

Clinical Practice Guidelines: What are their scopes?

*Decisions from doctors' councils
can be codified into guidelines*
Plato

The clinical practice guidelines (CPGs) are defined by Field as “the collection of systematically developed recommendations to assist practitioners and patient decisions about appropriate health care to resolve a clinical problem in specific circumstances” (1). Its fundamental purpose is to offer recommendations to the physician, based on scientific evidence, to resolve problems that he/she has to face every day when treating the patients. These recommendations are a framework that provides the physician with the best available evidence to perform a better clinical practice, to make clinical decisions and to offer the patient an appropriate treatment.

The CPGs are documents in which specific questions are made, the best scientific evidences are organized and flexible recommendations are given. Their objectives are to improve the clinical practice, to educate doctors and their patients, to reduce professional variability and to improve patient care and, accordingly, the population's health is improved (2). On the other hand, the systematic way in which the CPGs are made facilitates its critical revision, avoids errors, resolves controversies, and provides useful information.

There are different types of CPGs, based on consensus, on experts' opinion and on evidence-based medicine, very much in fashion just now. In this type of CPGs, the methodology used is systematic, explicit and reproducible, and follows a series of steps, from the asking of questions, the search, evaluation and synthesis of literature (evidence) to the drawing up of useful recommendations for clinical practice.

On the other hand, some situations have been outlined where it is recommendable to develop and have a CPG (3,4,5):

- When there is a big variability and/or uncertainty in the approach to some entity.

- When there is no consensus for the management of an entity.
- When there are clinical problems or situations of high social or economic impact.
- When an appropriate practice significantly reduce the morbidity and mortality produced by a disease.
- When the diagnostic tests or treatments produce adverse effects or unnecessary costs.

On the other hand, CPGs do present some difficulties:

- They are expensive to make, because following the evidence-based guidelines in medicine not only requires a great effort, but also the availability of specialized groups.
- Some times they do not provide the answer to the questions asked, they do not have the best evidences or may require some local adaptation.
- They require continuous up-dating.

Now, making a comparison, the CPGs provide the physician with flight coordinates, within which he/she has a wide maneuverability, depending on the patient's characteristics, the type of problem occurring, the availability of treatments, the experience, etc. All this leads to characterizing the physician-patient relationship.

The CPGs have not been, or are, conceived as strict and specific management protocols (it is to be remembered that protocols are rigid criteria outlining the management steps for a single clinical condition); neither are they strategies to obtain treatment costs (it would be difficult to do so, given the multiple flight routes that may be developed within the CPGs), and much less they are strategies to penalize (fine) the physicians or to define whether the medical conduct is ethical or not.

As to these two last features (fines and ethical reasons), the pretensions in Decree 131, January 21st. 2010 (Social Emergency) are inadmissible, suggesting a total ignorance by the government bodies regarding the scope and purpose of the CPGs.

This is reflected in the drafting of the regulatory decrees. For example, in the use of the *words guides, protocols, standards, technical norms and medical doctrine* (defined as a "set of conclusive concepts and recommendations based on the analysis of the scientific evidence") there is lack of word clarity and a mixture of concepts, objectives and scope that only betrays a terrible ignorance in this matter.

Now, pretending that a CPG should serve a mean to fine or not a colleague is ridiculous, and really shows not only the ignorance in the subject, but also the deviation from the CPG's purposes. Furthermore, to bring into the sphere of ethics a matter that is the competence of the quality committees leads to confusion of roles and of the CPGs' reasons for being.

Finally, we can only hope that by the time this editorial is read, the Constitutional Courts has declared the Social Emergency decree unconstitutional and that this misstep, to a great cost for the Colombian people, has served, paradoxically, to join us together around our professional and our patients' interests.

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