Why Can't Clinical Policies Be Relevant to Practice?

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Clinical policies have become a constant feature of the health care landscape. They are showing up in all forms and at an alarming rate. With the broad scope of our practice, family physicians derive the benefit (or feel the brunt) of many of them. So prevalent are clinical policies, that this issue of the *Journal* contains four original articles [1-4] and an editorial[5] that deal with clinical policies. In one way or another, all suggest that clinical policies fall short of their promise to clarify a clinical dilemma, reduce practice variation, improve quality of care, or reduce costs. How can this be? Are practicing physicians ignorant or uninterested in improving the care they provide? Or more likely, are most clinical policies a bit too simple and primary care a bit more complicated than is generally recognized?

The current precedure for producing clinical policies is to incorporate existing research data and expert opinion into a clinical policy and disseminate it broadly in the primary care community. Although clinical policies based only on expert opinion continue to litter the environment, they are generally not taken seriously outside the narrow community that produced them. A more rational approach to clinical policy development, and one championed by the American Academy of Family Physicians, is based on a systematic search for and careful analysis of existing evidence, supplemented by opinion only where critical evidence is absent.

Nonetheless, even clinical policies based on available evidence must rely in part on expert opinion at critical junctures. Despite major progress of the research enterprise of family medicine over the past 20 years, most of the research used to produce clinical policies is still done in settings very different from those in which most family physicians work. Most NIH-funded research continues to focus on a carefully restricted realm of investigation, studied in highly selected patients, in which the study endpoints are "hard" physiologic measures. Although this research is necessary to elucidate basic disease mechanisms, it is not adequate to undergird clinical policies that will help primary care physicians deal with most of the problems most patients have most of the time. It is this gap in the science base of primary care that leads to clinical policies that frequently rely on expert opinion, and often for very critical issues. Family practice researchers are rapidly closing this gap, but at the current rate of funding, we are still many years away from building even a modest science base that will inform clinical policies for family practice.

But there is yet another more subtle problem. Even when guidelines are firmly based in available evidence, they are poorly assimilated into practice, as evidenced by the research reported in this issue. Why is this so? Conventional wisdom holds that this is largely a problem of dissemination and suggests that more research is needed to devise strategies to more effectively bludgeon the recalcitrant family physician into compliance.

This, of course, is nonsense! Family physicians are strongly motivated to do the right thing, and actively seek mechanisms to reduce uncertainty and improve their care. Clinical policies that appropriately address critical dilemmas in family practice would be of great value, and would be rapidly and widely adopted. Unfortunately, clinical policies are too frequently an oversimplification of the complexity of the interaction of the patient, the physician, the problem, and the psychosocial context of the patient's life.

Clinical policies would be much more easily assimilated in primary care practice if they were relevant and helpful. To achieve relevance, they must address a clinical issue that is seen by the physician or the patient, or both, as a problem, and they must effectively reduce the ambiguity of clinical practice. How much more rational (not to mention successful) would be the process of developing and implementing clinical policies if they were developed in a way that produced relevant answers to the questions: what is the problem for which the clinical policy is a solution? who sees it

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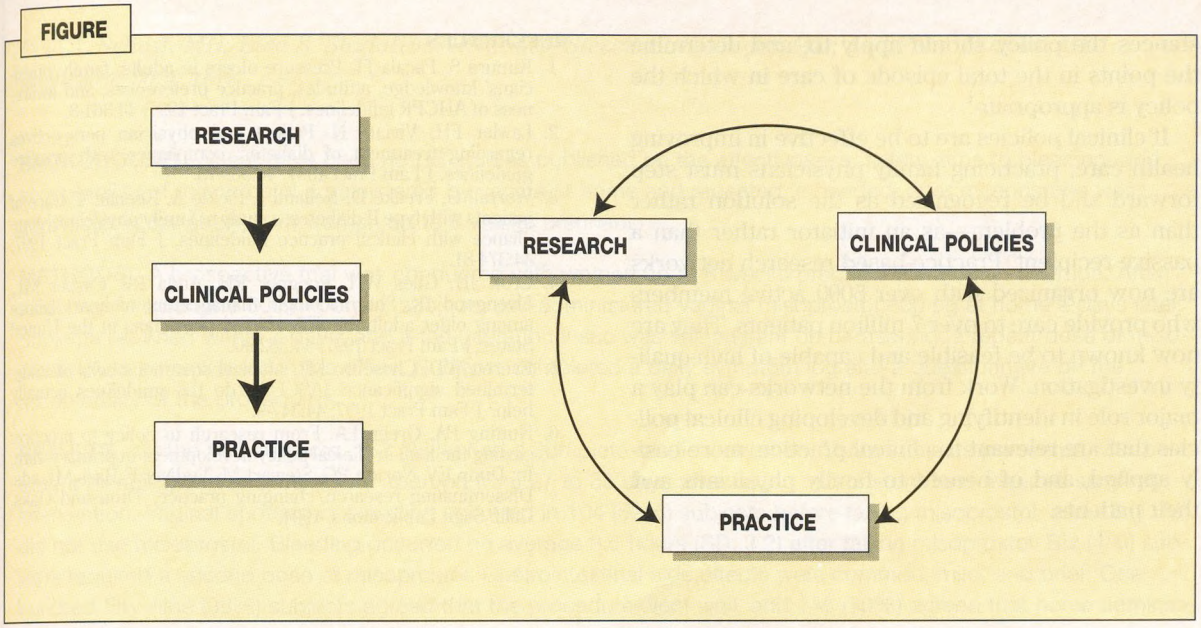
FIGURE



as a problem? the patient, the physician, or both, or merely a third-party interloper in the medical care process?

This would clearly require that we think differently about the development of clinical policies. The widely accepted model is an approach from the top down, as shown in the Figure, in which research is summarized into clinical policies and implemented in practice. This model should make practicing physicians very nervous, since it begs the critical question of what informs research in the first place. Most research, of course, is driven by the results of previous research, and the research community becomes the major consumer of research, all with no obvious connection to the needs of practice. I propose that we adopt a different model, one in which the needs of practice and the practicing physician drive the process, identifying relevant research questions and framing clinical policies that address the many vexing challenges of primary care practice.[6]

This approach should sound familiar to many family physicians. It is our discipline that has pioneered an approach to research that unites the practicing physician with the researcher to ask and answer questions that arise every day in the care of our patients. More than 20 practice-based research networks in family practice have emerged and are actively conducting research. These networks of practicing family physicians are developing rigorous methods to capture and describe health and health care events that arise in their everyday practice. More importantly, the networks are developing strategies to effectively marry the wisdom and insights of the practicing family physician with the systematic methods of inquiry required to address practice-relevant questions. The integral relationship of research questions generated by practitioners and addressed within the practice setting forms the critical link that reunites practice and research.

Having made this much progress in research, the next step should be to close the loop, as shown in the Figure. Note, however, that the interactions are bidirectional. For clinical policies to be developed in a way that they can actually be implemented, there needs to be a great deal more information at the outset on the settings and circumstances in which they are intended to be used. Practice-based research networks provide an important window on primary care practice and can play a central role in developing clinical policies. This should start with a careful description of current practice in all its complexity to avoid development of a clinical policy where no problem actually exists. Critical information is also needed to select and frame a relevant clinical policy topic, determine which patients and clinical circum-

stances the policy should apply to, and determine the points in the total episode of care in which the policy is appropriate.

If clinical policies are to be effective in improving health care, practicing family physicians must step forward and be recognized as the solution rather than as the problem—as an initiator rather than a passive recipient. Practice-based research networks are now organized with over 5000 active members who provide care to over 7 million patients. They are now known to be feasible and capable of high-quality investigation. Work from the networks can play a major role in identifying and developing clinical policies that are relevant to clinical practice, more easily applied, and of benefit to family physicians and their patients.

REFERENCES

1. Kimura S, Pacala JT. Pressure ulcers in adults: family physicians' knowledge, attitudes, practice preferences, and awareness of AHCPR guidelines. J Fam Pract 1997; 44:361-8.
2. Lawler FH, Viviani N. Patient and physician perspectives regarding treatment of diabetes: compliance with practice guidelines. J Fam Pract 1997; 44:369-73.
3. Worrall G, Freake D, Kelland J, Pickle A, Keenan T. Care of patients with type II diabetes: a study of family physicians' compliance with clinical practice guidelines. J Fam Pract 1997; 44:374-81.
4. Croft JH, Giles WH, Roegner RH, Anda RF, Casper ML, Livengood JR. Pharmacologic management of heart failure among older adults by office-based physicians in the United States. J Fam Pract 1997; 44:382-90.
5. Everett WD, Chesebro MJ. Atypical squamous cells of undetermined significance (ASCUS): do the guidelines actually help? J Fam Pract 1997; 44:347-9.
6. Nutting PA, Green LA. From research to policy to practice: closing the loop in clinical policy development in primary care. In: Dunn EV, Norton PG, Stewart M, Tudiver F, Bass MJ, eds. Disseminating research/changing practice. Thousand Oaks, Calif: Sage Publications, 1994.