regulation would be so strict as to jeopardize any features of market competition that remained.

The AAFP plan, to my reading, leans toward the side of increased regulation, and this direction is fully defensible. But, if one has gone that far, what reason remains to continue to put up with the inefficiency of a multipayer system? One has gone virtually all the way to government-mandated and government-regulated health care, so why not adopt a single-payer system and accrue the monetary benefits of that system instead of just paying the political and economic costs? The only reason, it would seem, not to take that last step is the attraction of the ideological veneer of "private enterprise." Is that veneer worth, say, $50 billion in excess administrative costs that could otherwise have gone into better care for the underserved?

The AAFP has done us a great service with its bold and well-reasoned proposal. We must now take the debate forward and proceed to refine the proposal along with the political action required to get meaningful and thoughtful health care reform on the public policy agenda.

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Clinical Guidelines And Primary Care

This issue of *JABFP* inaugurates a new feature, "Clinical Guidelines and Primary Care." The last several years have seen a flurry of attention to the process of medical care, with a growing number of clinical guidelines or policies developed and disseminated by many organizations in the United States. The list of groups involved in the clinical guideline business now includes the National Institutes of Health, the Agency for Health Care Policy and Research, and many specialty societies and groups, including the American Academy of Family Physicians with its own Clinical Policies Task Force. The Institute of Medicine has been actively involved through a committee to advise the Public Health Service on clinical practice guidelines, and its recommendations were released in 1990.[1] Increasingly, published clinical guidelines are finding their way into monographs and both general and specialty clinical journals, where they frequently encounter mixed reactions among clinician readers.

The Institute of Medicine has observed that diversity in clinical practice can range from acceptable to unacceptable, that well-constructed clinical guidelines can help to illuminate what is acceptable, and that these assessments can change over time. Its report points out that diversity in clinical practice may be acceptable "when the scientific evidence to support different courses of care is uncertain" and that "some degree of diversity may be warranted by differences in individual patient characteristics and preferences and variations in delivery system capacities related to locale, resources, and patient populations." On the other hand, "diversity in practice is unacceptable when it stems from poor practitioner skills, poor management of delivery systems, ignorance, or deliberate disregard of well-documented preferable practices."[1,pp 104-5]

The potential advantages of clinical guidelines, as well as their problems, are legion. To the extent that they can represent mainstream medical care under specific circumstances based on current scientific evidence, they can be useful in medical education, quality assurance, and encouraging improved standards of delivery of health care services. On the other hand, there are many steps along the way in the creation of clinical guidelines that could lead to compromise or even invalidate their application in everyday practice. There is a common tendency, for example, for such guidelines to be developed by "expert consensus," based more on opinion and global judgments than on objective assessment of available scientific evidence. Add the absent or nominal participation of primary care physicians to this process, and it is no surprise that many clinical guidelines being released today seem to lack validity and relevance to the diversity and complexity of primary care settings.

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As any group involved in developing a clinical guideline soon discovers, the process is complex and intensive. The Institute of Medicine has proposed the following eight criteria for a "good" clinical guideline[1 pp 100-1]:

- Validity (i.e., for expected health and cost outcomes, if followed)
- Reliability-reproducibility (e.g., another set of "experts" would arrive at same recommendations)
- Clinical applicability (with explicit applications to defined patient populations)
- Clinical flexibility (with known or expected exceptions identified)
- Clarity (i.e., precise and unambiguous terms)
- Multidisciplinary process (including all key affected groups)
- Scheduled review (to accommodate new evidence or changing professional consensus)
- Documentation (i.e., consensus of the process, evidence used, assumptions)

Given the plethora of clinical practice guidelines now being released, their variable quality and relevance to primary care, and the resultant confusion that often follows among physicians as to the applicability of the guidelines in their own practices, *JABFP* is initiating a regular review examining the development of selected clinical practice guidelines involving common clinical issues in family practice and primary care. Reviews will be done largely by family physician generalists with expertise in clinical epidemiology and guideline development. Dr. Alfred Berg, Associate Editor, will play a key role in this process and has coauthored the first review on guidelines for the diagnosis and management of asthma, which appears in this issue.[2] Two other members of the Editorial Board have special interest and expertise in this area, (Drs. Frame and Wall), and collectively they serve on such groups as the US Preventive Services Task Force and the AAFP Clinical Policies Task Force.

The format of these reviews will likely evolve with experience, but the review of asthma guidelines serves as a useful starting point. It can be anticipated that these reviews will range within a spectrum from positive to negative. It is our hope that the negative ones will have some influence on the quality and relevance of future clinical guidelines being developed by various groups for application in primary care. Some of the subjects currently under review include screening for scoliosis, estrogen replacement therapy, hyperbilirubinemia in the newborn, restrictive airway disease in children, and head injury in children.

Most clinical guidelines affect primary care directly and should not be accepted without active dialogue and involvement of family practice and the other primary care disciplines. Good clinical guidelines can improve the quality of primary care, but they must be based on rigorous review of available scientific evidence and accommodate the many complexities of the primary care environment, such as individual preferences of patients and their families, availability of local resources, and so on. *The Journal of the American Board of Family Practice* is apparently the first clinical scientific journal to undertake an examination of the process of clinical practice guideline development. It is our hope that the resulting dialogue will serve to increase the quality and relevance of these guidelines in primary care and ultimately to improve the quality of care received by patients in the many diverse primary care settings throughout the country.

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