and gender.

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Next, the entity for which the guidelines was written was very *narrowly* defined. They were not writing about the hot, red ear in a febrile child. They were not writing about a six-month-old or a five-year-old. They were not writing about otitis media with effusion in a child who has cystic fibrosis, seizures, or renal failure. My medical life has not been like that. Problems in my patients come in clusters. There is a sidecar loaded with other baggage in many of the cases I see. Here, we see one of the ways, for the time being, that you may duck the guidelines. Just find a coexisting problem or complication and mention it. The narrowness makes it easy.

The panel pays lip service to judgment. They say, "The Panel recognizes the clinical circumstances of individual patients can require additional judgment of health care providers and parents regarding therapy."[12] This loophole may be subject to closure later, but for now is there. As many situations as it represents, it comes in for scarce mention in this little volume of 100 pages. It does pop up twice more in the three page algorithm published in the book. Boxes number 6 and 17 contain this, "Exit this algorithm to individualized patient management appropriate to the clinical situation." See how you must *exit* the algorithm to achieve appropriate individualized patient management. This permission suggests another difficult but more fundamental means to minimize guideline damage. Enlist selected patients. Let them read (on their own time, preferably) extracts of guidelines. Let them see how their government (or insurer) is treating them as members of a herd while you are trying to individualize.

Next, see how the panel managed to deal with scientific information. They *voted* on it! It reminds me of the story of a camp counselor in Texas who took a bunch of inner city delinquent kids on their first hike in the woods. They were tough little knots. They came across an armadillo and fell to violent argument amongst themselves as to the sex of the creature. Couldn't tell. Armadillo-deprived they were. Wasn't covered in sex education class in Houston. No obvious place to apply a condom. Finally, on the verge of getting into a fistfight, they decided on a democratic solution. They voted. The majority made the unsuspecting armadillo female, and they hiked on in peace.

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The AHCPR panel of experts operated on that model. They voted on whether or not the available evidence constitutes strong recommendation based on high-quality scientific evidence, or a moderate recommendation based on good-quality scientific evidence, or mere recommendation based on limited scientific evidence. If there was inadequate evidence, they would substitute panel consensus which was graded as strong or merely expert. In addition, they offered clinical options in case they wouldn't occur to you.

When evidence is insufficient, there is always received opinion. If it is voluntary, there is little problem. If guidelines become mandatory, however, when opinion is not heeded, there is always The Tribunal. Oh, Galileo, where are you? Do you recognize these people in black robes? Are they related to the ones who made you recant?

For otitis media with effusion, none of their proposals contained anything stronger than mere recommendations.

Other AHCPR Clinical Practice Guidelines are available to you, the provider, and these include:

- The Management of the Functional Impairment of Adults by Cataracts
- Urinary Incontinence in Adults
- Management of Early HIV Infection
- Diagnosis and Treatment of Depression in Primary Care (2 volumes)
- Screening, Diagnosis, Management, and Counseling in Sickle Cell Disease in Newborns and Infants
- The Diagnosis and Treatment of Benign Prostatic Hyperplasia
- Acute Pain Management in Operative or Medical Procedures and Trauma

Leaving aside these more specific concerns, let us return to an overview of the idea of clinical guidelines for medicine.

By their very nature, the guidelines are impersonal, not individualized. Does American medicine at this time in its existence need a more impersonal approach? Dr. Albert Mully, chief of Massachusetts General's general internal medicine unit says, "Averaging is at the heart of population-based decision-mak-

ing. That poses a great risk that we'll end up giving interventions to people who would not choose them and withholding treatment from those who want it. Only individual patients can define what 'value' is in health care."[13]

On the other side, the chief of staff for specialty services of Seattle's Group Health Cooperative of Puget Sound says that teams of allegedly independent physicians can produce "roadmaps that may get us from our current system of individual care to population care."[14] Are these roadmaps that we really need? In a choice between individual and population care where does our loyalty lie? Besides that, are your exam rooms really large enough to fit a *population* into them?

Synopsis

In summary, let's review some of the issues with clinical practice guidelines:

1. The guidelines are *disease*-oriented rather than *patient*-oriented. This orientation to disease is an affliction of modern medicine which the guidelines did not originate, but which they can aggravate. The context in which problems occur, the beliefs of the patient, coexisting disease, financial issues, malpractice liabilities, and so forth, are not sufficiently in view. For the time being, we may reassert our decision-making capacity by noting those features which the guidelines acknowledge they cannot manage.

2. The guidelines seem particularly susceptible to becoming mandatory rather than advisory.

3. Clinical practice guidelines will offer a carrot in addition to a stick. That is, obedience to them may be shelter from legal assault if guidelines obeyed.

4. Clinical practice guidelines omit effective consideration of epidemiology. The prior probability of a particular diagnostic entity varies not only by geographic area, but also by the patient-mix of each practitioner. Knowledge of the prior probability of disease is a very helpful clinical tool, for which guidelines do not seem to allow adequate use. The prior probability that a patient's headache in my [family] practice is originating from a brain tumor is exceedingly low. While still low in the practice of a neurologist, it would be I believe orders of magnitude higher. Each practitioner should be able to use that kind of information.

5. Clinical practice guidelines can be conceived as the adverse but flip side of an existing error in medical practice. If we were free to use guidelines in an uncoerced fashion, they could go a long way toward helping us to avoid wallowing in subjectivity and IGBO type of clinical problem solving. IGBO is "I Got Burned Once." We missed a case of "epiglootis oogagus acutus" and now it leads the differential every time, though it is a one in three million occurrence.

6. Practice guidelines are not uniform. Even if they were all correct, we cannot follow them all simultaneously. Different reference groups have different emphases. It is easy to see whose ax is being ground. Follow the money.

7. Practice guidelines presume that "health" is objective, knowable, and that all are in agreement about it. It is not. Health is subjective, incompletely knowable, and not at all in agreement. One patient will insist on having a benign spot in her skin removed and the next will have tattooed a similar spot in the same place. One will want a headache removed no matter what, while other people keep their headaches, since they serve certain social functions for them.

8. Practice guidelines will tend to reduce physicians to box-checkers. Solving the problem efficiently to the physician's and patient's satisfaction will become less important than having a record that shows all the right boxes were filled in, literally. As a particular example of this, watch for practice guidelines to overemphasize *preventive* care (which, by the way, is one of the more over-promoted and under-proven areas of medicine) and distract from pleasing the patient who has a definite agenda. Guidelines threaten to insert the agenda of a third-party between the doctor and the patient.

A model for state-run clinical practice guidelines would be the classroom schoolteacher. The classroom teachers fill out forms produced by superiors, teaches the students selected by others during hours determined by others, and uses the textbooks and methods chosen by their employers. In a former life as a school psychologist, I observed state bureaucrats in elementary classrooms with stopwatches to assure that the teachers spent sufficient time trying to teach who conquered Quebec to fifth grade children who could not yet read. The classroom teacher is simultaneously extolled as central to education and at the same time is allowed little leeway for real exercise of professional judgment. If you are in family practice or other "primary care," watch out! We are being extolled as the marvelous answer to so much of what ails American medicine. See, however, how much real judgment we are retaining. Gatekeeping is bad enough. Worse, we won't even be real gatekeepers. We'll be plantation overseers. The owner will set the rules.

9. Clinical practice guidelines implicitly but powerfully determine what medicine, health, and healing *are*. Interventions that don't look very "medical" will not appear in guidelines. On [rare] occasions I have curtailed a long pattern of

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patient visits for a variety of ailments which eluded any diagnosis but a symptomatic one. The maneuver has been to help the patient to get a job. Presto! The visits drop off to a trickle, and the patient is happy. Find that in a guideline.

10. Innovations will be stifled. Who can try it if it isn't already written down? How *much* of clinical medicine is judgment! How little is hard information.

How to Respond?

1. Get on committees and become a sea anchor. This helps, but is at best a rear guard action. You may slow down the advance of improper use of guidelines, but it can still advance.

2. Proactively contest the publications by explaining each deviation from them. This gives victory, but a Pyrrhic victory. You may win, but they have ground you down by making you spend time on trivia.

3. Be willing to be involved as defense witness in malpractice suits after becoming knowledgeable about likelihood ratios and other similar processes which can keep guidelines in their proper place in court. Admittedly, this is a slow, difficult process, but then, short of a return to constitutional government and sound medical economics, there is no basic solution. We arrived where we are by mis-education and a grindingly slow educational route will have to constitute a major part of the answer.

4. Inform your patients of what is going on. Explain what the guidelines would have you recommend, give your actual advice, and let the patient help decide. I find that patients prefer my judgment to that of unknown "experts" who pretended miles away and years ago to be able to decide what ought to be done in their particular situation.

5. Move to another nation. An acquaintance in plastic surgery moved to Greece and says the clinical freedom and cash system there is wonderful. I worry, however, that the spirit which generated this threat from guidelines appears to be universal.

6. Get on hospital committees where guideline battles may be won rather than merely delaying a loss.

7. Inform the public via public media. This is expensive in that it takes time and you must prepare to take some hits from the other side, which always seems to be better funded (with tax money).

8. In all endeavors, operate toward the vital parts. That is, see what is *principally* wrong and make your incision and dissection over that part. It may be slow, dangerous, and more expensive, but it has cure in view, not palliation. Mandatory guidelines, when they come, are principally wrong. The medical care of persons is ineluctably idiosyncratic.

William Osler said: "It is better to treat the patient that has the disease than to treat the disease." In the final analysis, our responsibility is to the a particular patient, in a particular context. To the extent that guidelines can help us perform that function, they can be well used. Otherwise, they obstruct. Beware the coming obstructions.

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