ISSUE BRIEF

What, How, and Why

Peter J. Morris

Practice guidelines are not new, but they continue to evolve—from ad-hoc practice standards, informed expert opinions, and consensus-based guidelines to best-practice and evidence-based guidelines that improve individual and community outcomes. From the extensive national guidelines of the US Preventive Services Task Force to state and local initiatives, this issue of the NCMJ explores the development and implementation of clinical guidelines that are now (along with cost and patient experience) the third of the Triple Aim objectives, the new "north star" of our profession.

Cookbook medicine," we snorted. "No appreciation for the art of medicine," we pontificated. "All is lost," we predicted. And yet, the apocalypse did not come.

Clinical guidelines, once reviled, are here to stay. Even the most curmudgeonly physician must now admit that the lists of therapies, medications, and interventions have grown long, as has the time it takes to research journals or connect with consultants. Hallway conversations with peers work in the moment, but there are so many moments.

Key to this resurrection and ascension has been the reframing of guidelines from suggestions to evidence-based recommendations; in some cases, guidelines have become gospel. Physicians have long been beholden to brilliant colleagues and consultant mentors. Now, our colleagues and mentors have been gathering together again and again to place conviction side by side with evidence and to develop and disseminate the evidence-based practice guidelines that define the gold standard—and the community standard of care.

In this issue, Moyer and Bibbins-Domingo explain, from their first-person experience, the role of the US Preventive Services Task Force in crafting evidence-based guidelines through discussions regarding the quality of evidence for or against an intervention [1]. In an accompanying sidebar, Edgerton deconstructs the occasionally bewildering levels of evidence that distinguish evidence-based recommendations from best-practice protocols and consensus guidelines [2].

In a commentary about Community Care of North Carolina (CCNC), Tilson explains how CCNC has brought practical consensus guidelines from the halls of tertiary medical centers to computer screens and bulletin boards of doctors' offices across the state [3]. Thanks to these guidelines, clinicians need not be placed on hold to discuss the next step in the work-up and referral of common, often vexing, conditions. Unneeded referrals no longer lengthen the time to the next available appointment or delay prompt referral for much needed consultations.

Hawes and Tong [4] describe the best-practice algorithms that guide choices of effective and cost-effective prescription medicines. Pharmacists who once peered out from behind glass windows now accompany clinicians on rounds and share clinic space, providing onsite consultation and education for clinicians and staff alike.

The benefits of clinical guidelines reach beyond the walls of the exam room. Winslow and colleagues [5] detail the collaborative efforts of emergency medicine practitioners to create protocols that assure these personnel respond with the best and most timely interventions while the patient is en route to the hospital and that the next level of care is expertly and expeditiously implemented immediately upon the patient's arrival in the emergency department. In an accompanying sidebar, Pearson reminds us that the time-honored guidelines for cardiopulmonary resuscitation are continually updated by the American Heart Association based on the most current evidence available [6]. Astoundingly, the maxim of "ABC" can become "CAB," even after all these years. Even sacred cows are subject to change based on evidence.

Clinical guidelines can also be driven by community outcomes. In her commentary, Berrien and colleagues [7] describe how our state's persistent and nagging disparity in infant mortality and maternal morbidity can be addressed by programs designed to promote early prenatal care and timely postpartum visits, decrease elective caesarean sections, and employ known interventions to prevent preterm birth. These evidence-based pregnancy medical home interventions not only decrease the cost of care but provide economic incentives via increased reimbursement to clinicians, thus doing right by clients and doing well for providers.

Clinicians bristle that cost considerations should guide practice, but payer guidelines and coverage do indeed

Electronically published September 11, 2015.

Address correspondence to Dr. Peter J. Morris, North Carolina Institute of Medicine, 630 Davis Dr, Ste 100, Morrisville, NC 27560 (peterjmorrismd@gmail.com).

N C Med J. 2015;76(4):228-229.
0029-2559/2015/76404

inform practice. In her commentary, McCauley reminds us that payers not only seek to appropriately reward recommended care but also aim to discourage ineffective, harmful, or unproven care [8].

Free and charitable clinics depend on a rotating shift of volunteer clinicians. As McAdams and coauthors discuss in the Spotlight on the Safety Net column, guidelines can better assure continuous and consistent quality of clinical interventions across providers [9].

Information technology and electronic health records both place clinical guidelines at our fingertips (literally) and facilitate audit and continuous quality improvement in clinical practice. In his commentary, Cykert [10] describes the benefits of automated clinical guidelines while warning of "alert fatigue," the feeling of being overwhelmed by the volume of bells, whistles, and persistent and nagging reminders that this much more could or should be done at this visit or the next. In another commentary, Vander Schaaf and colleagues [11] bring us back to reality, pointing out that we sit at a turning point that can change populations, close gaps, and narrow disparities.

Like so many opportunities in medicine, it has been easier to agree on the *what*, but we cannot stop there. When the research is done, the evidence weighed, the recommendations written, and the word distributed to wary celebration—there still remains the *how*.

There is of course a *why*, as well. Kemper [12] and Willson [13] remind us that the *why* comes one patient at a time, as it must if we are to practice our art. NCMJ

Peter J. Morris, MD, MPH, MDiv editor in chief, *North Carolina Medical Journal*; executive director, Urban Ministries of Wake County, Raleigh, North Carolina.

Acknowledgments

Potential conflicts of interest. P.J.M. has no relevant conflicts of interest.

References

1. Moyer V, Bibbins-Domingo K. The US Preventive Services Task Force: what is it and what does it do? N C Med J. 2015;76(4):238-242 (in this issue).
2. Edgerton L. Decoding levels of evidence. N C Med J. 2015;76(4):240-241 (in this issue).
3. Tilson EC. Dissemination and adoption of guidelines: the experience of Community Care of North Carolina. N C Med J. 2015;76(4):251-255 (in this issue).
4. Hawes E, Tong G. Implementing evidence-based guidelines: the role of ambulatory care pharmacists. N C Med J. 2015;76(4):247-250 (in this issue).
5. Winslow JE, Fernandez AR, Swanson D, et al. North Carolina College of Emergency Physicians' guidance document on emergency medical services. N C Med J. 2015;76(4):256-262 (in this issue).
6. Pearson DA. Review of clinical guidelines for cardiopulmonary resuscitation. N C Med J. 2015;76(4):257-259 (in this issue).
7. Berrien K, Ollendorff A, Menard MK. Pregnancy medical home care pathways improve quality of perinatal care and birth outcomes. N C Med J. 2015;76(4):263-266 (in this issue).
8. McCauley JL. Guidelines and value-based decision making: an evolving role for payers. N C Med J. 2015;76(4):243-246 (in this issue).
9. McAdams LA, Carr A, Jones C, Hill L. Use of evidence-based clinical practice guidelines at Matthews Free Medical Clinic. N C Med J. 2015;76(4):269-270 (in this issue).
10. Cykert S. The benefits and concerns surrounding the automation of clinical guidelines. N C Med J. 2015;76(4):235-237 (in this issue).
11. Vander Schaaf EB, Seashore CJ, Randolph GD. Translating clinical guidelines into practice: challenges and opportunities in a dynamic health care environment. N C Med J. 2015;76(4):230-234 (in this issue).
12. Kemper AR. Implementing guidelines one patient at a time. N C Med J. 2015;76(4):267-268(in this issue).
13. Willson CF. Translating medical guidelines into practice. N C Med J. 2015;76(4):231 (in this issue).