



Acceptance or rejection of clinical standardization? Chilean doctors discuss clinical practice guidelines and benefit packages

¿Aceptación o rechazo de la estandarización clínica?
Médicos chilenos hablan de las guías clínicas y
canastas de prestaciones

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ABSTRACT This study analyzes the degree to which Chilean doctors accept the standardization of clinical health care associated with the 2005 Health Reform AUGE-GES (from the Spanish *Acceso Universal con Garantías Explícitas - Garantías Explícitas en Salud*). Using 18 semi-structured interviews, four hypotheses were explored in relation to the level of acceptance of standardization and its variation according to years of clinical experience, the type of instrument (clinical practice guidelines or benefit packages), and the specialty (medical or surgical). Rather than a generalized rejection of the standardization of clinical procedures, the results suggest important differences within the discourse of the doctors. The level of acceptance depends both on years of clinical experience and the type of instrument evaluated. We discuss the implications of these results for the design and implementation of successful health reforms, incorporating the rationale of the medical profession and its emphasis on individual discretion, variability of treatment decisions, and the ability to adjust to the particular circumstances of the practice.

KEY WORDS Professional Practice; Professional Autonomy; Attitude of Health Personnel; Practice Guidelines; Cost Control; Chile.

RESUMEN Este estudio analiza la aceptación de los médicos respecto de la estandarización de la atención clínica que conlleva la reforma de Acceso Universal con Garantías Explícitas (AUGE) y de Garantías Explícitas en Salud (GES) iniciada en el año 2005 en Chile. Se realizaron 18 entrevistas semiestructuradas, en las que se exploran cuatro hipótesis vinculadas al nivel de aceptación de la estandarización y su variación según los años de práctica clínica, el tipo de instrumento (guía clínica o canasta de prestaciones) y la especialidad (médica o quirúrgica). Los resultados sugieren que no existe un rechazo generalizado hacia la estandarización de los procesos clínicos, sino importantes diferencias en el discurso de los médicos. El grado de aceptación depende tanto de los años de experiencia clínica como del tipo de instrumento evaluado. Se discute la implicancia de estos resultados para diseñar e implementar reformas de salud exitosas, que consideren la racionalidad de la profesión médica y su énfasis en la discrecionalidad individual, variabilidad terapéutica y capacidad para adecuarse a las circunstancias particulares de su práctica.

PALABRAS CLAVES Práctica Profesional; Autonomía Profesional; Actitud del Personal de Salud; Guía de Práctica Clínica; Control de Costos; Chile.

INTRODUCTION

The increasing use of clinical practice guidelines and benefit packages for clinical standardization represents a fundamental change in the health-disease-care process. This change has been extensively discussed in the social and health sciences and has been many times described as an increase in scientific-technical rationalization within health practices (1). Nevertheless, the available evidence about the point of view of doctors regarding this standardization is limited (2). This study seeks to contribute to the theoretical debate on clinical standardization through the analysis of the discursive reactions of doctors towards the standardization of their practice, as well to help guide health care reform processes which entail greater clinical standardization. Specifically, this study explores the level of acceptance reported by Chilean doctors regarding the clinical standardization introduced with the clinical practice guidelines and benefit packages which are part of the reform of Universal Access with Explicit Guarantees (AUGE, from the Spanish *Acceso Universal con Garantías Explícitas*) and *Explicit Health Guarantees* (GES, from the Spanish *Garantías Explícitas en Salud*).

The AUGE-GES reform, which was initiated in the year 2005 in Chile and inspired by the approach of social rights in health, requires health institutions to comply with a set of legal and administrative regulations based in international law (3). This comprehensive reform of the Chilean health system prioritizes health care resources for certain pathologies (amounting to 69 pathologies in the year 2011) chosen after considering the prevalence, incidence, morbidity, invalidity and costs related to the disease. The reform also includes clinical practice guidelines which determine the maximum wait time for receiving care, and benefit packages which detail the medicines and treatments included for each covered pathology. Upon certification of the health care received by a patient with an insured pathology, the National Health Fund of Chile transfers to the provider, whether public or private, the resources defined by a universal premium. In short, the reform provides individuals with specific pathologies four guarantees: access, opportunity, funding and quality (4).

The quality guarantee is particularly important for this study since it requires health establishments to comply with minimum standards, although these standards cannot be legally demanded until the accreditation of providers has been completed. When this guarantee comes into law, it will be especially important to understand doctors' acceptance of the clinical standardization. Notwithstanding, the evaluations of the reform carried out up to this date have paid little attention to the effects of clinical standardization and have focused on the waiting lists and the effectiveness of the services (5-7).

Studies conducted in Anglo-Saxon countries indicate that doctors' level of acceptance of clinical standardization is generally low (8-10). In these research studies, doctors reported their disagreement with the evidence used in the design of the clinical practice guidelines and the benefit packages, their disconformity with the rigidity or simplicity of the design and their concerns regarding the risk of inducing bad practices (8).

Medical sociology has tried to explain this low level of acceptance of standardization by suggesting that medical profession practices respond to the concept of autonomy, self-regulation, personal responsibility and practical rationality (11-14). Doctors tend to adopt suggestions only if they match their own criteria, are reluctant to modify their clinical practice based upon abstract considerations and found their clinical criteria in a practical rationality which highlights the importance of adjusting the dose, time and intensity until finding what is best for each patient in particular. Generally, doctors give priority to complex and flexible clinical criteria which allow for running risks rather than following a set of standardized routines (13). Taking into account this theoretical background, four hypotheses were explored related to the level of acceptance of standardization and the variation in acceptance according to the number of years of clinical experience, the type of instrument (clinical practice guidelines or benefit packages), and the specialty (medical or surgical):

1. The level of acceptance of standardization is generally low among doctors, who evaluate standardization instruments with clinical criteria far removed from routinization and rigid treatment norms.

2. Doctors from recent cohorts of graduates and with less clinical experience report a higher level of acceptance of medical practice standardization.
3. The AUGE-GES clinical practice guidelines have a greater level of acceptance than the benefit packages due to the fact that the guidelines were designed with the participation of doctors and therefore respond more directly to expert criteria and scientific evidence. On the other hand, the benefit packages generate less acceptance within the medical community since they standardize health care costs according to economic criteria, not necessarily to medical criteria (15).
4. Surgical specialties report greater acceptance of the standardization since they treat more localized pathologies in which the curative process occurs mainly at the hospital, whereas medical specialties have to deal with chronic and multisystemic pathologies in which the doctor has to adjust regularly the treatment dose according to the patient (16).

These four hypotheses as a whole explore the degree and variability of the acceptance of clinical standardization expressed by the doctors.

MATERIAL AND METHOD

In order to explore empirically the four hypotheses of this study, a qualitative methodology of semi-structured interviews was used, able to capture individual experiences and meanings as well as discourses that refer to social meanings in the environment, such as practices and criteria shared by the social group with which the interviewee identifies (17).

Fourteen doctors and four administrative professionals (a doctor, a nurse, a secretary and an engineer) were interviewed. Although this study is focused on practicing doctors, the administrative professionals routinely evaluate the implementation of clinical practice guidelines and benefit packages; therefore, the information they provide allows for the improvement of the guidelines used for the interviews with doctors and for the exploration of the external validity of their opinions through data triangulation (18).

The initial sampling was purposive or theoretical, expanding to the contacts of the interviewees through a snowball or avalanche system. Only interviewees working in public hospitals in the east, southeast and northern areas of the city of Santiago, with work experience in the utilization of guidelines and packages, were selected. The sample size was established striking a balance between the criterion of theoretical saturation – which states that there is no need for a new interview if it no longer provides significant information – with the criterion of maximum heterogeneity, which implies dividing the sample into medical specialties (cardiology, neurology, neonatology and rheumatology) and surgical specialties (neurosurgery, traumatology and urology), and years of experience (less than 15 years and 15 years or more) (19).

All the interviews were conducted by one of the authors between October 18 and December 10, 2010, in private offices or cubicles within the hospitals during the interviewees' free time. At the beginning of each interview, the research topic was explained to the participants, their confidentiality was assured, and their informed consent was obtained before continuing on with the guiding questions of the interview. These interview guides (available by request) sought to discover the opinions regarding clinical health care standardization and were organized into four topics: clinical practice guidelines and protocols, AUGE-GES clinical practice guidelines, AUGE-GES benefit packages, and consequences of the AUGE-GES reform. The depth with which each of these topics was touched depended on the interviewees' experiences and their reactions to the guiding questions, resulting in interviews that lasted from between 30 to 60 minutes.

All the interviews were transcribed and the relevant opinions were incorporated as direct quotes within a table, divided into sections according to the topics of the interview guide as well as other emerging themes. Following the principles of grounded theory, these data were used to re-elaborate theoretical concepts and to explore the explanatory power of each of the hypotheses (20). The following section summarizes the results obtained through revelatory quotations and a graphic illustration of the tendencies within the interviewees' opinions.

RESULTS

The interviewees’ opinions were classified within a simple qualitative hierarchy as supporting or contradicting each hypothesis, or as neutral in the case of ambiguity or lack of opinion. This information allowed us to calculate the total number of opinions that support, are neutral towards or contradict each hypothesis. Figure 1 summarizes these results and uses spheres of different sizes to illustrate the distribution of qualitative opinions according to their degree of support for each of the hypothesis.

In the first row of Figure 1, it can be observed that the results of the analysis of the interviews are contradictory to the hypothesis of a generally low level of acceptance of standardization. A discourse of low acceptance exists along with another of greater acceptance. The first discourse emphasizes that “medicine is an art” which must consider simultaneously the patient and the best medical practices. This discourse recognizes the importance of using the best medical practices, but also emphasizes that a doctor’s practice does not correspond to an unambiguous, mechanical association between the disease and its cure.

These guidelines began to be created awhile ago, and the tendency is for [them] to increase the protocolized management of patients... but that takes out a little of the “art of medicine,” so why do it? Otherwise, everything is going to be transformed into identifying a disease, making it fit a diagnosis and implementing that guideline, that norm... and medicine is not really like that... Like I said, there is a lot of personal variability in the different diseases that people might have... (Medical Specialty, 15 or more years of experience).

The discourse of greater acceptance emphasizes the importance of a clinical standardization that includes the criteria of “flexibility and therapeutic innovation.”

The guidelines help guide us a little – excuse the redundancy – in taking care of the patient’s pathology, and that’s the reason why when someone is drawing up a clinical guideline, it is ideal for it to be the most – to try to handle well the pathology, in terms of the diagnosis and the treatment, but always leaving room for the variations that one may make regarding the specific management of the patient. (Surgical Specialty, less than 15 years of experience).

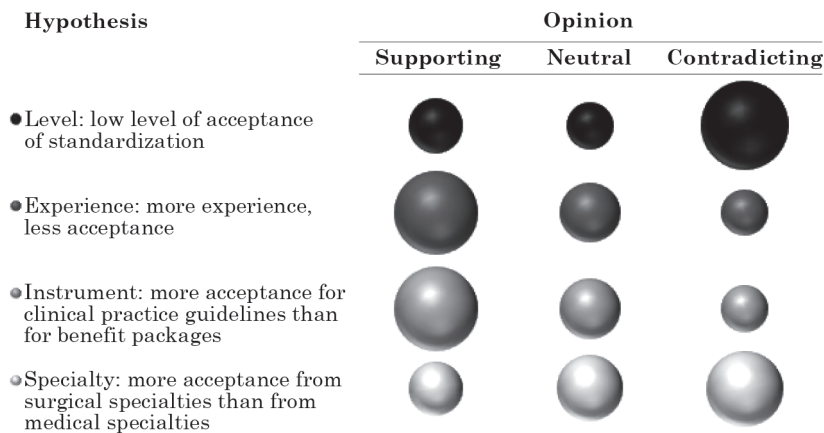


Figure 1. Distribution of total interviewee opinions according to their degree of support for each hypothesis. Santiago de Chile, 2010.

Source: Own Elaboration.

The second row of Figure 1 shows strong support for the study's second hypothesis, which is that the level of acceptance of standardization depends on the years of clinical experience. The results suggest a combination of the effects of age and cohort. In particular, fewer years of clinical experience and having been trained as a specialist using European and American clinical practice guidelines are associated with a greater acceptance of the standardization.

Essentially the idea is that all the traumatologists within the service be aware of the guideline's content and understand it, and ideally all of them read and know what the guidelines are about, but it is not easy, especially when there are traumatologists with... with more years of experience. Some of them will apply the guidelines, some of them will not, depending on what their experience, their reality, has been like it and how their career has gone... (Surgical Specialty, less than 15 years of experience)

Health and patients are not rigid. The evolutions of diseases are not rigid. They do not always present themselves as they should... when they appear, they can always – a disease can have thousands of manifestations which cause it to develop, and sometimes it isn't so simple... So something that is not rigid cannot be made rigid, cannot make rigid... you can put a disease within certain parameters, but you cannot try to put concrete limits to it. (Medical Specialty, 15 or more years of experience)

The third row of Figure 1 also suggests that the opinion of interviewees tends to support the third hypothesis. Specifically, the results suggest that the clinical practice guidelines are more accepted than the benefit packages. An important group of interviewees, without differences by age or specialty, holds that guidelines have meant better access and opportunity in patients' health care.

What I see in this reform is that the moment of diagnosis of serious diseases has obviously improved and the treatment of such diseases has been much timelier. That is very

important progress that AUGE has made in certain pathologies. (Medical Specialty, 15 or more years of experience)

Despite the existence of a discourse favorable towards the standardization introduced by the clinical practice guidelines, the guidelines are also criticized for maintaining restricted treatment alternatives which reflect resource limitation criteria instead of better care.

Let's see... one would always like for it to be more broad, for example in patients with arthritis, where we have GES, and in patients with osteoarthritis, what is not contemplated, especially in patients with osteoarthritis, what is not contemplated is joint replacement, prostheses. There's not even the possibility of having surgery; it's not contemplated in the GES guidelines [...] That makes you frustrated, because they're not complete, they're not what you would want, they're not what the patient really needs. (Medical Specialty, 15 or more years of experience)

Medical practice standardization that brings with it resource restrictions is clearly controversial among doctors and generates even more rejection when evaluating benefit packages. These packages are criticized for not financing the best medicines, not adjusting to the providers' real cost and not considering complications.

It's true that the implementation of the packages has established a minimum of what should be used. But the floor has to be raised [...] It doesn't matter if [the medicines] are cheap, they also need to be good. What's bad is if they're cheap versions and there is evidence that they are not the best. That's what is questionable. It's an ethical problem... You wouldn't take those medicines yourself, or give them to a relative... (Medical Specialty, 15 or more years of experience)

The fourth row of Figure 1 shows that the interviewees' opinions contradict the fourth hypothesis of this study. Specifically, surgical specialties do not seem to be more susceptible to standardization

than medical specialties (the opinion of medical specialties can be seen in previous quotations). Certainly, surgical specialties deal with more localized pathologies than the medical specialties and carry out the healing process with much more frequency at the hospital. Nevertheless, surgeons trust extensively their own criteria and, furthermore, they specialize in particular surgical techniques which they adjust according to their experience, the patient's circumstances and the resources in their work environment.

It's that the guidelines are developed using a pool of patients, using patient statistics, regarding how some drugs or procedures are going to work on them, and there are patients who may escape those results. That's the reason why you should have open doors when using the guidelines in order to be able to treat these types of patient variations. (Surgical Specialty, less than 15 years of experience)

...considering the environment of doctors, in the sense that we are very different and all have forceful opinions, are almost – almost arrogant oftentimes regarding our personal opinion, then a guideline that we all can apply is a guideline quite difficult to create [...] As a guide I think it's ok, but when it ends up being followed to the letter, suddenly it's a little dangerous, and it's also a bit tedious professionally and academically. (Surgical Specialty, 15 or more years of experience)

All these results hold when exploring the discourse of the administrative professionals included in the sample, which suggests the external validity of the results.

DISCUSSION

This study used semi-structured interviews to explore the level of acceptance reported by doctors regarding the clinical health care standardization that the AUGE-GES reform entails. The results do not suggest the existence of a widespread rejection of standardization, but they do suggest

important differences among doctors' discourses, in which some groups emphasize the benefits and others the difficulties.

The results also show that the level of acceptance of standardization depends on the years of experience and the type of instrument. The level of acceptance is greater among doctors with less experience whose training is recent, since they tend to have less confidence in their own criteria and to be more familiarized with the use of standardization instruments in other countries than older doctors with more experience. Continued education arises in this context as a key aspect for the sustained success of the AUGE-GES reform and other reforms with a clinical standardization component, especially if it is taken into account that young doctors educated within new medical standards could decrease their level of acceptance as they accumulate experience.

Regarding the variation in the acceptance of the standardization according to the type of instrument, the results suggest that the clinical practice guidelines generate more acceptance than the benefit packages. Generally, these guidelines are considered as flexible and appropriate, although in some cases professionals would have expected greater offer and validity of therapeutic alternatives. A challenge of the AUGE-GES reform which has not yet been overcome is the establishment of a hierarchical order among the indications of the benefit packages. As packages detail the medicines and treatment which will be effectively financed, every time a doctor decides to use a treatment that is not covered, a difference is produced between the real cost and the money transferred by the public or private insurer. This fact makes doctors' opinions more critical regarding the use of packages.

As a whole, the results of this study highlight the importance assigned by doctors to the possibility of choosing between different therapeutic alternatives and to adapting themselves to the patients' particular circumstances and the context of their medical practice (21). This rationality of the medical profession has a dialectical relationship with the increasing use of scientific evidence in medicine. A dialectical relationship implies a tension between thesis and antithesis, in this case described as a paradigmatic struggle between the traditional pathophysiological approach oriented to the individual and the epidemiological

approach oriented to populations (22). A dialectical relationship also implies a synthesis, in this case defined as a false dichotomy between the pathophysiological approach and the epidemiological approach since both have to simultaneously consider individual and population factors, are determined by the context (historical, political, economic, social, cultural and institutional), and achieve unity in the doctor's subjectivity (23-25). The recognition of this dialectical relationship and its influence in the health-disease-care process when designing and implementing health reforms may contribute favorably to its success.

The results of this study possess important practical implications for the guiding of AUGE-GES reform efforts. This reform has meant a national reorganization of health care, seeking to improve epidemiological indicators and user satisfaction, while at the same time introducing tools for the standardization of medical practice. Once the provider accreditation process has been completed, the AUGE-GES reform contemplates the

possibility of legally requiring quality standards to be met that, together with the standardization effect already introduced by the clinical practice guidelines and benefit packages, will probably affect clinical discretion in an important way.

Considering the results presented in this text, future studies could use surveys and representative samples in order to analyze the topic with quantitative methods and extend the research, for example, to contemplate differences in the level of acceptance of standardization depending on the role doctors play within their profession. The variability found in this study is substantial, but it could have been underestimated by not including academic doctors and general doctors with large administrative responsibilities. Estimating with precision the variability in the acceptance of clinical standardization will help guide more efficiently the efforts to reform the Chilean health care system and contribute to the global discussion about the consequences of the standardization of medical practice.

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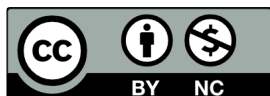
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