# *Can "Best Practice" Guidelines lead to worse care?*

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# *A tale of two NSTEACS* Patient 1*

- May 2001
- Male, age 69, no past history of coronary disease
- HT controlled on Rx, ex-smoker 5y
- Tight chest pain, at rest, 30 mins+
- 111 – transfer to hospital, pain settling
- ECG – minor inf-lat ST depression (temp)
- Troponin –ve but later +ve (TT 0.12)
- No further symptoms

*Non-ST-elevation Acute Coronary Syndrome

# *A tale of two NSTEACS* Patient 2*

- May 2001
- Male, age 69, no past history of coronary disease
- HT controlled on Rx, ex-smoker 5y
- Tight chest pain, at rest, 30 mins+
- 111 – transfer to hospital, pain settling
- ECG – minor inf-lat ST depression (temp)
- Troponin –ve but later +ve (TT 0.12)
- No further symptoms

*Non-ST-elevation Acute Coronary Syndrome

# *A tale of two cities*

## *Patient 1*

- Admitted to CCU Ivorytower Hosp
- Rx ASA/BB/statin/LMWH
- Rx clopidogrel/ACEI/ tirofiban
- Angio next day – PTCA
- D/C day 3

## *Patient 2*

- Admitted to CCU/HDU St Elsewhere-on-sea Hosp
- Rx ASA/BB/statin/LMWH
- D/W Ivorytower Hosp, accepted for angio
- Day 5, no transfer date yet, feels well, negotiated discharge

# *ACS Guidelines for New Zealand*

- May 2001 – meeting of cardiologists and physicians from most NZ 3º and 2º centres
- Review of US, UK, European and Austral(as)ian guidelines
- Fairly uniform recommendations
  - Well beyond present practice & resources in NZ
- Resolve for “best practice” guidelines
  - Costing & implementation to be addressed later
- Agreement to perform national audit

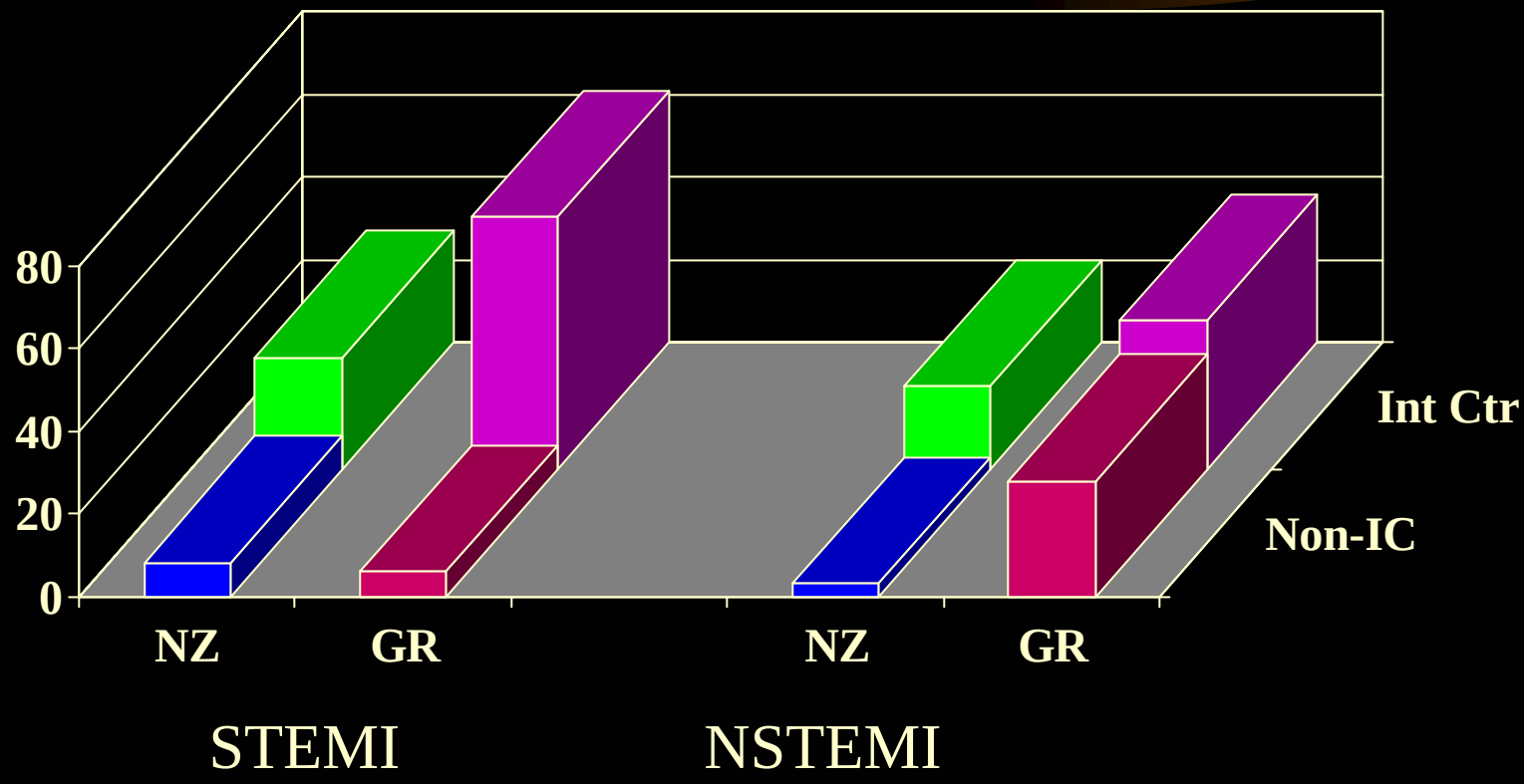
# *ACS Guidelines for New Zealand*

- Slow further development
  - minimally funded, delegated to small group in GLH
  - Early 2004 - distribution to cardiologists for comment
  - consultation with others …?
- New Zealand Guidelines Group (NZGG) process
  - used for Cardiac rehab, CVS risk, diabetes, stroke ….
  - open committee, domination more difficult
  - perception of capture by non-clinicians
- Jul 6th 2004 – announcement of funded NZGG process by MoH
- November 2004 – funding approved, further development awaited

# *NZ Acute Coronary Syndromes Audit and GRACE Registry*

- NZ Acute Coronary Syndromes Audit (NZACSA)
  - Comprehensive audit of likely coronary chest pain over 2 weeks in May 2002
  - 930 patients (318 to Int Ctr, 612 to Non-IC)
    - STEMI 11%, NSTEMI 31%, UAP 36% (721)
  - Published July 9th, 2004 (NZ Med J)
- GRACE Registry
  - International audit along similar lines
  - Publication 2003

# *PCI in NZ and GRACE Interventional Centre v Non-IC*



# *Where are we now?*

- *De facto* guidelines being followed by clinicians
  - Inconsistent utilisation
  - Standard drugs, “expensive” drugs, angio/intervention
  - “Grey zone” and paradox of age and comorbidity
  - Presumably patchy outcomes
- Secondary hospital frustration (sense of obligation to refer - slow referral process)
- Tertiary hospital triage crisis – cardiac activity dominated by acute ACS referrals
- “Official” guideline process slow to start

# *Expectations*

- Cardiologists
  - Full implementation of “best practice” guidelines
  - Compromise distasteful
  - Upfront resources must be provided
  - Political campaign
  - Debate on long-term cost-effectiveness
- Ministry/DHBs
  - Yet to declare their hand
  - Interest in wider healthcare interventions, cost-effectiveness and political pressures
  - Capped resources …but
  - CVS specified priority area

# *Conclusions and issues*

- Present state deeply unsatisfactory
  - Inequities of care serious and widening
  - Increasing tension and frustration
  - Well short of best available care for all
- Should “best practice” guidelines be a tool with which to exert political pressure?
- Should “best practice” guidelines be adapted to the economic environment?
- If so, how (in a way acceptable to clinicians)?
- If not, will guidelines improve or impair healthcare?