Considering Values and Contexts in Clinical Practice Guidelines: Are We Becoming More Person-Centred?

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Abstract
Clinical practice guidelines (CPGs) have become ubiquitous in medicine, created to promote rational and standardized clinical decision-making. CPGs are often criticized for overlooking patient values and contexts, which many argue deserve a more explicit place in recommendations. This article explores the role of patient values and contexts in CPGs based on a critical discourse analysis of Canadian Diabetes Association (CDA) Guidelines from 1992-2013. We highlight emerging discourses related to person-centred care in CDA guidelines during this period, which support an increasing emphasis on collaboration and shared decision-making, as well as consideration of patient values and contexts. We discuss possible reasons for this shift and the implications for practitioners. Despite this encouraging trend, our analysis also suggests areas for improvement, particularly concerning the integration of patient preferences in clinical decision-making and research.

Résumé
Clinical practice guidelines (CPGs) have become ubiquitous in medicine, created to encourage rational and standardized clinical decision making. The current emphasis on CPGs grows out of a longer history of regulation and standardization in healthcare during the 20th Century, reinvigorated more recently by the Evidence-Based Medicine (EBM) movement. The EBM movement promotes at its core “practice guidelines based on rigorous methodological review of the available evidence.” Since its inception, EBM has faced criticisms regarding what some consider its overzealous and often indiscriminate application of evidence-based guidelines. Several authors raise concerns about the applicability of CPGs for large patient populations, particularly the elderly with multiple comorbidities who are most often excluded from clinical trials. CPGs are also criticized for being too directive and overlooking important considerations such as patient values and contexts, which many argue deserve a more explicit place in recommendations.

Proponents of EBM have acknowledged the tension between providing individualized care and promoting best practices based on high quality medical literature. Recently, Greenhalgh et al. wrote of a ‘crisis’ in EBM, listing several problems facing the movement such as difficulties applying CPGs to patients with multiple medical conditions and the loss of person-centred care that may result from the rigid application of CPGs. The group called for a ‘renaissance’ in EBM, recommending a renewed focus on individualized care and shared decision making.

Despite the identified need, integrating patient values and contexts into evidence-based CPGs remains problematic. Research suggests CPGs poorly incorporate patient preferences, although there may be a recent trend towards increasing consideration of preference evidence. Some critics contend that CPGs engender rigid standardization that is inherently in conflict with flexible, contextual clinical judgement. Others argue that creating a space for patient values requires a more pluralistic concept of evidence within EBM. Sociological research examining EBM knowledge production shows how evidence-based CPGs often implicitly incorporate extra-evidentiary factors—such as pragmatic, political, and ethical considerations—into their recommendations. Similarly, patient preferences may play a role in shaping CPGs, supported by new initiatives to directly involve patients and the public in guideline development. Indeed, the evolution of CPGs over the past two decades suggests that patient values and contexts received increased attention in recent recommendations. Here, we highlight examples of emerging person-centred discourses in one prominent CPG, the Canadian Diabetes Association (CDA) guidelines, and discuss the implications for practitioners.

Emerging Person-Centred Discourses in Canadian Diabetes Guidelines

The CDA guidelines, issued every five years since 1992, are among the longest standing evidence-based diabetes CPGs, internationally-recognized for their quality and rigour. We conducted a critical discourse analysis of CDA guidelines from 1992-2013 to examine discourses related to patient values and contexts. Critical discourse methodology analyzes language for what it reveals about knowledge, power relations, and social practices. We identified three emerging discourses related to person-centred care in CDA guidelines during this period, which support an increasing emphasis on collaboration and shared decision making, as well as consideration of patient values and contexts.

Discourses of collaboration

The most evident shift in CDA guidelines from 1992-2013 is a major focus on collaboration between practitioners, patients, and families, which has replaced the more prescriptive language of earlier iterations. Earlier guidelines discuss patient education and ‘self-care’ as a way to motivate patients to meet CPG targets, rather than as a means to engage with patients to foster mutual understanding. In the 1992 and 1998 CPGs, patient involvement is framed in terms of a “rights and responsibilities” discourse. Patients have the right to be “fully informed and involved in their treatment,” which amounts to receiving “sufficient, appropriate information about their condition and its complications to enable them to grant informed consent to the treatment prescribed.” These rights also are accompanied by patients’ responsibility to “cooperate and communicate openly and honestly” with healthcare professionals.

The greatest change occurs from 2003 to 2008, with the inclusion of an additional chapter on “Self-management Education,” which goes “beyond a focus on adherence to guidelines and treatment prescriptions” to incorporate “non-didactic (e.g. active, participatory) education.” Patient education is no longer viewed as the unidirectional dissemination of knowledge to ensure adherence, but rather emphasizes interventions to facilitate “participation,” “alliance” and “partnership” between patients and healthcare providers. Responsibility is shifted to providers, who must demonstrate “acceptance (respect) for the individual’s perspectives.”

Collaborative discourses are not only apparent in recommendations about patient education, but also in
guidance to practitioners about their utilization of the CPGs. The 1998 CPGs state that primary care physicians have an “obligation to incorporate and evaluate clinical practice guidelines,” a strong mandate that places the onus squarely on the provider. In 2003, this “obligation” becomes distributed among the interdisciplinary diabetes healthcare team, and by 2008 it is replaced by less prescriptive language. The 2008 CPGs recommend that diabetes care should be “community-based, culturally and socially appropriate, and respectful of age, gender and socioeconomic conditions.”

**Discourses of context**

Updated CDA guidelines also demonstrate increasing consideration of patients’ sociocultural contexts. This development is best illustrated by the creation of recommendations for specific populations, especially Aboriginal peoples. Early CPGs vaguely allude to the unique challenges faced by Canada’s First Nations, Inuit and Métis populations. Although they suggest that healthcare practitioners incorporate “traditional values and customs into the overall treatment approach,” they do not offer explicit, actionable strategies for how to achieve this goal. As of 2013, CPGs highlight the importance of patient contexts in diabetes care.

The 2013 guidelines are the first CPGs to acknowledge how “historic-political and psychosocial factors, stemming from a history of colonization that severely undermined Aboriginal values, culture, and spiritual practices,” contribute to higher rates of diabetes and worse outcomes.

The updated CPGs offer more specific approaches for prevention, screening and management, and encourage attention to contextual factors such as food security and community infrastructure. In contrast to the 1992 CPGs, which conceded that addressing sociocultural barriers “may well be beyond the scope of the average medical practitioner,” the 2013 CPGs share recommendations for “System Interventions,” such as the inclusion of Aboriginal health workers in multidisciplinary teams, to improve the provision of care.

**Discourse of values and preferences**

New to the 2003 CDA guidelines was the disclaimer that: “Healthcare professionals must consider the needs, values and preferences of individual patients,” a statement re-iterated in 2008 and 2013. The 2013 CPGs further recognize that “patient preferences are not always included in clinical research, and, therefore, patient values and preferences must be incorporated into clinical decision making.”

Although these most recent CPGs encourage practitioners to consider the perspectives and wishes of patients, they offer no guidance about how such factors should be incorporated into practice. Determining how patient preferences should influence choices such as dietary or pharmacologic interventions is left to the discretion of individual practitioners. Thus, while this emerging discourse underscores the importance of patient values in clinical decision making, its integration with other evidence-based recommendations remains incomplete.

**Discussion**

Our analysis of CDA guidelines from 1992-2013 revealed three emerging discourses, which suggest an increasing emphasis on collaboration, patient values and contexts in diabetes care. These changes may result from the inclusion of patient representatives in CDA guideline development in 2013, which reflects a rise in increasingly informed healthcare consumers—so-called ‘expert patients’—striving for greater control over their medical care.

Other conditions that contributed to this shift include the growing research on the importance of individualized care and patient empowerment in the management of chronic diseases. Taken together, these evolving discourses may herald a greater focus on shared decision making and person-centred care within EBM.

Despite the shift towards person-centered care, CPGs remain imperfect. Our analysis suggests some areas for improvement. The person-centred discourses identified could benefit from further elaboration, particularly concerning the integration of patient preferences in clinical decision-making. Although the language of recent CPGs is less directive, it remains unclear how practitioners should weigh patient values, especially if a patient’s preferences conflict with recommendations. Clearly, the healthcare provider must maintain an open mind, and use clinical judgement to balance patient preferences with evidence-based recommendations; however, current CPGs offer little guidance on how this is best accomplished, stressing the continued need to educate practitioners in skills of practical reasoning. Moreover, recognition that “patient preferences are not always included in clinical research” should encourage research methodologies that better integrate patient values, such as collaborative inquiry or participatory action models.

Lastly, one must be cognizant of the ‘gap’ that exists between CPG recommendations and their application by practitioners; whether or not these emerging discourses have a tangible impact on the delivery of care remains an open question requiring further study. Nonetheless, the emerging person-centred discourses identified here suggest a
potential shift, which we hope marks a genuine trend towards more reflective CPGs within a more nuanced and inclusive understanding of EBM.

Author contributions
*Both BCY and LR were involved in the conception and design of this project, and the analysis and interpretation of data. BCY prepared the initial draft of the manuscript with input from LR. Both authors reviewed and approved the final draft for publication.

References