Are guidelines good value for money?

Strapline: Is it time to rethink guidelines?

The perfect clinical guideline will merge published literature with expert and patient opinion, be easy to understand and have widespread uptake and support. All of this will lead to measurable improvements in patient care. Over the past decade, guidelines have become a key part of the landscape and the number of guidelines has grown rapidly (Fig. 1). An estimate from a selection of prominent societies suggests that more than 120 clinical rheumatology guidelines have been produced in the last 15 years. This seems a good time to ask if current guidelines are fit for purpose, whether they make any difference to clinical practice, how they can be improved, and whether they provide good value for money.

There are a number of validated processes to ensure that guidelines are of a high quality. Some organizations publish instructions on how to assemble guidelines using standardized operating procedures (SOPs). The EULAR has produced an SOP for guideline development that uses the Appraisal of Guidelines for Research & Evaluation (AGREE)-II instrument for quality assessment [1]. This SOP, first published in 2004 and updated in 2014, seems to have raised standards. A review of the quality of EULAR management recommendations found the use of the SOP for guideline development has been associated with improved quality over recent years [2]. While the process of literature review and development of key recommendations seems well established, areas for improvement identified included the need for more patient involvement, planning for dissemination and the need for regular updates. All guidelines should include a research agenda and implementation and audit tools, and they need to be updated at regular intervals with a frequency determined by the subject matter and how quickly new research is produced in the field. A recent analysis of clinical guidelines suggested that one in five guideline publications were outdated after just 3 years [3].

It is not always easy to tell if guidelines lead to improvements in the quality of patient care; however, some examples do exist. The British Society for Rheumatology guidelines for the management of early RA published in 2006 appears to have been associated with a step up in the prescription of MTX in the first year after diagnosis [4]. Conversely, failure to adhere to the EULAR treatment guidelines for early arthritis was associated with an increased risk of radiographic progression and functional impairment [5].

For guidelines to be successful, they must seem reasonable, be accessible and be readily accepted by the clinician. This requires awareness of the guideline in the first place, agreement with the guideline, and a desire to adopt and then adhere to it [6]. Leakage in guideline use may occur at all of these steps [7]. Currently a large number of clinical guidelines are produced by various organisations, sometimes on the same area of management, making it difficult for clinicians to choose which one to follow. There are also disease areas in which multiple organisations have produced guidelines with differing recommendations or covering different therapies. For example, EULAR have included guidance related to glucocorticoid use in their recommendations on the treatment of RA, whereas the ACR 2012 guidelines have omitted this [8]. Guidelines can only be really effective if there is also a plan for dissemination, and a process that assesses the clinician’s agreement with the guideline is vital. This level of agreement is not only an important measure of quality but also provides an opportunity to broaden the clinician involvement that has been exploited in the development process for some guidelines. The Evidence, Expertise, Exchange Initiative provided a model of guideline production that effectively canvassed the views of several hundred international rheumatologists at multiple times during the development process [9]. Digital technology and social media web-based systems might also be used to improve access to clinical guidelines and allow increased interaction between those that produce and those that use the guidelines.

Given the large number of guidelines in circulation, we need to think carefully about which guidelines we really want to produce. Increased efficiency could be introduced by considering the common themes across guidelines. For example, all rheumatology guidelines could start with common generic recommendations that are important to all disease types, such as stopping smoking and losing weight. Given all of the difficulties in adhering to clinical guidelines, awareness at least would be improved if all guidelines were available from a limited number of sources. This need has been recognized, with increasing collaborations between EULAR and ACR in a number of clinical areas. While guidelines rely on the combination of evidence and expertise, the specific information needed from trials is often not available. With this in mind, the process of guideline development should be considered as an important opportunity and resource to demonstrate the gaps in current knowledge.

So what about value for money? High-quality guidelines appear to improve quality of care; however, the true value of any guideline is difficult to quantify precisely. The process of guideline development consumes large amounts of resources that can be measured in time given by experts, assembling the required clinical expertise, clinical fellows, task force meetings, time taken to go through the rigorous
Fig. 1 Summary of the number of guidelines produced by a selection of major rheumatology societies, 2000–15


process involved and the necessary financial support by rheumatology organizations. It might make an interesting project to accurately determine the true cost of this.

The numbers and quality of clinical guidelines has increased in recent years. This has partly been driven by the presence of SOPs and by an increased body of experience in the methodology used. Guidelines need to be adapted to complicated clinical situations and for this reason cannot be too rigid. However, there is some evidence that guidelines can lead to improvements in the quality of care and that failure to comply can be associated with poorer outcomes. Preventing clinicians from being overwhelmed by too many guidelines could be achieved by greater focus on those that are the most important to them, and by identifying common themes between guidelines to produce generic stems and approaches. These steps are likely to improve adoption and adherence to guidelines, which will in turn help to maximize value for money.

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