Guidelines: what for?

Diretrizes: para quê?

José Antônio Baddini Martinez

Medical societies and related institutions have been committing substantial efforts and resources to the preparation and dissemination of documents addressing various medical issues. Are the efforts made, the time spent, and the money invested justified?

Initially, we should bear in mind that the term "guidelines" describes such initiatives far more accurately than does the formerly used term "consensus". Experience shows that a well-written text often hides heated discussions and conflicting views, as well as disputes that are settled by a small margin of votes. Such documents can therefore hide the existence of dissenting opinions on controversial issues. Therefore, there is hardly a consensus behind a "consensus". It is reasonable to assume that the same is also true for guidelines.

An analysis of guidelines developed by different countries reveals that the issues addressed are generally relevant, such guidelines usually covering medical conditions that are highly prevalent, that are extremely severe, or that involve major diagnostic and therapeutic questions. Given the large number of issues addressed, the complexity of such issues, and the fact that it is impossible for one single person to have a profound knowledge of the numerous fields of medicine, it would be unwise to opine on the contents of such documents. However, because such guidelines mobilize the greatest names in their respective areas and require rigorous methods, we can assume that the contents are highly reliable. According to the Brazilian Medical Association and the Brazilian Federal Medical Council, the development of guidelines "seeks to build, in an ethical manner and with rigorous scientific methods, the foundations for medical management recommendations by using the means of current science critically and with no interest other than improving the doctor-patient relationship".[1]

Who benefits the most from the development and dissemination of guidelines? First and foremost, patients do. Adherence to guidelines protects patients from being submitted to procedures and therapeutic interventions whose efficacy has not been proven or that are acceptable only in experimental settings. In addition, the use of well-established protocols for procedures and therapies usually results in better clinical response, fewer undesirable side effects, and lower costs. We live in an era in which information is universally accessible and rapidly disseminated online. Although many health professionals disapprove of patients' using the Internet for medical information, this search for information can become the starting point for providing clarification of the selected approaches and for promoting greater adherence to the proposed treatment.

Physicians also benefit from the use of guidelines. This is particularly true for those who are unfamiliar with the issues addressed by the guidelines. A pulmonologist treating a patient with asthma and type 2 diabetes will certainly benefit from reading guidelines for the management of the latter disease. In addition, let us not forget that following the recommendations of medical societies is always a powerful defense against medical malpractice lawsuits. Physicians should be familiar with guidelines. However, that does not mean that physicians are required to follow all of the recommendations for all patients! Documents issued by the Brazilian Medical Association and the Brazilian Federal Medical Council state that "the information presented herein shall be subject to physician evaluation, physicians being responsible for selecting the appropriate approach on a case-by-case basis, taking into consideration the clinical status of each patient".[2] This is the point at which medicine becomes an art rather than a science. Guidelines are not able to anticipate every situation or cover all of the peculiarities that might arise in daily practice. Good judgment, clinical reasoning, and professional experience—concepts that might sound old-fashioned or even obscure to some of the younger physicians—certainly play a relevant role in the interpretation and application of guidelines in individual cases. Obviously, we should not go as far as to imitate the behavior that was once attributed to a famous old American professor

of medicine, quoted as stating the following: "I do not read consensuses. I write consensuses". However, good clinicians will always be able to adapt evidence-based recommendations to the needs of their patients.

Physician adherence to guidelines is at the heart of this discussion. There is evidence that physician adherence to guidelines can be quite low not only in the field of respiratory diseases but also in other medical fields.[3-6] This seems to be particularly true for nonspecialists and physicians working in the field of primary health care. Although this is a problem that is difficult to solve, educational initiatives and efforts to disseminate the published contents certainly play a central role in solving the problem.

In addition to strictly following guideline recommendations, physicians should be able to recognize their own limitations and the existence of difficult cases. In such cases, the most appropriate approach is to refer the patient to a specialist or even a superspecialist.

The current issue of the Brazilian Journal of Pulmonology includes the "Highlights of the Brazilian Thoracic Association (BTA) Guidelines for Interstitial Lung Diseases", a summary of a comprehensive manuscript that will be distributed to all BTA members.[7,8] The initiative of the BTA Interstitial Disease Committee to develop those guidelines was bold and daring. It is extremely difficult to address the topic of interstitial lung diseases in a fairly brief manner. This is due to the length and complexity of the topic, as well as to the enormous number of questions that remain unanswered. In addition, the rapidity with which new knowledge in the area accumulates often surpasses the ability of authors to write texts that are completely updated. The sheer number of collaborators involved in the project adds an extra challenge to the endeavor.

Despite all these obstacles, we were really pleased to see that the final versions of the manuscripts were objective, easy to read, and rich in essential information to clinicians specializing in interstitial lung diseases or not. We propose a general classification of interstitial lung diseases and provide clear, step-by-step guidelines for the diagnosis of interstitial lung disease. In addition, various processes are discussed individually, including therapeutic considerations of a general nature, as appropriate.

Such a satisfying final product is the result of years of hard work by a large number of collaborators, all of whom are listed as authors. However, we should highlight the dedication and enthusiasm of Dr. Bruno Baldi and Dr. Carlos Pereira, who were the project coordinators. We should also emphasize the fact that the project was made possible by the decisive support of the previous and the current BTA Boards.

Naturally, the general considerations opening the present editorial also apply to the newly published guidelines. The objective of those considerations was to allow us to reflect on the value and real usefulness of this important, recently completed work by the BTA Interstitial Disease Committee.

The publication of those guidelines demonstrates the high level of maturity of Brazilian pulmonologists, who have gained international prominence in numerous sectors. It is now up to the readers to enjoy such an exceptional work and, more importantly, incorporate it in their daily medical practice.

José Antônio Baddini Martinez
Associate Professor,
Pulmonology Section of the
Department of Clinical Medicine,
University of São Paulo at
Ribeirão Preto School of Medicine,
Ribeirão Preto, Brazil

References

1. Cerri GG, Jatene FB, Nobre MR, Bernardo WM. Introdução. In: Amaral JL, Andrade EO (editors). Projeto Diretrizes [monograph on the Internet]. São Paulo: Associação Médica Brasileira/Conselho Federal de Medicina; 2008 [cited 2012 Jun 13]. [Adobe Acrobat document, 6p.]. Available from: http://www.projetodiretrizes.org.br/projeto_diretrizes/texto_introdutorio.pdf
2. Jardim JR, Oliveira JC, Rufino R, editors. Projeto Diretrizes. Doença Pulmonar Obstrutiva Crônica [monograph on the Internet]. São Paulo: Associação Médica Brasileira/Conselho Federal de Medicina; 2001 [cited 2012 Jun 13]. [Adobe Acrobat document, 8p.]. Available from. http://www.projetodiretrizes.org.br/projeto_diretrizes/042.pdf
3. Gourgoulianis KI, Hamos B, Christou K, Rizopoulou D, Efthimiou A. Prescription of medications by primary care physicians in the light of asthma guidelines. Respiration. 1998;65(1):18-20. PMid:9523363. http://dx.doi.org/10.1159/000029222
4. Mattos W, Grohs LB, Roque F, Ferreira M, Mânica G, Soares E. Asthma management in a public referral center in Porto Alegre in comparison with the guidelines established in the III Brazilian Consensus on Asthma Management. J Bras Pneumol. 2006;32(5):385-90. PMid:17268740. http://dx.doi.org/10.1590/S1806-37132006000500003
5. Navaratnam P, Jayawant SS, Pedersen CA, Balkrishnan R. Physician adherence to the national asthma prescribing guidelines: evidence from national outpatient survey data in the United States. Ann Allergy Asthma Immunol. 2008;100(3):216-21. http://dx.doi.org/10.1016/S1081-1206(10)60445-0
6. Lima SM, Portela MC, Koster I, Escosteguy CC, Ferreira VM, Brito C, et al. [Use of clinical guidelines and the results in primary healthcare for hypertension]. Cad Saude Publica. 2009; 25(9):2001-11. http://dx.doi.org/10.1590/S0102-311X2009000900014
7. Baldi BG, Pereira CA, Rubin AS, Santana AN, Costa AN, Carvalho CR, et al. Highlights of the Brazilian Thoracic Association Guidelines for Interstitial Lung Diseases. J Bras Pneumol. 2012;38(3):282-91.
8. Comissão de Doenças Intersticiais, Sociedade Brasileira de Pneumologia e Tisiologia. Diretrizes de Doenças Pulmonares Intersticiais da Sociedade Brasileira de Pneumologia e Tisiologia. J Bras Pneumol. 2012;38(Suppl 2):S1-S133. In press 2012.