Guidelines are not directives

Year by year politicians seem compelled to regulate the activity of their citizens more and more. Despite paying lip service to the democratic concepts of autonomy and local decision making they continue to strengthen their central authority with the result that individual freedom of action is diminished.

This is nowhere truer than with the medical profession. Although government believes itself to have the inalienable right to legislate on the one hand, and direct on the other, they have discovered a new, and seemingly less coercive means of controlling behaviour – the guideline. I am not certain of the exact antecedents of the guideline, or when the first one in history was written, but it might have been the Ten Commandments.

In medicine this sort of prescriptive list of the correct way of treating patients is relatively new and until recently it has been left to doctors to publish in learned journals or textbooks. Now guidelines are seen as necessary tools of good management. The managers and the politicians have insisted, in their relative ignorance of the subject, on being both the authors and activators of these best practice recommendations, which they publish as guidelines or protocols. Multitudes of guidelines have been manufactured in Whitehall, in the regions and in trusts up and down the country. It is a growth industry of some magnitude but is it healthy for the patient or the doctor?

WHO ARE GUIDELINES FOR?

Not only, so the argument goes, may the guideline modify the clinician's behaviour but it also appeals to the administrators and politicians, who practise medicine on computer screens. It seems both to standardize treatment and also protect the system to some extent from legal attack. Some doctors have embraced this new fashion wholeheartedly and are very enthusiastic about the efficacy of these new guidelines (Langsford et al, 2001).

The fact that not all patients can be stereotyped to fit within the narrow confines of a guideline seems hardly to have crossed anyone's mind but then there is growing concern that guidelines cannot solve the problems of poor care and lack of equipment or of plant and manpower. Sometimes they can be used as shields by managers to protect themselves and leave the onus on the doctors to find and apply the resources needed to implement the guideline. Worse still they may actually be harmful in some circumstances.

In a paper reviewing a Canadian task force's evidence-based guidelines for diagnosing pneumonia in children the authors concluded that the guidelines were unreliable (Rothrock et al, 2001). In my own field I was surprised to discover in reading the government's guidelines on the use of infliximab in inflammatory bowel disease that there was not one full-time gastroenterologist on the main advisory committee. Instead there were many health economists, epidemiologists and managers. With committees structured in this way it is not difficult to see how guidelines might be unsound.

Sometimes guidelines have been seen as a means for governments to control expenditure and much criticism of the National Institute of Clinical Excellence (NICE) guidelines has been forthcoming. Other guidelines, such as the Department of Health cancer guidelines with their prescriptive referral suggestions, can be criticized as distorting traditional referral patterns between doctors built up over decades through trust and good communication. I can think of no other country in the Western world that is doing this so blatantly and destroying many a good unit in the process.

The title of this editorial, however, is narrower than this. It implies that guidelines are not compulsory or legally binding but only voluntary codes of practice. There are possible weaknesses in this argument. In a detailed editorial concerning the use of glycoprotein IIb/IIIa inhibitors in acute coronary syndromes Poole-Wilson (2002) lays out physicians' concerns about the legal status of these NICE guidelines. He suggests there is much confusion and:

> **'if guidance from NICE is not a guideline but a direction to follow in a murky area of current controversy, then that should be made explicit'.**

I would agree with him that while the courts will probably support a physician exercising his/her independent professional clinical judgment when there are conflicts created by these published documents there may be circumstances when the NHS might not.

LEGAL RAMIFICATIONS

Clinical guidelines are developed by clinicians and/or managers and they could form part of the evidence of a case in a court of law. However, the Department of Health is aware of the potential dangers of such instruments and have spelt out that out-of-date guidelines might become actionable if not revised regularly as current practice changes.

The Department has also stated that guidelines should be constructed in such a way that allows deviation from them (Department of Health, 1996). In a cogent editorial in *Archives of Disease in Childhood* Tingle emphasizes this by pointing out that if a doctor followed a guideline that was inappropriate to their patient's condition the doctor could be deemed negligent (Tingle, 2002).

It is acknowledged that clinicians are worried about protocols because it is thought that failure to follow them could be construed as malpractice. According to Tingle, a legal academic, this is not correct and the Bolam test still applies. This is reassuring from the medicolegal point of view because the individual doctor can therefore apply his/her own standards to their work whether there are published guidelines in place or not. However, it begs the question as to what attitude authorities lower than the courts will take if a doc-

tor breaches a guideline. Medical or non-medical managers, who may not be fully aware of either the Department of Health's let out clause or of current legal opinion, may take a different stance. Individual doctors may thus find themselves in contest not with the lawyers but with their employers. The resulting professional dispute might be unpleasant and the outcome for the doctor deviating from the guideline somewhat unjust.

It is clear from the published literature that guidelines are not directives and should not be perceived as such. They are more like aide-memoires to be used as an adjunct by good clinicians. Poor or inappropriate guidelines can, and should be, contested in the courts if a body of responsible medical opinion is at variance with their recommendations. In this sense doctors can protect their clinical freedom to devise the best treatments for their patients and will have the support of the law if they have the support of their peers.

However, guidelines may be seen as directives by managers, who are themselves ignorant of the subtleties of medical practice. It therefore is clear that clinicians may need their wits about them if a serious conflict arises and may be forced to seek clarification from the courts. However, guidelines that do not directly relate to clinical matters, such as to which unit a doctor should refer a particular problem (see above), may truly be considered as directives in the sense that the courts are unlikely to ever become involved in any dispute of this nature and thus can afford the medical profession no third party protection when these guidelines are ignored.

CONCLUSIONS

It can be categorically stated that guidelines are not directives in the normal sense of the word, and although guidelines, protocols, advice sheets, formularies and directives may aid the doctor in the treatment of their patient, the guideline itself may create dilemmas of its own. HM

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KEY POINTS

- Proliferation of guidelines are a current phenomenon.
- Not all guidelines fit all patients.
- Guidelines applied which are out of date may constitute negligent practice.
- The Department of Health accepts that guidelines are not directives.