Clinical Practice Guidelines (CPGs) are becoming a part of the practice of health care, and physiotherapy is not excluded. We have seen an increasing number of CPGs, are being asked to implement them, and told they are important, but why?

**What is a CPG?**

Clinical practice guidelines are designed to provide a link between the best available evidence and clinical practice. When written carefully, CPGs can offer guidance on treatment options based upon the established effectiveness of available therapeutic options (including no treatment), a patient’s individual clinical situation, minimisation of harm, and cost.

Clinical practice guidelines are not intended to be recipes, as every clinical situation requires judgment in its application. Similarly, CPGs do not provide the only way to treat a particular condition, but do provide the standard of care in the most typical situations. In other words, a well-designed CPG can be one more tool in your clinical armamentarium to provide your patients with the best possible care. For the busy practitioner, incorporating the recommendations of a well-written and valid CPG into your routine practice can be the most efficient way to ensure your practice is in line with current research and peer reviewed standards of care.

**How do CPGs differ from systematic reviews?**

A systematic review provides the highest level of evidence for answering a specific clinical question, particularly for treatment interventions. A CPG, on the other hand, translates this evidence into treatment options for a specific clinical condition. A well-written CPG will comment on the strength of evidence upon which it is based. If it does not, it may simply be based on the author’s opinion.

Depending upon the complexity of the condition, a CPG may rely on more than one systematic review, as well as other types of evidence. For example, a systematic review may examine the efficacy of TENS for post stroke shoulder pain, while a clinical guideline is likely to rely on the evidence from several systematic reviews (slings and supports for post-stroke shoulder pain, the efficacy of positioning, etc) and incorporate this into an overall guide to the management of post-stroke shoulder pain.

**How are CPGs developed?**

In Australia, the National Health and Medical Research Council has carefully described how to develop a CPG (NHMRC 1999). Several steps are outlined:

- Planning the CPG to address a specific clinical issue but still considering variation in practice.
- Assembling a multi-disciplinary team (including consumers).
- Basing the CPG on sound evidence.
- Making the CPG readable.
- Disseminating the CPG fully (including versions for consumers).
- Evaluating the impact of the CPG.

**How do I know if a CPG is valid?**

When presented with a CPG, we need to know whether we should believe it and follow its recommendations. Several tools for the appraisal of CPGs have been published, but the comprehensive and easy to use Appraisal of Guidelines for Research and Evaluation (AGREE) instrument is the one we prefer (AGREE Collaboration 2002).

The AGREE instrument uses both quantitative and qualitative assessment and rates the CPG, with a summary score, according to the level of agreement with a set of criteria under sub-headings of the essential components of a CPG. The AGREE instrument is outlined in Table 1.

**What are the limitations of CPGs?**

Although CPGs can be enormously effective in improving patient care, they can also be potentially harmful (Woolfe 1999). Therefore, it is important to appraise a CPG before adopting it into your practice. The data upon which the recommendations are based may be wrong. Research may be misinterpreted, missed, or have value judgments placed upon it. While CPGs have benefits from a societal and cost point of view, in some cases the recommendations may be at odds with individual patient needs and rigid recommendations may not allow for individual variation, for either the patient or the practitioner providing care. Many are concerned that CPGs may create a “standard” against which clinicians are judged without taking into account outside variables (Hurwitz 1999).
These limitations can, we believe, be overcome if practitioners learn how to differentiate between a valid and useful CPG and one that may be opinion-based or not applicable to their situations. There needs to be recognition from providers, patients and policy makers that CPGs are not, and cannot be, “cookbook health care”. The best evidence is only helpful when used in the context of a particular patient in a particular environment, interpreted and applied by clinical experience.

When developed with appropriate methodology, disseminated effectively and implemented well, CPGs have the potential to both improve patient care and ensure efficient practice.

Acknowledgments This editorial is based on content from the Graduate Certificate of Evidence-based Practice offered by the Monash Institute of Health Services Research, Monash University. Sally Green is the course co-ordinator.

We are grateful to Elmer Villanueva for his comments on this manuscript.

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