Dynamic Chiropractic

YOUR PRACTICE / BUSINESS

Better Care, More Cheaply: The Advent of Practice Guidelines

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The fall meeting of the American Back Society will take place in San Francisco, December 1-4. It has been planned to focus on the coming sweeping changes in health care delivery and reimbursement, with special presentations on outcome studies, managed care, health care reform, managed competition, family practice, and cost-effective diagnostic and therapeutic procedures. As always, the presentations will be multidisciplinary, and I hope many chiropractors will find the time to take advantage of what has become the world's best back meeting. You may contact the American Back Society at 2647 E. 14th St., Suite 401, Oakland CA 94601, Tel (510) 536-9929, Fax (510) 536-1812.

"Better care, more cheaply": there's no simpler way to say it. That phrase appeared in my last column, in reference to the public mandate that increasingly confronts all physicians to develop better practice guidelines. Three months ago, Ms. Clinton's task force on national health care had gone into hibernation, while the President was attempting to weather the storm over his economic plan. Today it's the other way around: the economic plan is law, while the health plan is that is scheduled for release later this week is poised to become the next great legislative and societal conundrum.

Mark Chassen, recognized authority on standards of care in medicine, writes[1] that such standards address problems in three categories:

Over use: medically incorrect decisions to apply diagnostic or therapeutic procedures, where either alternative or no procedures would have been more appropriate;

Underuse: failure to employ medically appropriate procedures;

Improper use: poor performance of a medical procedure.

Up until now, practice guidelines emphasized the problems of underuse and improper use. More recently, owing to the economic downturn and the widespread perception that the disproportionate inflation in medical costs has and will continue to have a lot to do with it, the overuse problem has attracted most of the attention. Not surprisingly, this channels reformist energy toward cost-containment. Chassin quotes one report to Congress as follows: "Practice guidelines may be unique among available methods to contain costs in that they can increase the quality and efficiency of care in the process of slowing down increases in expenditures."

By their very nature, practice guidelines engender confrontation. Indeed, they're supposed to. Doctors practice in an environment that is dominated by a series of uneasy truces, unholy alliances, and often unmitigated warfare: between clinicians, researchers, and instructors; physicians and their regulators;

payers, doctors, and trial attorneys; and finally, between patients and everyone else. Sometimes the professional concerns that lead toward the formulation of guidelines are not the same interests which eventually take the most advantage of them, as when a physician-based effort to improve care by eliminating unnecessary procedures provides an opening for payers whose sole concern is to limit costs. Where are these same payers when physicians, hoping to increase the quality of care, are led to recommend a more intensive level of care for certain conditions, or perhaps extend accessibility for certain types of care to new population sectors? Although the current economic environment paints any effort at implementing practice guidelines in the colors of cost-containment, it must be emphasized that "quality assurance," in Mercy's words, requires not less but more appropriate care -- which, in some cases, will mean more intensive or generally available care.

In the medical profession, it would be an understatement to say that the process of introducing practice guidelines has not gone ahead as smoothly as had been desired. Attaining provisional consensus and publishing practice guidelines has proven to be the easy part, compared with the more difficult task of devising a mechanism to implement them. Several studies have shown that the mere production and dissemination of guidelines to physicians, without follow-up, is almost completely useless. Sometimes there is partial compliance with new recommendations for a year or more[2], but most doctors continue their existing practice methods. Even when guideline awareness and even agreement is high (according to one study, 94% and 85% respectively one year after dissemination[3]), follow-up studies and physician testing show that actual understanding and detailed knowledge of the guidelines remains remarkably low. Even more telling, when physicians claim to have altered their procedures in accordance with the new recommendations, records review indicates that their actual practice habits have not changed by nearly as much as their self-reported practice habits.

Chiropractic physicians, who are also going through the emotionally-wrenching process of coming up with practice guidelines, are likewise having a difficult time of it. Although the fundamental problems to be addressed are the same - overuse, underuse, and improper use - the chiropractic and medical professions face somewhat dissimilar tasks, based on differing interprofessional practice parameters. Although we chiropractors have a few diplomate programs, the great majority of us practice as generalists, whereas most medical practitioners belong to specialties. The latter got involved some 15 years ago in formulating guidelines for specific biomedical technologies, under the auspices of the NIH. Any set of chiropractic practice guidelines necessarily would have to be broader in scope and probably less detailed than those formulated by specialty panels of medical practitioners.

Although the medical profession has been at it longer, with several specialties having gone through consensus procedures and published some partial practice guidelines, the chiropractic profession should be very proud of its preliminary efforts. In a way, the Guidelines for Chiropractic Quality Assurance and Practice Parameters (the Mercy Guidelines document)[4] is simultaneously more ambitious and more comprehensive than extant medical standards. (See reference no. 5 for a very favorable review.) It should also be pointed out that the Mercy Guidelines are inherently less specific, less "standards-of-care-like," than their more elaborated medical counterparts.

Medical physicians have resisted implementation of practice guidelines for a number of reasons, but mostly because they are vehemently opposed to what they call "cookbook medicine": a set of simple and inflexible rules that would dictate medical practice, preventing the exercise of appropriate clinical judgment in specific, atypical circumstances. Chiropractors have also expressed their distaste for any conceivable "cookbook chiropractic." Good guidelines will have to take into account the infinite

diversity of patients and the complexity of clinical practice, if they are to avoid appearing to fetter physicians in the trenches of clinical practice.

Physicians have also voiced other reservations regarding practice guidelines. Some fear they may discourage technological innovation, say, by freezing currently existing procedures as the norm. Others fear becoming more vulnerable in some medicolegal circumstances, or perhaps being buried in an avalanche of new regulations that could generate the paper trail from hell. Some even worry about their income ....

I don't intend to comment on these specific concerns, all of which are well addressed in the references I cite, especially the Chassin article. However, there is a related matter which so far has received very little attention, and that has to do with the attitudes and personalities of clinical physicians. "Panels of Distinguished Advisors" may suppose that guideline recipients would be grateful that a bunch of experts have sacrificed their time and energy to come up with something useful, and yet it doesn't quite work out that way. No matter how well-intentioned, the effort will add up to nothing - or worse - if clinical doctors, deeply entrained by narrowly focused mindsets, are simply not receptive to the message. Anyway, isn't the road to hell paved with good intentions?

Drs. Joanne Nyiendo[6] and Robert Jansen[7] have both administered well known and highly-regarded psychological tests to chiropractic students in an attempt to characterize their personalities in relationship to occupational choices and communication skills. (Both feel that the results are fairly projectable to field doctors.) Nyiendo profiles male and female chiropractic students separately, comparing the outcomes to similar studies on medical doctors, nurses, and physical therapists. Both of the studies found, contrasting the chiropractic students to the general population, a significantly greater proportion of "NF" types (N for "intuitive," F for "feeling"). Nyiendo finds this preponderance of NFs to exist among medical doctors as well, although to a lesser extent. She also finds that chiropractors, compared with medical doctors, are more "perceiving" and less "judging."

Jansen, quoting Kiersy and Bates, writes: "Self-determination is viewed as a crucial structure in the NF's work environment. Autonomy is highly valued as an earmark of unique identity. They are extremely sensitive to even a hint of imposed structure, to the notion of authoritarianism, or in fact, to any move on the part of management that could be interpreted as circumscribing individuality. ... They need an abundant opportunity to discuss possible change long before it is to be implemented." It's rather obvious how this preponderance of NFs in medicine and chiropractic may have impacted the process of guideline formulation in both professions. Furthermore, the situation in chiropractic maybe relatively more complex because of its preference for perceiving over judging.

In another survey[8], Jansen characterizes chiropractors' attitudes toward practice standards and the organizations developing them. "A principal components (factor) analysis was performed to extract possible coherent patterns of attitudes among respondents." The most focused attitude that was detected, which the author labels the "conservative" point of view, is fundamentally opposed to standards of care development. The next most focused attitude, the "moderate" position, favors a consensus process and the validation of practice standards. Jansen goes on to delineate the implications of this attitude patterns for the development of standards of care in chiropractic, warning that "it will probably be difficult or impossible to address the entire profession effectively with a single communication approach, and perhaps would not be wise to attempt to do so."

Coulter and Adams[9] express well a fairly ubiquitous belief: "What is clear is that if chiropractors do not develop [guidelines] for themselves, outside parties (such as third-party payers) will do it for them." Now that some provisional guidelines have come into existence, it is obviously the case that if physicians do not guarantee their implementation, than outside parties (such as payers and politicians) will - in their own way, and for their own purposes. Given that guidelines dissemination alone is not adequate, there have been suggestions for programs that would supplement dissemination with face-to-face, hands-on, regionally-based, and ongoing educational programs for doctors[10]. Hopefully, those individuals who will conduct these programs will be sensitive to the attitudinal structure of those whom they would hope to favorably impress.

In the present socioeconomic climate, no doctor has the medicolegal or ethical luxury of declining to participate in the struggle that inexorably ushers in the era of practice guidelines. "Not all practice styles can be right, and the profession has an obligation to find out which ones are."[11] Just as formulation of guidelines must precede implementation, so must implementation precede evaluation of utility. The ultimate test of a set of practice guidelines is always its predictive validity, the extent to which its adoption in clinical practice actually leads to better patient outcomes[12]. It is clearly in the patients' interests that internecine squabbling and professional immaturity not get in the way of this historical process.

NOTES

1. M.R. Chassen. Standards of care in medicine. Inquiry 25:437)453. Winter, 1988.

2. Kosecoff et al. Effects of the National Institutes of Health consensus development program on physician practice. JAMA (258)19:2708)2713. Nov. 1987.

3. J. Lomas et al. Do practice guidelines guide practice: the effect of a consensus statement of the practice of physicians. NEJM (321)19:1306-1311. Nov. 1989.

4. Haldeman et al, ed. Guidelines for Chiropractic Quality Assurance and Practice Parameters. Aspen Publishers. 1993.

5. Guidelines for chiropractic quality assurance and practice parameters. In Abstracts of Clinical Care Guidelines (5)3:7-14. April, 1993.

6. Nyiendo et al. A study of chiropractic students using the Meyers-Briggs type indicator with comparison to other health professionals. JCE:133-145. March 1992.

7. Jansen, R. Personal communication. Manuscript in preparation.

8. Jansen, R. A Survey of American Chiropractors' Attitudes Toward Practice Standards and the Organizations Developing Them. Sep. 1991.

9. Coulter, I., Adams, A. Consensus methods, clinical guidelines, and the Rand study of chiropractic. ACA Journal of Chiropractic: 50-61. Dec. 1992.

10. Leape, L. Practice guidelines and standards: an overview. QRB:42-49. Feb. 1990.

11. Fletcher, R.H., Fletcher, S.W., Clinical practice guidelines. Annals of Int Med(113)9:645-647. Nov. 1990.

12. M.R. Chassen. Standards of care in medicine. Inquiry 25:437-453. Winter, 1988.

NOVEMBER 1993