Multiprofessional guidelines: can we move beyond tribal boundaries?

Developing and implementing healthcare guidelines remains a surprisingly complex and challenging undertaking. This process is further complicated when considering the multiprofessional contributions and intersectoral approaches to care. Different subgroups of the healthcare population have different perspectives and priorities and raise different issues all of which should theoretically add depth and strength to the guideline. However, developing a guideline which reflects this approach to health care can be an intricate and expensive venture and several pitfalls need to be avoided. It is an area where successful implementation is likely to have significant health gains and is high on the list of priorities in the United Kingdom health service agenda of clinical audit, clinical guidelines, and clinical effectiveness.

Maternity care is an excellent example of healthcare professionals working closely together therefore creating opportunities for collaborative quality initiatives. A subject in which there are major quality issues is that of the management of threatened miscarriage. As far as we can find out, there are few national guidelines about the care of women with threatened miscarriage—and none have been produced in the United Kingdom. However, the Miscarriage Association has produced guidelines for good practice which are a useful starting point.1 Threatened miscarriage is one of the commonest complications of pregnancy in which women seek medical aid, usually from their general practitioner in the first instance. It is one of the commonest reasons for admission to a gynaecological ward or an early pregnancy assessment unit. Furthermore the quality of health care crucially affects a woman's experience of miscarriage,2 with considerable emotional impact on women, which is often trivialised by the medical profession. A recent study undertaken in The Netherlands3 illustrates some of the problems that may be encountered when trying to develop and implement guidelines for the management of threatened miscarriage, which crosses professional and sector boundaries. In The Netherlands the key professionals responsible for caring for women who are threatening to miscarry are similar to those in the United Kingdom. The Dutch College of General Practitioners produced an evidence based guideline on the management of threatened miscarriage in 1987.4 Fleuren, et al (in this issue) explore midwives' compliance with the guideline.3

The development and implementation of high quality guidelines on maternity care require three essential activities—namely, collaboration, communication, and consultation between all those involved in providing maternity care: primarily obstetricians, midwives, general practitioners, and the women cared for. Such interaction should encompass the important issues of education and knowledge of guidelines for all practitioners involved in the implementation. This study shows common problems that can occur with compliance and clinical applicability when collaborative approaches to guideline initiatives are not used. Healthcare professionals needed to assess the package of care and also to understand the work and the values of colleagues from other professions.5

Clarity of each professional's role and responsibility for appropriate care is an essential component of shared clinical guidelines. For example, in the Dutch study the guidelines recommended that vaginal speculum examinations should be undertaken. It could be argued as this particular procedure is not routinely performed by midwives, it shows a lack of professional consultation in the design phase and as a result may lead to non-compliance in clinical practice. Consideration of the dissemination and implementation should also be an integral part of the development of a guideline. Ownership of a guideline is a key component to compliance and affects issues of dissemination and evaluation.6 Are professionals such as midwives, general practitioners, and obstetricians traditional and tribal in their approach to developing clinical guidelines in maternity care? How much have we changed over time in reflecting the contemporary issues that need to be incorporated in development of guidelines?

High levels of compliance with a guideline does not necessarily mean that the midwives agreed with the Dutch guidelines on miscarriage. Accepting and using are two different concepts; therefore acceptance should not be mistaken for compliance. Assessment of the professionals’ attitude to the guidelines in practice should ideally be part of the evaluation of the guidelines, and the Dutch study explored this aspect in detail.6

Analysis of other areas in the Dutch study where there was poor compliance with the guidelines showed that compliance was affected by women's decisions, views, and choices. One particular area was the use of diagnostic ultrasound scanning for maternal reassurance. The involvement of the woman or patient in producing good quality guidelines is paramount,7 and no more so than on the subject of miscarriage. The Dutch guidelines were produced in 1987, and important changes have occurred over time in relation to patients' or women's views of and involvement in guideline initiatives. A culture of patient
participation and representation has emerged in relation to health care. This has been widely recognised in healthcare planning globally.6,7 It is unclear whether this approach was recommended or adopted in the development of the Dutch guidelines in 1987. We appreciate the shortcomings and suggest further development of the guidelines by involving patients.

In aiming to create a philosophy of patient-centred care, with the patient central to the audit cycle or spiral of improving health care, maternity services provide an opportunity for this to arise. One example from the United Kingdom is the government initiative *Changing childbirth,* aiming to give women choice and control in their care. Should we not be applying this concept of patient-centred care to team work on guidelines throughout all areas of health care?

In planning and developing quality health care in particular clinical guidelines, patient involvement creates empowerment. Healthcare professionals are learning the importance of this concept. However, we cannot be complacent. The need to ask explorative and challenging questions remains essential—for example, are healthcare professionals totally committed to the ethos of guideline development, and are all the stakeholders represented in this process? Evaluating guideline implementation and compliance should highlight these issues.

Healthcare professionals should feel confident and assured that clinical guidelines are not a means of coercion of the individual clinician by managers or senior professionals.8 Guidelines can only assist healthcare professionals as autonomy, clinical freedom, and clinical responsibility remain important so that local circumstances and the needs and wishes of individual patients can be accounted for in their application and interpretation. This is important to the delivery of good quality team health care in all areas, particularly so in maternity care.

Lessons in this study are applicable to many countries in relation to improving team activity and creating conditions in which hospital doctors, general practitioners, midwives, and nurses have time to talk to each other to consider issues of quality together. This type of dialogue is necessary and important in moving towards a truly integrated perspective of quality health care and women centred maternity care. The professional barriers need to come down. Guidelines are produced for one reason, and one reason only, to improve the quality of care.6

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