The Brazilian Cardiology Trainee: Guidelines and Freedom

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"[...] for conscience and moral principles, we are free and therefore responsible, but we are guided by the principle of causality [...]"

(Hanna Arendt)

The Brazilian cardiology trainee, a resident for instance, is guided by a library of validities of the medical literature, hierarchically arranged according to specialty associations, known as guidelines. They represent models of the bedside clinical construction, and are made available through information technologies, such as franchising to be locally reproduced. Guidelines intend to reduce enigmatic biases, and influence patterns in each generation.

Guidelines progressed steadily from poorly accepted recommendation to wished-for convenience of predictability systematization, into *do*, *do not do*, *probably should be done*, *probably should not be done*[1].

As *do*, *do not do* is actually a guideline of "truths", and not a regulation of "convictions", its application cannot ignore the clinical acuity which demands freedom and responsibility, in order to avoid deformation of the human shape of recommendations.

To ponder on a decalogue which is customary to Bioethics seems to help the Brazilian cardiology trainee to maximize advantages of the guidelines when making clinical decisions and in the educational process as a whole, and to minimize deficiencies in patient care and in infinite-literature.

1) The good principles and well-known benefits of guidelines justify the increasing expectation for availabilities, but do not qualify *do*, *do not do* as the eleventh commandment, or as the master key at the bedside. Rigid assumptions or hints of predators of clinical judgement are not usually welcome by the individualist core of physicians, who value the room of experience.

Flexibility becomes a vital characteristic of the *do*, *do not do* when it is recognized that the adequate use of literature data is only possible by connecting them to the real bedside world. The *do*, *do not do* process is favored over results, at any cost.

Key Words

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2) As a "translational agent", the specialists associations use a scientific-ethic-legal glue to stick class and level labels to a still restrict percentage of topics in Cardiology, and with a minority of scientific accuracy A level.

The Brazilian cardiology trainee feels, therefore, released from the *do*, *do not do* of guidelines in most of the decisions to be made, and immune to the possible impact that the political dimension of the specialists association, linked to the paradigm of an evidence-based Medicine, may have on his/her internal freedom. This situation may even result, paradoxically, in a feeling of abandonment due to the absence of a *do* such prescription, which predicts a better immediate and late prognostics, and of a *do not* justified by uselessness and inefficiency. Guidelines raise feelings of sympathy for the imperative.

Furthermore, as early as on the first stage of the *trial-guideline-education process* there is an increase of the above-mentioned impact over the individuality of the physician[2]. It is a boomerang effect: someone knew the right question to ask to a multicentric research protocol; that the Brazilian cardiologist trainee wonders if he/she should *do* or *not do* the new answer-knowledge in his/her hands, certainly level A label and possibly I/IIA class, if integrated to the guideline.

3) Practicability, agility, uniformity in the use of the guideline and little time available discourage the detailed analysis by itself, paper by paper, book by book. The wish for a critical reading of the issue commented on or referred to, already explained by the committee to which an implicit procuration was given, is itself erased.

There is a risk that, if the "do right" to the patient is not well founded, the physician is reduced to an algorithmic procedure of *do or do not do*. Furthermore, in trying to avoid showing lack of knowledge or of will, there is the possibility of slipping into the negligence of an application unfit for a particular one-patient.

To feel free from internal and external obligations is a safeguard guaranteed by Bioethics, allowing better decision-making, unstained by possible components of a forced decision, emotionally or financially convenient to the physician[3].

4) Exclusions due to pragmatic, mathematical and ethical notions of research projects[4,5] explain why it is not enough to turn on the guideline-GPS and follow the selection of classes and levels. The professional must be free to use his/her own calculations to adjust the satellite-guideline of the specialists association to the signals received from the one-patient.

5) The guideline is a live document which may be permeated by feelings of regulation from the professional authority and leveling off of experienced and inexperienced professionals.

The possibility of looking like "coercion by an authority"

induces a teflon effect[6] in the universal adhesion to guidelines[7,8] and compellingly reminds of George Orwell's (1903-1950)[9].

The truth, however, is that the guideline project has never intended to mean to represent a telescreen, newspeak or thought police similar to what was presented in 1984[9]. Even cost-benefit and auditing intentions, that could represent interests other than the patient's, are light years away from the intention of privacy invasion.

It is always interesting, however, to raise the alert, so no Big Brother, Hippocrates is the watcher!

6) The authority of the specialists association and the qualification of selected members of our "adoptive family" of specialists are contracted to establish the guideline document. Although every opinion on this and that published issue may seem unanimous, the consensual *better* or *not-better evidence* may be only partial, in a voted decision.

The specialists association is not the Ministry of Truth of the *1984* novel, rewriting the past; even when "[...] errors and inconsistencies of the original publication are corrected as possible [...]", this is informed in the introduction of the *ACC/AHA* guideline[10]. The information is preserved, and the knowledge, science permit, cousin to meta-analysis, is recreated.

Not-better evidences persevere, obviously, good publications - and citations. They are susceptible to a second opinion and must never be labeled as lack of evidence and ironically mentioned as clairvoyance. In the science of uncertainty and the art of probability, a method abashed by $p < 0.001$ may excel in the bedside real world, before the non-beneficiary of statistically higher probabilities of success.

7) The Brazilian cardiology trainee listens to two different tunes of the *do*, *do not do* learning involving guidelines: the pater-tune in the classroom and the frater-tune at the bedside.

The pater-tune is the educational-ethical-legal voice that impersonates "patriotism" and "somewhat-stepfather fatherhood" in scientific forums.

The "patriotism" makes an analogy with our *Order and Progress* inscription, expressing the belief in a development imposed from above and in the lesser value of a spontaneous ordering. The positivism is always criticized.

The "somewhat-stepfather fatherhood" reflects the political power of the specialists association to concentrate the writing of guidelines. It demands cultural, scientific and geographical considerations.

The pater-tune echoes the frontiers of techno-scientific excellence with a theoretical no-freedom in dealing with the guideline-science and the protocol-science of multicentric research projects.

The pater-tune of opinion leaders with or without conflicts of interest and a strong group effect may result in a poor environment for the expression of personal experiences by others.

8) The bedside frater-tune, on the other hand, shows that the practice of Cardiology by the bedside is not exactly a "Government policy".

The learning of the appropriate modulation of the frater-tune to be used in the different daily needs is benefited by practical freedom, to adjust the meaning of the state of the art, guideline and result of acronymous multicentric projects to the one-patient.

9) *To keep an active interaction between the classroom pater-tune and the bedside frater-room* represents a useful advice for the Brazilian cardiology trainee, with a connection with Bioethics.

10) It is clear that the bedside coexists with the impossibility to have complete freedom to choose the scientific knowledge at the bedside, independently of the human wishes of the one-patient.

A humanized science is projected as a basis for the Brazilian cardiology trainee to commit with approaching the bedside with his/her hands unchained to handcuff-guidelines. With free hands, the trainee may take hold of compass-guidelines, and simultaneously show the way by direct visual assessment. The trainee will therefore proceed in direction to the dominion of clinical expertise, free from pressures to fit the patient into guidelines, moving as an individual physician side by side with pressures and values of a compatriot society.

This pathway leaves her fingerprints in the beneficial and non-detrimental, separates him/her from any possible reductionist newspeak and contradicts the thought crime assumption[9] in any disobedience to the guidelines.

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