

## Should Clinicians Rely on Expert Opinion or Empirical Findings?

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In this issue, Frances et al<sup>1</sup> offer a rationale for and describe the methodology used in developing consensus practice guidelines. The methodology involves presenting researchers who are known for their work on a certain disorder with clinical vignettes illustrating a variety of clinical situations and asking them how they would proceed in these situations. The responses of the experts are compiled to produce what Frances et al call the consensus guideline. Frances et al have mounted an extensive campaign to disseminate consensus guidelines to practitioners, insurance companies, and managed care executives, with the goal that the guidelines become policy in many health-care settings. Four guidelines have been published in psychiatry to date, and Frances et al hope to publish guidelines in other fields of medicine as well.

Certainly the objective of these practice guidelines—to improve the quality and cost-effectiveness of care—is laudatory. The guidelines also have much to recommend them. The authors have succeeded in drawing to their expert panels the best clinical investigators in the field. Even though the funding for this project was provided by pharmaceutical firms, the practice guideline for obsessive-compulsive disorder,<sup>2</sup> for example, rates exposure and response prevention, a psychosocial therapy, as a first-line treatment, providing some reassurance that the guidelines do not simply serve promotional motives. Additionally, a guideline that views exposure and response prevention as a first-line treatment can improve the quality of care that patients with obses-

sive-compulsive disorder receive, since, despite strong empirical support, exposure and response prevention is underutilized by clinicians.

Despite these strengths of the consensus guideline project, we believe that a guideline founded on expert opinion rather than empirical data is a bad idea, for the following three reasons: (1) experts can be wrong; (2) consensus guideline methodology teaches clinicians to rely on experts, not empirical findings; and (3) consensus guidelines blur the distinction between clinical questions for which data are available and clinical questions for which no data are available. We propose an alternative means of improving the quality and cost-effectiveness of care—training clinicians to use evidence-based methods of practice and providing the resources they need to do this efficiently.

### Why Consensus Guidelines Are a Bad Idea

*The consensus guideline is founded on expert opinion, and experts can be wrong.* Consensus guidelines developed using the methodology described above are founded on expert opinion. We believe the term “expert opinion” is more accurate than the term “consensus” as a descriptor of the central methodological feature of the guideline, and therefore we use that term to describe it.

Practice guidelines founded on expert opinion are a bad idea because experts can be wrong. As Frances et al acknowledge, “the history of medicine has taught us that the aggregate consensus even of the best experts often misses the mark.” Numerous diagnostic procedures and therapies once widely used by practicing clinicians have proved, once randomized controlled trials were done, to be useless or even harmful. One example is the use of diethylstilbestrol (DES) to prevent problems in pregnancy. When studied later in randomized trials, DES did not improve outcomes in pregnant women and in fact contributed to the development of serious medical problems, including vaginal cancer, in their offspring.<sup>3</sup> Another example is the use of gastric freezing to treat ulcers.<sup>4</sup>

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Certainly the fact that the current guidelines' experts are clinical researchers means that their recommendations are likely to be based on empirical findings. Nonetheless, experts can be biased, for example, favoring the interventions they study. Reports of empirical data can also be biased, but empirical studies are less likely to be biased than expert opinion. Empirical studies also are more highly valued to the degree that the design of the study eliminates bias.

*The expert opinion guideline methodology teaches clinicians to rely on experts, not empirical findings.* Clinicians' failure to rely on empirical findings is a significant problem in mental health practice today. For example, numerous therapies for anxiety disorders that are well supported in the empirical literature are rarely used by clinicians.<sup>5,6</sup> Miller et al<sup>7</sup> observed that in the treatment of alcohol abuse, "the negative correlation between scientific evidence and application in standard practice remains striking, and could hardly be larger if one intentionally constructed treatment programs from those approaches with the *least* evidence of efficacy" (p. 33). Many more examples of this sort could be given.

One method for reducing the discrepancy between clinical practice and empirical findings is to publish guidelines (like the consensus guidelines) in which experts tell clinicians to use the therapies the experts have shown to be empirically effective. This method accomplishes the limited goal of pushing clinicians to use effective treatments for problems covered by expert opinion guidelines.

However, expert opinion guidelines do not address (and in fact exacerbate) clinicians' under-reliance on empirical findings and methods. Thus, even if clinicians relying on expert opinion are now using exposure and response prevention to treat obsessive-compulsive disorder because the experts recommend it, these same clinicians may continue to rely on insight-oriented psychotherapy to treat panic disorder because this method is endorsed by a consensus of professionals in their community. Clinicians also may be inattentive to new research findings in areas covered by existing guidelines because they already "know" (from the expert opinion guideline) how to treat a particular disorder.

Frances et al assert that the expert opinion guideline does not supplant empirical data but rather serves as a bridge from the available data to the dilemmas encountered in clinical practice that are not answered by data. For example, the expert opinion guideline assists clinicians when a patient with obsessive-compulsive disorder does not meet the typical stringent selection criteria of randomized controlled trials (and

thus the results of these trials cannot be assumed to apply to the case). Frances et al argue that an expert opinion guideline is needed in this situation.

We have several responses to this argument. First, if the goal of the expert opinion guideline is to build a bridge from the empirical findings to specific clinical situations, this bridge is not well constructed. The empirical data foundation of the bridge is missing. If the guideline is intended to encourage clinicians to use the results of randomized, controlled trials when they are applicable (and to rely on experts when the patient does not meet the trials' selection criteria, for example), then the guideline must provide information about the results of published trials and their selection criteria; none of this information appears in the expert opinion guideline on obsessive-compulsive disorder<sup>1</sup> we have seen.

Second, if empirical data are not available to support the efficacy of a certain intervention in a certain clinical situation, reliance on expert opinion is not the obvious best alternative. Consider the following situation. Imagine that *you* are the patient. Your physician informs you that you have a life-threatening medical disorder. You have hypertension, so you would not have met inclusion criteria for the randomized controlled trials studying treatment of your problem. What would you want your physician to do? Refer to an expert opinion guideline (if a guideline has been published for your clinical problem)? Or retrieve through his or her computer the results of an on-line literature search reporting the findings and selection criteria of the latest randomized controlled trials on your disorder? If the trials exclude hypertensive patients, the physician could search for studies, including single case reports, testing the hypothesis that the presence of hypertension contraindicates the trial-supported treatment. We speculate that most patients would prefer the second action plan. Unfortunately, most clinicians do not currently have the skills and resources they need to follow this plan, and we return to this issue in our recommendations below.

Third, if empirical data are not available to answer a clinician's question about how to manage a particular clinical situation, publication of a treatment guideline answering that question is premature. Telling clinicians to adopt a therapy before good data supporting its utility and safety are available makes little sense.

Finally, the expert consensus guideline does not build a bridge from empirical findings to clinical situations but instead substitutes expert opinion for empirical findings. Clinical questions answered by randomized, controlled trials are also addressed in the

expert opinion guideline. Thus, for example, the expert opinion guideline for obsessive-compulsive disorder answers the following questions: "What is the first-line treatment for obsessions for the average patient with moderately severe obsessive compulsive disorder?" "For compulsions?" "What number of sessions is needed to treat the average uncomplicated obsessive-compulsive patient?" (pp. 30-31 of the guideline).<sup>2</sup> All these questions (and others answered in the guideline) have been answered by randomized controlled trials; clinicians do not need to refer to expert opinion to answer these questions.\*

*The expert opinion guideline does not distinguish between clinical questions for which data are available and clinical questions for which no data are available.* Publishing expert opinion guidelines that answer clinical questions for which data are available and those for which data are not available blurs the distinction between what is and is not known. It also impedes research and may even affect funding decisions. For example, suppose an investigator writes a grant proposal to address the question, "What is the best treatment for obsessive-compulsive disorder complicated by comorbid social phobia?" If an expert opinion guideline already answers this question, the funding agency may view it as not worthy of research support.

In summary, we believe that practice guidelines founded on expert opinion are a bad idea because experts can be wrong, because the guideline encourages clinicians to rely on experts rather than empirical findings, and because the guideline impedes research by blurring the boundary between what is and is not known empirically.

### **Evidence-Based Practice: An Alternative to Expert-Based Practice**

We believe that empirical data and methods, not expert opinion, are the best guide to effective, safe, and cost-effective practice. We propose that resources now devoted to writing expert opinion-based guidelines instead be devoted to training clinicians in the skills they need to function as evidence-based practitioners and to producing the resources clinicians need to use these skills efficiently.

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\*Certainly there are clinical situations in which relying on experts is appropriate. Sackett et al<sup>1</sup> suggest that consultation with an expert is particularly helpful when treating a patient who has a problem the clinician rarely sees but which the expert sees frequently. However, Sackett et al<sup>1</sup> do not recommend complete reliance on the expert even in this situation, and they argue that "unless you want to abdicate your own critical appraisal role, ask the expert where to find the answer, not *what* the answer is!" (p. 336).

To function as evidence-based practitioners, clinicians must know how to correctly interpret and critically appraise papers published in the scientific literature, how to use results published in the literature to select diagnostic tests and therapies, how to search the empirical literature to answer clinical questions, and how to keep up to date with the latest developments in their field.<sup>4,8</sup>

To make efficient use of empirical findings, practitioners must be able to quickly access results of clinical trials and other research studies. In the United Kingdom, efforts led by Archie Cochrane, Iain Chalmers, the National Health Service, York University, and others have resulted in the collation of results of randomized trials. The National Health Service in the United Kingdom has funded a database, called DARE (Database of Abstracts and Reviews of Effectiveness), of abstracts of meta-analyses and review papers of efficacy data for a wide range of clinical disorders and problems that can be searched via the Internet. The database is available at <http://nhscrd.york.ac.uk>. Related initiatives in the United States include the computerized searchable databases provided by Medline and others, as well as the practice guideline initiative of the Agency for Health Care Policy and Research,<sup>9</sup> which has produced a series of practice guidelines that are based on careful review of the empirical literature. Another related initiative is the Task Force on Empirically Supported Therapies developed by Division 12 (Clinical Psychology) of the American Psychological Association.<sup>10</sup>

In conclusion, we recommend that efforts to train and encourage clinicians to use evidence-based methods and findings be strengthened and that initiatives (such as the consensus-based practice guidelines) to develop compendiums of expert opinion be abandoned.

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