# The Evidence-Based Guideline Era

Tomi Spenser FRCGP

Department of Family Medicine, Faculty of Medicine, Technion-Israel Institute of Technology, Haifa, Israel

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Guidelines, in some shape or form, have always been part of the medical profession. After all, *primum non nocere* is really a three-word guideline – maybe even still the most important of all.

The evidence-based guideline movement has its roots in the genius of Lawrence Weed's problem-oriented philosophy [1]. The movement has now reached its adolescence, manifesting (in Eriksonian terms) the "identity versus role confusion" struggle.

The timely article by Dahan et al. in this special issue on Family Medicine [2] demonstrates this struggle beautifully. The authors call upon family physicians to find this identity by leading "a public discussion on the suitable definition for guidelines in the context of family medicine in Israel." Let this discussion begin right here and now:

Two initial questions are implied in the authors' call:

In what way is the context of family medicine different from any other clinical context? "Taking a good history" is of prime importance in every medical specialty. In primary care, because, as the authors remind us, a significant bulk of patient-general practitioner contacts remains undiagnosable for a long time, a complete history, including a family history, is of even greater importance. History-taking and diagnostic guidelines (so far not evidence-based) [3,4] are therefore relatively more important in family practice than evidence-based treatment guidelines.

Family medicine, today more than ever, is based on multi-professional collaboration and teamwork. The clinical guideline for each specific ailment must be relevant and acceptable to each group of health professionals involved in the treatment of patients with that ailment, whether in primary or secondary care.

**In what way is Israel any different from any other devel-oped country?**

The answer seems to be that each country is different. It is doubtful whether some are more different than others.

Israel, together with more than 20 other countries, has been a member of the WONCA European Working Party on Quality in Family Practice (EQuiP) (Chairman: Professor Richard Grol) ever since its inception. One of the activities of the group was the attempt to reach European consensus on the treatment of acute otitis media. After many hours of discussion it became clear that no consensus could be reached. It was therefore decided that each of the countries represented should write its own guideline. It will be interesting to see if, in the end, a European consensus can be reached. It should be noted that EquiP has reached a consensus regarding quality indicators for the medical record and its audit in primary care. A Hebrew translation of these guidelines has been published [5].

The Israeli guideline on AOM was written by the Working Group on Quality of the Israel Association of Family Physicians. It is based on a consensus among community and hospital physicians of all the specialties who deal with AOM and is intended for their use. The guideline has recently been published very handsomely by Clalit Health Services [6].

It became clear early in the preparation of the guideline that the emphasis must be on the diagnostic criteria. The reason for this was the fact that in the literature the criteria for the diagnosis of AOM were all different or lacking altogether. Therefore treatment outcomes were probably not comparable, even in the few randomized controlled trials on the subject. The AOM guideline contains the following definitions:

- A clinical guideline should be used as an educational tool to update knowledge and provide a basis for discussion and improvement.
- Guidelines should be updated every one to two years. This is especially important in guidelines involving antimicrobials because of the development of resistant strains and the advent of new medications.
- All guidelines should be provided with a statement on the strength of the evidence on which its various recommendations are based. This evidence is drawn from systematic reviews and meta-analyses of randomized controlled trials.
- Patients' – and especially parents' – experiences, opinions, beliefs and feelings should always be listened to and considered together with the evidence from the literature. Decisions should then be taken jointly with the patient.

This last one is the essence of family medicine. If we ignore it, we are, in the words of Andrew Herxheimer (Emeritus Fellow of the Cochrane Collaboration), in danger of turning evidence-*based* medicine into evidence-*biased* medicine (personal communication).

There are two developments, however, without which the guideline movement will not grow into a mature, viable adult:

- We must initiate randomized controlled trials of guidelines to determine to what extent they are implemented; and if

AOM = acute otitis media

not, why not; and if they are, to what extent do patients benefit by them. [7,8]. Such studies can be seen as a form of audit, and public funds must be allocated for them.

- In order to avoid conflicting recommendations, we must establish a national clearinghouse for Israeli guidelines. Such a center, consisting of representatives of all Israeli bodies which at present publish their own guidelines – would meet periodically, set standards and make sure that published guidelines are updated at least every two years.

Let the discussion continue!

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**Correspondence:** Dr. T. Spenser, Kibbutz Sasa, 13870, Israel.
Phone: (972-4) 698-8580
Fax: (972-4) 698-8702