EDITORIAL

Cardiovascular Guidelines in German Health Care: Confusion in Implementation

Ina B. Kopp

Editorial to accompany the article: "Physicians' Knowledge of and Compliance With Guidelines: An Exploratory Study in Cardiovascular Diseases" by Karbach et al. in this issue of *Deutsches Ärzteblatt International*

Patients suffering from arterial hypertension, coronary heart disease and/or heart failure do not always receive diagnostic and therapeutic procedures of clearly proven benefit that have been recommended nationally and internationally in guidelines. In recent years an increase in the awareness and implementation of guideline recommendations has been observed but there still remains room for improvement. Targeted dissemination of the guidelines and educational programs, that is, an intensification of traditional routes of knowledge transfer, are not suitable for maximizing the remaining potential for improvement (1). This is also suggested by the exploratory analysis of indicators in the current study by Karbach et al. Health care that conforms to guidelines with a favorable effect on the quality of results can definitely be achieved (2, 3). Interestingly, hospital physicians and cardiologists appear to have fewer reservations about guidelines than primary care physicians (1–5).

Acceptance of guidelines: a multifactorial phenomenon

The first prerequisite for guidelines to succeed is a high level of methodological and content-related quality (6). Karbach et al. confirm, however, that this alone is not sufficient. The National Disease Management Guidelines for Chronic Coronary Heart Disease and the S3 Guidelines for Heart Failure from the German College of General Practitioners and Family Physicians (*Deutsche Gesellschaft für Allgemeinmedizin und Familienmedizin*, DEGAM) achieved above average good results with the German Guideline Appraisal Instrument (*Deutsches Leitlinien-Bewertungsinstrument*, DELBI) in an assessment published in the Medical Library (*Arztbibliothek*) by the National Association of Statutory Health Insurance Physicians (*Kassenärztliche Bundesvereinigung*, KBV) and the German Medical Association (*Bundesärztekammer*, BÄK). Whether the primary care physicians surveyed by Karbach et al. were aware of this is not clear, however. Marketing strategies based on the features of quality and transparency for "good" guidelines are still underutilized.

A fundamental objection to guidelines may be that primary care physicians greatly value both the long-term relationship with a patient and his or her everyday

reality as well as their own professional experience and intuition and therefore consider individual therapy and therapy complying with guidelines to be contradictory (7). According to definitions, however, guidelines should reflect current knowledge in order to support physicians and patients when making decisions about appropriate care (6). Whether the guidelines can actually be implemented in a particular situation must be verified with due regard for the present circumstances, such as concomitant diseases and the individual preferences of the patient. This is also set out in the guidelines mentioned. There is obviously a need for greater publicity that emphasizes that guidelines are not intended to encourage medicine-by-numbers but are rather appropriate sources of information and an important element in an integrated model of clinical decision making processes.

If primary care physicians consider guidelines to be threats to their therapeutic autonomy, they will make little use of them despite being aware of their contents. On the other hand, primary care physicians use other sources of information (journals, continuing education, peer communications with experts) (7) and many regularly participate in quality circles (8). It can therefore be assumed that even physicians with a hostile stance towards guidelines have acquired appropriate knowledge of drug treatment of cardiovascular diseases. If primary care physicians consider knowledge acquired in this manner to be obtained voluntarily, they are more likely to implement this knowledge and as a result to treat patients in compliance with guidelines. This could be a reason for the minimal differences observed by Karbach et al. in the prescribing behavior between physicians with a detailed and with a superficial knowledge of guidelines. Unfortunately, it is not known which sources of information were used by the respondents and to what extent the contents of the questionnaire used demonstrate specific knowledge of guidelines or general expertise.

An important starting point to facilitate acceptance of guidelines is to emphasize the need for active debate about the contents instead of uncritical acceptance or premature dismissal. Quality circles are a suitable forum in which to communicate the contents of guidelines, to discuss individual experiences, and to

AWMF-Institut für Medizinisches Wissensmanagement, Philipps-Universität Marburg; Prof. Dr. med. Kopp

collectively develop implementation strategies against the backdrop of local conditions. Guideline authors require appropriate feedback from clinical practice to be able to specifically consider problems of implementation when reviewing guidelines. To avoid being outdated, the choice of suitable guideline topics and contents should be subject to ongoing critical checks.

Implementation of guidelines: knowing does not mean acting

Guidelines are required when a need to improve the quality of care has already been determined, that is, when it seems necessary to change the behavior of the target group. The barriers to this step even with a broad understanding and acceptance of available treatment recommendations are illustrated by the classic example of “hand hygiene in the hospital” (9). Concrete interventions based on psychological theories that explain human behavior such as learning theories and cognitive theories are necessary to achieve the desired change (9, 10).

When planning future projects on guideline implementation the following must be taken into consideration:

- Knowledge of guidelines is not a valid substitute for the parameter “acting in accordance with guidelines”.
- A single intervention will have very little effect.
- A broadly applicable model for combining different interventions does not exist.

More promising is the development of a combined strategy tailored to the individual problem, the specific context, the needs of the target groups, and the barriers to these strategies that have been collectively identified (9, 10). Quality indicators to measure to what extent guidelines are implemented and their effects on the outcomes of health care should be proposed by the guideline authors on the basis of recognized methodological standards and stringent determination of requirements. Their use must have a tangible benefit for the documenting physician, however. The time needed for documentation and compliance with regulatory requirements is already considered to be a big problem among German primary care physicians (5). Voluntary quality programs, in which comparative feedback on a physician’s outcomes and support for developing solutions to problems are guaranteed, have proven to be particularly effective (2). Such an exchange also provides a basis for incorporating the concerns of practicing colleagues when reviewing guidelines and maximizing the current potential for improving the care of patients with cardiovascular diseases.

Conflict of interest statement

The author declares that no conflict of interest exists according to the guidelines of the International Committee of Medical Journal Editors.

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Corresponding author

Prof. Dr. med. Ina B. Kopp
AWMF-Institut für Medizinische Wissensmanagement
c/o Philipps-Universität
Karl-von-Frisch-Str. 1
35043 Marburg, Germany
kopp@staff.uni-marburg.de
kopp@awmf.org

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