New renal guidelines; is more better?

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Guidelines for optimal diagnosis and treatment are a standard in current health care. They guide practitioner and patient decisions about appropriate health care in defined disease areas. Given the rapid developments in renal disease diagnosis and the multiplicity of available interventions, guidelines become an important tool in this area not only for optimal health care, but also to satisfy rules of accountability and transparency. Thus, to the question ‘do we need guidelines in nephrology?’ the answer is clearly, YES. However, the mere existence of a guideline does not guarantee that we are actually improving health care. In fact, although designing a guideline is a major effort, the biggest challenge appears to be its implementation [1, 2]. Many studies indicate that guideline recommendations are insufficiently followed in practice [3, 4]. For example, regarding risk factor management in patients with diabetes or chronic kidney disease, it was found that up to 59% of patients received less care than recommended according to the guidelines [5, 6]. Especially, guideline implementation for the management of albuminuria appears to be poor [5–7]. Additional efforts are needed to implement chronic kidney disease guidelines in practice [8]. Much of the research has been conducted in primary care, but studies suggest that specialists perceive even less need and are less inclined to adopt guidelines when compared with primary care or less experienced physicians [2, 9].

Nagler et al. [10] report in this Journal about the ‘European Renal Best Practice (ERBP) Guideline development methodology: towards the best possible guidelines’. Clearly, the authors recognize the problem and are actually not only focusing their efforts on an accurate guideline development process, but also try to tackle the relative lack of success of implementation by introducing dedicated experts in this field to the guideline team, optimizing the wording of recommendations, as well as taking specific measures involving the opinion of a panel of ‘users’.

We question, however, whether these measures will actually help in daily practice, since they do not solve several important obstacles to guideline adherence [11], such as (i) the vast number of different guideline bodies, (ii) the diversity of their guideline advice, (iii) the diversity of health-care providers and patients and (iv) the limited applicability of single-disease guidelines to patients with co-morbid conditions. The renal community counts at least six guideline bodies according to Nagler et al.: global KDIGO (Kidney Diseases Improving Global Outcomes), Latin-American SLANH (Sociedad Latino-Americana de Nefrología e Hipertensión), Australian/New Zealand KHA-CARI (Kidney Health Australia—Caring for Australasians with Renal Impairment), American KDOQI (Kidney Disease Outcomes Quality Initiative), Canadian CSN (Canadian Society of Nephrology) and English UK-RA (United Kingdom Renal Association). If that is not enough, we believe that there are more, such as the Renal Physicians Association Clinical Practice guidelines or the European Association of Urology guidelines, as well as hypertension or diabetes guidelines drafted by non-renal guideline bodies, which often include ‘renal diagnosis or therapies’. In addition, many countries have guideline organizations like the English National Institute for Clinical Excellence (NICE), the Scottish Intercollegiate Guidelines Network (SIGN) or the Dutch Institute for Healthcare Improvement (CBO), which develop a broad range of either multidisciplinary guidelines or guidelines for specific target users [12]. The mere fact that we have so many guideline bodies may, and most likely does, confuse the end users. In addition, these different bodies issue guidelines on the same topic, with partly diverging advice [13]. This definitely is not helping smooth implementation, it is in fact counterproductive, given the competing demands and time limitations perceived in practice. The suggestion that the ERBP will deal with this by searching for guideline...
niches that are not yet filled, seems very impractical: where does the end-user look for a specific guideline in this multitude of ‘supply’. On the other hand, we do need guidelines that fit the diversity of end users. It is important to make recommendations that are simple, understandable and applicable for all target groups [2, 14]. In particular, national guideline organizations aim to address issues that are of importance to the specific local end users. Global bodies like KDIGO, but also the ERBP, cannot extend extensively deal in their advice with local medical ‘habits and needs’. National guidelines are needed allowing for variation in organization of health care, as well as available (and reimbursed) diagnostics and treatments [15]. Moreover, co-morbidity is common in patients with kidney diseases, and patients may fall ‘between’ different specialties. For patients with chronic diseases and complex conditions, single-disease guidelines may be unfitting [16], and overarching guidelines are needed [17, 18].

Is there a better solution? A central world guideline-body with representation of different regions which require different treatment approaches would be ideal. Is this feasible? Yes, we believe it is. For diabetes guidelines, it was shown that many national guidelines rely on international guidelines, and especially recommendations of the American Diabetes Association strongly influenced other guidelines [15, 19]. For kidney diseases, KDIGO is a good example of a global body derived from a country initiative (KDOQI), which could guide local standards of care. This body should then also spend efforts in the integration and harmonization of guidelines for related or common coexisting diseases in such a way that practice recommendations in different guidelines are complementary rather than contradictory [20]. If one would structure this with subcommittees that cover regions or countries that require specific local attention and that have guideline committees in place, one could have the benefit of a single structure, with the option to serve the local needs by interactions with the local committees. This approach would mean most likely: efficient use of expertise, time and money; one standardized methodology; no duplication; better discussion on the common themes and on the exceptions; learning from each other; central repository for skills, training, techniques and data as well as the issued guidelines. The current structure of guideline production and implementation will not improve health care to the required standards, despite the fact that all people involved in doing this work should be recognized for their outstanding jobs and efforts, including the contributors to the ERBP.

CONFLICT OF INTEREST STATEMENT

The authors have no conflict of interest to declare. This paper has not been published previously in whole or part.


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Received for publication: 15.11.2013; Accepted in revised form: 18.11.2013