

Strengthening primary care: the role of clinical practice guidelines

Introduction

Clinical practice guidelines (CPGs) have been developed, disseminated, and implemented to assist health providers and patients to make clinical decisions, reduce unwarranted variations, and assure and improve the quality of care. The role CPGs may play as a means of strengthening primary care in Hong Kong has yet to be explored.

The Hong Kong College of Family Physicians began to draft guidelines on conditions like diabetes mellitus,¹ asthma,² and vaginal discharge³ in 1991. The Department of Health's Professional Development and Quality Assurance website currently displays CPGs on pertinent primary care conditions like type 2 diabetes mellitus, hypertension, and lipid management.⁴

In his 2009/2010 policy address, the Hong Kong Chief Executive pledged to provide additional resources for developing chronic disease management protocols.⁵ At this crossroad, where CPG development may play a role in shaping Hong Kong's primary care, what is the evidence that the use of CPGs improves patient health outcomes? What factors may facilitate primary care doctors' adherence to the guideline recommendations?

This issue—whether or not CPGs improve health outcomes in primary care—was debated during a recent symposium: 'Primary care for Hong Kong...the way forward'. A newly published systematic review of the impact of CPGs in The Netherlands reported improvement in the process and structure of care, with small but significant improvements in health outcomes (for example, glycosylated haemoglobin was lowered by 1.7%).⁶ Hence, there is some evidence that planned and thoughtful implementation of high-quality CPGs does improve the structure, process, and outcomes of primary care in specific populations.

The implementation of guidelines among primary care doctors

Surveys in The Netherlands, United States, United Kingdom, Italy, Canada, Australia, Denmark, Ireland, and Israel have found that most doctors are supportive of CPGs, finding them to be useful, educational, and likely to improve the quality of care.⁷ This positive attitude, however, does not automatically translate into practice changes. Nearly half of the respondents were concerned about the increased likelihood of litigation or disciplinary action.

Non-adhering doctors are those who are not aware of, or not familiar with, CPGs; who do not have the self-confidence to apply the recommendations; who do not expect to achieve good outcomes by following guidelines; who want to stick to their previous practices; and who are constrained by external barriers, such as patient preferences or a lack of resources.⁸

Qualitative studies in the United Kingdom, United States, Canada and The Netherlands have highlighted the value general practitioners (GPs) place on seeing every patient as a unique individual.⁹ Many GPs argued that population-based trials were not equally applicable to all and that use of a 'one-size-fits-all' prescription may pose difficulties in practices with differing demographics. Nearly all CPGs focus on single diseases, but many patients have multiple co-morbidities. Hence, flexibility or contextualisation should be built into the recommendations and CPGs should not be turned into performance measures used to critique the quality of primary care.

As yet no single method of implementing CPGs has been shown to be reliably effective in all settings and circumstances.¹⁰ In a study of Dutch GPs, within each guideline, individual recommendations encountered a unique pattern of barriers.¹¹ A UK ethnographic study showed that GPs seldom used formal sources of evidence that were codified in a direct, linear, or rational manner.¹² "Mindlines" (instead of "guidelines") were formed by brief reading (like leafing through a new guideline that had arrived in the mail), as much as by interactions with each other and by other knowledge that built on early training and experience. Hence implementation strategies should capitalise on the community context and on GP networks.

Conroy and Shannon¹³ wrote that "Success in changing clinical practice may depend less on scientific method and more on imagination, flexibility, enthusiasm and application of principles derived from marketing and social influence theories." Formats of CPG strongly influence the attitudes towards them, hence more thought should be put into making CPGs user-friendly and attractive. Grol¹⁴ pointed out that it is important to "know your target group" and "see their situation through their eyes". Several studies have shown that involving primary care doctors in the process of developing CPGs will enhance their use in daily practice.^{15,16} The use of economic incentives for guideline implementation is controversial. It

has been shown to be favoured by British GPs¹⁷ but other countries (for example, Norway) did not consider use of financial rewards a suitable method for promoting guideline implementation.¹⁵ Whether Hong Kong should follow the British model is open for discussion.

As guideline development is expensive, time- and skill-demanding, centrally developed guidelines are more likely to facilitate the concentration of resources for a comprehensive and trustworthy output. A recent *JAMA* editorial condemned the practice whereby pharmaceutical industry and specialty societies use guidelines to expand their share of the competitive medical marketplace.¹⁸ In Hong Kong, it is unlikely that primary care CPGs would be developed de novo, but the process of adapting international guidelines should be scrutinised to ensure the recommendations are made impartially.

Conclusion

If implemented, evidence-based CPGs can potentially improve quality of care. Worldwide, primary care doctors are supportive of CPGs. If guideline end-

users are involved, any central agency set up to adapt international CPGs is likely to be more efficient and credible. Further studies are needed to identify the strategies that are most significant, relevant and likely to have an impact on Hong Kong's guideline development policy.

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