In 2007 we demonstrated that the adherence to the guideline was rather poor but we could only speculate about the reasons at that time (Franssen et al., 2007). In the present paper, we identified the main barriers for non-adherence to the guideline, such as doctors finding it difficult to refuse demands of insistent patients and the lack of up to date patient information. In fact, gynaecologists who did not agree with the content of the guideline mainly wished to perform more diagnostic tests, for example karyotyping in all couples. Thus, disagreement with the content of the guideline appeared to be only a minor barrier for non-adherence (van den Boogaard et al., 2011).

Nevertheless, we obviously agree completely with Vlaanderen that the content of the guideline is continuously subject to new evidence. Currently, the Dutch guideline on recurrent miscarriage is under revision, with the level of evidence for recommendations provided. The lack of conclusive evidence on aspects of recurrent miscarriage, and the best available evidence will be summarized in the revised guideline. The results of our study and of the implementation strategy can then be used as a framework for adherence to the revised guideline on recurrent miscarriage in order to improve measurable quality of care for couples with recurrent miscarriage. These efforts form the never-ending quest for estimation of the truth.

References


E. van den Boogaard1,*, R.P.M.G. Hermens2, J.A.M. Kremer2, F. van der Veen1 and M. Goddijn1

1Department of Obstetrics and Gynaecology, Academic Medical Center, Center for Reproductive Medicine, Amsterdam, The Netherlands

2Radboud University Nijmegen Medical Centre, Scientific Institute for Quality of Health Care (IQ healthcare), Nijmegen, The Netherlands

*Correspondence address. Centre for Reproductive Medicine, Academic Medical Center, H4-205, PO Box 22660, 1100 DD Amsterdam, The Netherlands. E-mail: e.vandenboogaard@amc.nl

doi:10.1093/humrep/deu062

Advanced Access publication on April 3, 2014

Reply: Recurrent miscarriage: guidelines could be improved

Sir,

We read with interest the Letter to the Editor by W. Vlaanderen, as a response to our paper ‘Recurrent miscarriage: do professionals adhere to their guidelines’. Vlaanderen states that ‘if guidelines are poorly followed it might be a good reason to reconsider the guidelines’. In other words, that the poor adherence is a result of a poor guideline. This is an important statement and we would like to reply as follows:

In 2007 we demonstrated that the adherence to the guideline was rather poor but we could only speculate about the reasons at that time (Franssen et al., 2007). In the present paper, we identified the main barriers for non-adherence to the guideline, such as doctors finding it difficult to refuse demands of insistent patients and the lack of up to date patient information. In fact, gynaecologists who did not agree with the content of the guideline mainly wished to perform more diagnostic tests, for example karyotyping in all couples. Thus, disagreement with the content of the guideline appeared to be only a minor barrier for non-adherence (van den Boogaard et al., 2011).

Nevertheless, we obviously agree completely with Vlaanderen that the content of the guideline is continuously subject to new evidence. Currently, the Dutch guideline on recurrent miscarriage is under revision, with the level of evidence for recommendations provided. The lack of conclusive evidence on aspects of recurrent miscarriage, and the best available evidence will be summarized in the revised guideline. The results of our study and of the implementation strategy can then be used as a framework for adherence to the revised guideline on recurrent miscarriage in order to improve measurable quality of care for couples with recurrent miscarriage. These efforts form the never-ending quest for estimation of the truth.

References


E. van den Boogaard1,*, R.P.M.G. Hermens2, J.A.M. Kremer2, F. van der Veen1 and M. Goddijn1

1Department of Obstetrics and Gynaecology, Academic Medical Center, Center for Reproductive Medicine, Amsterdam, The Netherlands

2Radboud University Nijmegen Medical Centre, Scientific Institute for Quality of Health Care (IQ healthcare), Nijmegen, The Netherlands

*Correspondence address. Centre for Reproductive Medicine, Academic Medical Center, H4-205, PO Box 22660, 1100 DD Amsterdam, The Netherlands. E-mail: e.vandenboogaard@amc.nl

doi:10.1093/humrep/deu062

Advanced Access publication on April 3, 2014