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INTRODUCTION: PRACTICE GUIDELINES

Helpful Aids or Paradigm Shift?

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The profusion of clinical practice guidelines has been remarked on by many (3;6;8) and ascribed to a need to address the wide geographic differences in practice documented in the last quarter century (9;10), as well as to the increasing concern with the cost of health care. The idea is that guidelines, by outlining efficient care strategies, will enhance the quality of care and reduce unnecessary or unproductive expenditures. Others hold that guidelines are simply a means of transferring the results of research from the literature to clinicians (2;5). A darker view of guidelines sees them as instruments of control of medical practice by uncaring administrators concerned solely with cost reduction (4;7).

There is an alternative, however, that has received less attention. Perhaps guidelines are the first step in a change in the paradigm of medical practice—from that of an individual physician as artful autonomous arbiter of the course of action to that of a practitioner of a learned profession concerned simply with implementing the standards of practice. In the still prevalent paradigm, each patient is unique and so too is the presenting problem. Thus, the patient and the problem are thought not to be readily amenable to norms of care. The physician is viewed as a scientist required to embark upon a process of discovery of the "right" diagnosis and the "best" treatment, generating hypotheses and testing them based on knowledge of the "basic sciences" coupled with ingenuity. The alternative paradigm is that medicine, like other professions, faces recurrent problems that are alike and thus should be handled in the same way. The physician, from this perspective, is required to recognize the type of problem and then enact the proper, predefined steps to achieve an expected result. In doing so, the physician faces no requirement to understand the evidence that supports the recipe, much less any pathophysiology, biochemistry, genetics, and so on that may underlie it. Viewed this way, medical practice is not just aided by guidelines, it demands them for professionalism—and these standards come not from practitioners but from a cadre of nonpractitioners who are skilled in the required disciplines such as epidemiology, biostatistics, and modeling.

The authors of the papers in this section were asked to consider how clinical practice guidelines will affect the practice of medicine and the role of doctors in the 21st century. Will respect for the individual doctor's independence in diagnosis and treatment continue or will doctors be forced to adopt a more "cookie cutter" approach regulated by guidelines? What will be the impact of widespread access to guidelines through computer technology?

The response to this request is reflected in the papers in this issue, which cover a wide spectrum of topics. Included are the cognitive, ethical, economic, and social assumptions

underlying guidelines (Garfield, Giacomini, McGuire, O'Brien); the requirements for developing a guideline that will be accepted by a medical specialty society (Connis); the methods of appraising guidelines, measuring their effectiveness, and addressing their quality (AGREE Collaborative Group, Graham, Marshall); and ways of encouraging implementation and adherence (Garfield, Marshall, O'Brien). This broad swath across the current guidelines scene shows that the movement is still far from taking over the practice of medicine. While many guidelines are promulgated and some may be put into practice (Browman, Durieux, Garfield, O'Brien), they do not yet dictate most practice even within an HMO (Richman), and it is not clear that in their present form they will have the power to do so. Nevertheless, the situation in France may be a harbinger of central control of practice (Durieux).

After a decade or more of enthusiasm, guidelines seem to have more of a presence in academia, journals, and professional societies than in everyday clinical practice. A recent extensive review of the literature (1) identified a framework of barriers that prevent physicians from following guidelines—the majority related to physician attitude. Thus, widespread use of guidelines requires changing the physician's beliefs, through either persuasion or coercion. Medicine is taught both academically and in an apprentice system. Perhaps as the current teachers, steeped in medical autonomy, are replaced, a generation of young doctors will emerge who view guidelines not as useful suggestions but as an inherent, indeed central, normative component of professional practice.

Paradigm change or helpful aids? Even after examining these 10 articles written from very different perspectives, we find that the questions with which we approached this special issue of the *Journal* remain. The answers won't be found until the third generation hence, our professional grandchildren, starts practice.

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