Clinical pathways

Unique contribution of family medicine

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I have been traveling the country for 6 months, participating in different forums on improving quality of care for patients with chronic diseases. I would like to share my thoughts on the overwhelming enthusiasm for "clinical pathways" that I am seeing. Every conference I attended presented these types of initiatives: clinical pathways for the management of low back pain, asthma, diabetes, depression, palliative care—the list was endless. Nearly all the provinces are engaged in defining clinical pathways. I am concerned about the manner in which these initiatives are being undertaken. I do not question their objectives—quite the contrary. However, this movement, which is largely based on clinical practice guidelines, might contribute to the fragmentation of care if it continues to be fueled by a vision that focuses on the disease rather than on the person as a whole.[1] I am bringing it up because I believe that family medicine can make a unique contribution.

Clinical pathways, or *care pathways*, are tools used to manage quality in health care by standardizing processes. The objectives are to reduce variations in practice, improve interdisciplinary cooperation, integrate care, and, ultimately, improve clinical outcomes. Clinical pathways are clinical management tools used by health professionals to determine the best processes in their organizations to manage specific populations of patients according to the best available evidence.[2]

The concept of clinical pathways is closely related to that of disease management and dates back to the 1980s. The concept and objectives are laudable. Our patients can benefit from the standardization of care, as it helps reduce health inequities. While the limitations of a practice based on clinical practice guidelines for following patients with chronic diseases are increasingly evident,[1] it is disquieting to see that most pathways are developed by "specialized" teams using a disease-focused approach. This type of approach is risky, as it might not produce the desired results. A recent article based on the National Institute for Clinical Excellence recommendations for 5 common health problems clearly demonstrates that disease-focused clinical pathways based on current practice guidelines would result in complex, demanding treatment plans for people and an impressive polypharmacopoiea, even for elderly persons who present with only 2 of these problems in moderately severe forms.[3]

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It is one thing to say that recommendations must be tailored to each patient, but it must be done systematically to reduce the risks of "idiosyncrasies" caused by patients' and care providers' personal biases. How can evidence, recommendations, and individuals' goals be taken into account? How can we make the shift from an evidence-based practice to an evidence-informed practice that takes into account the unique situation of patients with multiple chronic conditions? In an article that some would consider controversial, Quill and Holloway introduce the concept of "preference-based medicine" and maintain that eliciting values and discussing goals of care are as important as finding evidence, and that making recommendations and seeking consensus are as important as decision making.[3] In this paradigm, quality care is not defined in a standardized way as achieving a treatment goal shared by all patients with the same disease, but as following a process that allows each patient to achieve the treatment goals that takes his or her situation as a whole into account.

Like Joanne Reeve, a family physician affiliated with the University of Liverpool in the United Kingdom, I believe that family medicine, thanks to its generalist viewpoint, can help make this shift. It requires a thorough understanding of the scientific process and its limitations, as it involves analyzing how knowledge derived from research on patient populations can be applied to each unique person we see.[4] If we want to avoid reproducing the silo approach to disease management of the 1980s, it is imperative that generalists—namely, family physicians—assume the leadership they are capable of to help develop clinical pathways that support integrated chronic disease management processes. These processes must be based on the best scientific evidence available, be tailored to the objectives of individuals and their families, and capitalize on the versatility of primary care clinicians.

References

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