

Guidelines in Surgery: Implications for Quality of Care at the University Hospital of the West Indies and Jamaica

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Medical knowledge is increasing at an exponential pace and as such standard of care applicable a decade ago may not necessarily apply today, depending on the condition and the level of evidence supporting the change. Patients now have access to a wide range of information, proportionate on their resources, motivation and level of education.

They expect a basic standard of care, and this duty is owed to the public by the doctors at the University Hospital of the West Indies (UHWI) and beyond. Additionally, being the premier teaching and research institution in the Caribbean for medical students, various postgraduate training programmes and a host of additional healthcare workers, it behooves practising physicians at the UHWI to uphold a certain standard of care for its patients. This has to be guaranteed irrespective of the patients' resources, social class, religion or admitting doctor.

Oftentimes, there is a delay in new medical knowledge (level-1 evidence) and its translation to clinical practice, and on average this can take-up to a decade (1, 2). The consequences of these evidence-to-practice delays are potentially significant, with risk of mortality, morbidity and significant healthcare and financial impact. Importantly, once there is a concerted effort to improve quality in clinical care, gradually over time we would improve results (3) across the spectrum of quality out-comes. There is evidence that cancer outcome can be improved by up to 30% with optimum application of best evidence with a 10% reduction in cancer mortality if the evidence for best practice was used. This improvement is noticeable both at well-performing hospitals and worse-performing hospitals and would have a substantial impact in achieving more from the limited spending of 4–7% allocated annually in the national budget to healthcare (4).

General dissemination of the best available evidence is just the first step in knowledge translation and potentially more difficult is the active process of implementation amongst the multiple stakeholders that will be necessary to effect change. Therefore, the entire health system may need to change. For example, the knowledge that 20–30% of patients presenting with locally advanced rectal cancer can be cured with neoadjuvant chemoradiotherapy' is only beneficial to the health system if these patients are identified (hence, routine MRI scans for patients with lower and middle-third rectal cancers) and opportunities are present for them to get this radiotherapy (which is often not the case currently in the public health system in Jamaica). Still, once fully implemented, if we can spare this large group of patients surgery that has significant morbidity and, at times, mortality. We can also readily see the significant cost-savings the health system will enjoy.

Quality of care in surgery has garnered increased attention both globally, regionally and nationally (5–7), with the expectation that implementation of current evidence-based guidelines will make a difference to patient care in Jamaica. The areas chosen were carefully targeted, namely, colorectal and breast cancers, gallstone pancreatitis, symptomatic gallstones in patients with sickle cell anaemia, preoperative anaesthetic evaluation, ICU admission and discharge criteria and management of the diabetic with a septic foot. They were selected for both their prevalence and hence the impact of standardized care, but also because of their special interest to our population (sickle cell anaemia and ICU admission and discharge criteria), and the possible cost-savings (preoperative evaluation).

Realizing that there were inconsistencies in how evidence-based medicine, in general, was being practised across Jamaica, The Department of Surgery, Radiology,

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Anaesthesia and Intensive Care at the UHWI led the initiative to develop evidence-based guidelines that were applicable to Jamaica and the region at special workshops (special mention and thanks to the Stewart's Automotive Group, sponsors of these workshops). Groups were formed to address each clinical practice guideline topic, and recommendations made based on a systematic review of the international and regional evidence. The recommendations are designed to be comprehensive and practical, while addressing the particular needs of the Jamaican and Caribbean population.

Each recommendation was given a grade once the quality of evidence was examined, with the objective of making strong recommendations based on high-level evidence. We recognize that this was not always possible, but recommendations were still made once there was certainty of benefit over harm.

We hope to have full implementation at all the teaching hospitals under the University of the West Indies/Ministry of Health agreement, with access to the guidelines through this publication, the Department website, the Association of Surgeons in Jamaica (ASJ) website (surgeonsja.org) and electronic healthcare platforms when possible. They will also be combined with various checklists, and clinical pathways once a firm diagnosis is established, and we also will combine the implementation of these guidelines with an audit and feedback exercise. Consideration can also be given to a rewards and disincentives package as we seek to change behaviour. Of course, once implemented and with appropriate audits, we should see positive results, *ie* improved quality

care. We recognize that this is a dynamic process and all guidelines developed are scheduled to be reviewed in five years after completion, with active monitoring of the literature for emerging/changing evidence, and revision at an earlier time, if necessary.

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