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Editorial

Establishing practice parameters

In the near future, the Parameters for the Diagnosis and Treatment of Asthma will be published in a supplement to THE JOURNAL OF ALLERGY AND CLINICAL IMMUNOLOGY. The purpose of this editorial is to review the basis for the development of this document and discuss its impact on the practicing allergist-immunologist.

In 1987, as asthma mortality rates in the United States increased,¹ the development of standards for the care of asthma was initiated. Over 50 experts in the field of allergy and immunology responded by drafting the sections that form the basis for the asthma parameters.

At the same time, the National Heart, Lung, and Blood Institute was developing a National Asthma Education Program that included Guidelines for the Diagnosis and Treatment of Asthma,² a document directed at enhanced management of asthma by primary care physicians. In addition to supporting this initiative, the American Academy of Allergy, Asthma and Immunology (AAAAI) and the American College of Allergy, Asthma and Immunology (ACAAI) continued to support their members who were developing parameters for the specialty of allergy and clinical immunology.

The establishment of boundaries for acceptable clinical practice by professional organizations is

Abbreviations used

AAAAI:	American Academy of Allergy, Asthma and Immunology
ACAAI:	American College of Allergy, Asthma and Immunology
AMA:	American Medical Association

not new. The American Academy of Pediatrics first developed guidelines 50 years ago.³ Such an approach has been endorsed by Congress and most professional organizations, with the support and guidance of the American Medical Association (AMA), the American College of Physicians, and the Council of Medical Subspecialty Societies. Over 1500 practice parameters have been developed by physician organizations. The AAAAI and ACAAI have been active for many years in drafting position statements and guidelines.

The AMA supports the use of the term *parameters* as an alternative to *standards*, which are perceived to be rigid, authoritarian, and binding. Use of the term *guidelines*, which has a less rigid connotation, is another alternative. Practice parameters have been defined by organizations such as the Institute of Medicine, as "systematically developed statements (of recommendations for patient management) to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances."⁴ Parameters "are a complicated refinement of many ideas, data, and value judgements." They are necessary to complement advances in technology and discard obsolete practices, when such action is supported by bio-

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medical research. Parameters can also be considered to be a mandate from society, especially for the poor, uninsured, elderly, and patients in long-term care facilities.

Parameters ideally should be developed by the specialty that is primarily concerned with the care of that patient population. It is in the patient's best interest for specialty organizations to establish such parameters on the basis of special clinical knowledge and experience. If specialty societies do not accept the challenge, others will. It is an anomaly for specialty societies not to set standards, because professional self-regulation ensures quality of care and provides an avenue for physician education.

Parameters should be data-driven, outcome-sensitive, evidence-based, thorough, unambiguous, user-friendly, and well documented. They should not be economically or politically motivated or based entirely on cost. Practice parameters will not change practice patterns unless there is confidence in the document and agreement with the process of revision. Reasons for developing parameters include the following: (1) improvement in quality of patient care, (2) reduction in variability of payment criteria, (3) prevention of the development of inappropriate statements about patient care by others less knowledgeable, (4) reduction in malpractice liability (AMA-derived data indicate that legal actions resulting from a specific condition or procedure decrease after the development of parameters), and (5) reduction in medical costs as a result of a reduction in inappropriate medical procedures. National costs for the treatment of asthma have been estimated to be \$6,200,000,000 annually. Forty-three percent is attributable to emergency department use, hospitalization, and expenses related to deaths.⁵ Studies have shown that we may expect a 50% reduction in hospital admissions and length of hospitalization by instituting relatively simple changes in practice behavior (i.e., increased use of corticosteroids combined with patient education and use of peak flow meters⁶). Agreement on practice parameters should help to resolve many of the issues that arise with third-party payers, because treatment can vary considerably for patients with similar conditions.

Parameters are closely linked to quality of care for patients with asthma. Is it possible to define and measure "quality of care"? Whatever the answer, patients are looking more and more to professional organizations to ensure this elusive concept. Quality of care has been defined as multidimensional and should reflect judgments

that services rendered were: (1) likely to produce the best outcome that could be reasonably expected, (2) given with attention to the ambience and aura of the patient-physician relationship, and (3) provided in a cost-effective manner. Quality of care not only involves the technical aspects of care but also the "art of care" (i.e., the milieu, manner, and behavior of the provider in delivering care and communicating with patients; the interpersonal humanistic dimension of medical practice, which reflects patients' and society's views, values, expectations, and demands). It is a dynamic concept that might be best assured by a continuing, formal, systematic program to identify problems, design activities to correct problems, and monitor corrective actions. Improvement in quality of care depends on education and feedback to health care providers.

Questions that should be asked are "Why do we choose certain patterns of practice behavior, where did we learn them, and what or whom is responsible for changing this behavior?" We must be certain that changes in practice behavior are based on a consensus regarding the scientific data, whenever possible, and not on economics or convenience. Although changes can be effectively proposed by developing practice parameters, such an approach is not universally accepted. Nevertheless, whether practice parameters are the best approach, they are here to stay for the foreseeable future. Without waiting for data to support the usefulness of practice parameters, Florida, Vermont, Minnesota, and Nevada have included them in health care system reform laws. Interest also remains high at a federal level, where practice parameters could be used as a mechanism for cost containment. Compliance with practice parameters can be used as a positive defense in malpractice cases, if they are developed for conditions or procedures that frequently lead to events for which negligence claims are filed, if they are widely accepted in the medical profession, if they are fully integrated into clinical practice, and if they are straightforward and readily interpreted in a litigation setting.³

The Parameters on the Diagnosis and Treatment of Patients with Asthma is the first in a series of parameters that is being developed by a joint task force of the AAAAI and the ACAAI, which includes representation by the Joint Council on Allergy and Immunology. Work groups under this task force are developing parameters for rhinitis, skin and in vitro tests used by allergists, allergen immunotherapy, urticaria/angioedema, anaphy-

laxis, stinging insect hypersensitivity, immunodeficiency, contact dermatitis, sinusitis, food hypersensitivity, and drug hypersensitivity. Parameters will also be developed when specific needs arise, as in the recently published Parameter on the Appropriate Number of Skin Tests. These parameters will be published for use by allergists-immunologists after extensive review by their peers. A survey done by the Joint Council on Allergy and Immunology on the practice behavior of certified allergists-immunologists revealed that few procedures are done in a similar way. Significant differences were seen in the number of visits for initial evaluation, number of tests, types of tests, frequency of follow-up, criteria for use of medication and allergen immunotherapy, use of spirometry, use of rhinoscopy, and duration of immunotherapy for Hymenoptera sensitivity.

Because a significant percentage of specialist care for asthma in the United States is provided by allergists-immunologists,⁶ it is appropriate that allergists-immunologists should play a role in establishing parameters that will aid in providing optimal care for the patient with asthma.

These parameters will have a significant impact on the treatment of patients with asthma. They have therefore been extensively reviewed by the Task Force, a number of board-certified members of both organizations, and the Executive Committee of the AAAAI and Board of Regents of the ACAAI. A first draft was submitted to both organizations in January 1992. The second draft, completed in October 1992, incorporated revisions recommended by reviewers selected by the AAAAI and ACAAI. After further review and revision, the current draft of this document has recently been submitted and approved by both organizations.

A document of this type must take into consideration the complexity and heterogeneity of asthma; an extraordinary amount of accumulating but often conflicting data; incomplete understanding of the causes, pathogenesis, and optimal treatment of the condition; and individual judgment required in the treatment of each patient. Indeed, each patient and his or her medical condition represent a unique diagnostic and therapeutic challenge. Nevertheless, medical knowledge and collective judgment dictate appropriate and inappropriate approaches to the management of any clinical condition. The Parameters on the Diagnosis and Treatment of Asthma have been formulated with recognition of these considerations. With this in mind, it is imperative that members of the AAAAI

and ACAAI take the time to review these parameters carefully and make appropriate comments.

The editors of this document recognize that there are different approaches to the diagnosis and treatment of asthma and have attempted to reach a consensus, sometimes with great difficulty, on various aspects of the management of asthma. When there is a legitimate basis for different management techniques, recommendations are flexible or there is discussion of different approaches that could be used. Particular features in individual patients, related both to the disease and the psychosociologic milieu in which asthma occurs, necessitate flexibility in therapeutic strategies. It is in the best interests of all involved not to stifle innovative approaches to the diagnosis and treatment of asthma but to continue to offer boundaries of *appropriate* practice behavior. It will be necessary to update the parameters frequently to modify accepted practice on the basis of emergence of new data.

An attempt has been made to keep this document succinct and relevant to the diagnosis and treatment of asthma. Each section is organized into a text with preceding summary statements. These summary statements reflect the editors' and reviewers' consensus on the most important points in each section. The Asthma Parameters should be viewed as a compendium of 46 different practice parameters. They are a comprehensive review of the salient features in the diagnosis and treatment of asthma and includes the following sections: (1) diagnosis and evaluation; (2) classification of asthma severity; (3) environmental avoidance; (4) pharmacotherapy; (5) immunotherapy; and (6) special problems, such as concomitant disease, anaphylaxis, pregnancy, nocturnal asthma, gastroesophageal reflux, reactions to aspirin or other nonsteroidal antiinflammatory drugs and preservatives, psychologic factors, asthma in occupational and school settings, asthma camps, management during labor and delivery, management of the hospitalized patient, and impact of socioeconomic, cultural, and geographic factors. They also contain a very important section on consultation with an asthma specialist.

There are a number of sound reasons for developing practice parameters. The overriding consideration must always be, however, an attempt to improve the level of care for patients, and by so doing, to decrease morbidity and mortality and improve the quality of life for all patients.

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