During my career, I have been on both sides of the clinical fence. From 1980 until 1992, I was a practicing nephrologist; from 1992 on, I have been a primary care physician (PCP). It should come as no surprise to the readers of CONSULTANT that I have found primary care practice to be much more demanding.

The volume of medical information has ballooned as time--and reimbursement--for patient care has diminished. There seem to be evidence-based guidelines for almost all aspects of medicine. The dilemma is how to incorporate these recommendations consistently into daily practice.

**INSIGHTS FROM A RECENT SURVEY**

Boulware and coworkers recently studied the application of guidelines for chronic kidney disease (CKD) in primary care practice. About 10 million Americans have CKD. Numerous studies have demonstrated that early referral to a nephrologist leads to improved outcomes in CKD. In fact, clinical practice guidelines specify targets for referral to specialty care, but they require recognition of CKD and its stages (from 1 to 5, with stage 5 representing kidney failure) to trigger appropriate referral.

The investigators mailed a questionnaire to a national sample of 304 physicians (126 nephrologists, 89 family physicians, and 89 general internists). The questionnaire described a hypothetical 50-year-old patient who is seeing a new PCP. She has hypertension of 10 years' duration and diabetes mellitus of 5 years' duration. Her blood pressure is controlled (125/80 mm Hg), but she has 1+ urine protein by dipstick measurement and a serum creatinine level of 2.1 mg/dL. Her insurance coverage permits specialty referral.

Applying either the Cockcroft-Gault or the Modification of Diet in Renal Disease (MDRD) equations for glomerular filtration rate (GFR) would give clearances of 32.1 and 35.4 mL/min/1.73 m², respectively. This patient thus has stage 3 CKD (30 to 59 mL clearance), and guidelines strongly suggest referral to a nephrologist.

Of the physicians who answered the questionnaire, 30% of family physicians, 15% of internists, and 2% of nephrologists were unsure of the patient's GFR. This finding may result from differences in the training of family physicians and internists. Eleven percent of family physicians were unsure whether microscopic examination of the urine was indicated (it is), and those in this group with more than 10 years of practice experience were least likely to recognize CKD, despite the elevated creatinine level. PCPs with more than 10 years of experience were least likely to recommend specialty referral, even though published guidelines attest to the benefits of such referral.

**TIME FOR A SOLUTION**

The failure of many clinicians to apply evidence-based guidelines in daily practice is not news. What we need to focus on is how to identify and overcome the barriers to implementation of these guidelines.

Boulware and coworkers observed that a "lack of awareness of clinical practice guidelines and lack of clinical and administrative resources were barriers to care," not financial issues. What do you think? Please e-mail your comments to me at ConsultantLive@cmp.com.

**References:**

