The Royal Australasian College of Physicians

This submission was developed in response to the NHMRC draft discussion paper, which sought feedback regarding the development of clinical practice guidelines.

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Consultation on NMHRC draft discussion paper *"Better informed health care through better clinical guidelines"*

Royal Australasian College of Physicians submission January 2016

Summary

This submission was developed in response to the NHMRC draft discussion paper, which sought feedback regarding the development of clinical practice guidelines.

Background

The Royal Australasian College of Physicians (the "College") welcomes the opportunity to provide feedback on the draft discussion paper "Better informed health care through better clinical guidelines", developed by the National Health and Medical Research Council (NHMRC) in consultation with the Australian Commission on Safety and Quality on Health Care and the Department of Health.

As medical specialists, College Fellows and Trainees are frequent developers and users of clinical guidelines, and are consequently well-placed to offer advice and suggestions on improving these guidelines.

Interested Fellows and Trainees of the College were invited to complete a short survey to assess their views on the draft discussion paper. In total, 37 responses were received from 34 Fellows and 3 Trainees. One Fellow lodged an additional response via email.

In brief, the survey respondents worked across a variety of contexts, with most employed in public quaternary or tertiary hospitals, and/or private practice. The majority of respondents (49%) were Fellows of the Adult Medicine Division, with 22% being Fellows of the Paediatrics & Child Health Division.

Forty percent of the respondents reported consulting guidelines on a weekly basis, with 29% consulting them at least once a month, and 17% consulting them daily. The Fellows and trainees consulted clinical guidelines for a variety of different reasons, such as when they feel unsure about best practice; in order to refresh their knowledge; in response to new research evidence being uncovered; and simply as a matter of course.

The results of the survey and the additional email form the basis of this response.

Key recommendations

Overall, the College believes that the discussion paper is a useful first step in improving Australian clinical guidelines.

Nonetheless, Fellows and Trainees have made a number of recommendations on the current draft. These are briefly summarised below.

The production of guidelines

Recommendation 1: Appropriate investment and funding is needed to support the development of clinical guidelines

Fellows noted that lack of funding and time are the key barriers to developing and maintaining good, up-to-date guidelines.

Because guidelines are typically developed by clinician volunteers, with already busy schedules, it is imperative that these volunteers are resourced appropriately, to ensure the guidelines are developed on time, and to an appropriate standard.

This may be facilitated through the provision of funding for research assistance or secretarial support, and we recommend that the NHMRC work closely with funding agencies to ensure sufficient resourcing of guideline development, monitoring and evaluation.

Recommendation 2: Where applicable international guidelines exist, they should be modified for the Australasian context

As one survey respondent noted, *"any guideline producing body should look to guidelines developed elsewhere and assess those against the local agreed standards for production and situation. If guidelines from elsewhere are assessed as good and applicable, perhaps they could be adopted by the local body and not re-researched and rewritten. There are a lot of good guidelines, and it would be inefficient to reinvent the wheel each time."*

For this reason, we recommend that before commencing the production of a new guideline, the group responsible for their production carefully surveys the international literature to see if any similar guidelines exist overseas. If these guidelines are found to be relevant, then they should be modified in accordance with Australian standards (and the appropriate approvals), rather than new guidelines being written.

Recommendation 3: Guidelines should be developed by clinical expert groups

The survey respondents agreed with the statement that the trustworthiness of clinical guidelines is important. However, they strongly emphasised that the trustworthiness of such guidelines is heavily dependent on the expertise of those who are involved in their development.

As one respondent noted, the trustworthiness of guidelines *"requires that they are produced and distributed by a respected and acknowledged source/organisation that is affiliated with the training college or university that is recognised as an authority for clinical practice by the end user."* In addition, the same respondent suggests that the guidelines must *"clearly state how they have been derived, what evidence has been used as their basis, how the expert group was chosen, what standards were set for the evidence base of data included in the guidelines, how conflicts of interest were resolved, and how updating is to occur."* These sentiments are

supported by a variety of research evidence, which have highlighted the importance of professional characteristics in guideline production.[1]

For College Fellows and Trainees, the trustworthiness of a guideline, and whether they will use it in practice, is strongly influenced by both the credibility of the underlying evidence, the credibility of the authors, and whether there is a demonstrated need for the guideline. For this reason, we recommend that respected authorities in the field be involved in the guideline development process, rather than relying on external bodies to develop the guidelines. As one Fellow notes, *"guidelines should be developed by the clinical groups who….are the experts with its care [sic]. Having external bodies develop guidelines without clinician buy-in is pointless",* as such guidelines will not be trusted or used. In addition, we expect that guidelines will be developed with significant consumer and carer involvement, as emphasised by the NHMRC.[2]

The US Endocrine Society Guidelines are cited as a good example of the way in which guidelines can be developed by clinical expert groups. Experts in the sub-specialty endocrinology fields work together to analyse the current literature on a certain condition, and then make recommendations for the general endocrinologist to incorporate into their practice. These guidelines are well-respected, and widely used both within the US and in Australasia, because they are written by experts, and use a clear and rigorous methodology.

In regards to the issue of conflicts of interest, respondents noted that it is common for experts in some clinical fields to also be advisors to pharmaceutical companies or industry, because they have such extensive expertise. We strongly support the need to declare and appropriately manage conflicts of interest. However, the existence of a dual interest, in and of itself, may not necessarily disqualify an individual from all participation in guideline development if the duality is appropriately managed.

Recommendation 4: Further involvement of members of medical colleges and specialty societies in guideline development is needed

The RACP welcomes the opportunity to continue to work closely with industry and jurisdictional bodies involved with guideline development. At the present, the role of members of medical colleges and specialty societies in the proposed guideline development process is marginal, More precisely, Colleges and their members are listed as "implementers" of the guidelines (Figure 2, page 12), when, as one respondent noted, *"Colleges need to be seen closer to the engine-room of generating the areas of need for clinical guidelines."* Another respondent remarked that *"the role of the Colleges appears to be marginal, but they could play a significant role in mobilising their members to participate in guideline development.*"

By involving members of Colleges and specialty societies in a more prominent role in all stages of guideline development, the NHMRC will be able to better utilise the extensive clinical expertise of these professional societies and their members in developing high quality, useful guidelines.

For this reason, we recommend the revision of Figure 2, and associated commentary.

The implementation of guidelines

Recommendation 5: There should be an increased focus on guideline implementation

Following on from Recommendation 4, although medical colleges are listed as playing a key role in the "implementation" of clinical guidelines, at the present, the draft document contains minimal information on how this process will take place. This is problematic, because whilst increasing efficiency in guideline production is important, *"unless the guidelines are actually implemented, efficiency in their production is valueless."*

Implementation is a challenge given the sheer volume of guidelines produced in Australia competing for clinicians' attention – estimated at 1046 being published between 2005 and 2013.[3] However this is a challenge that the Australian healthcare system has in common with other healthcare systems – a systematic review of the effectiveness and costs of different guideline development, dissemination and implementation strategies concluded that: 'There is an imperfect evidence base to support decisions about which guideline dissemination and implementation strategies are likely to be efficient under different circumstances.'[4] The review also found considerable variation in the impacts (on patient outcomes and clinical practice) reported by different studies.

A stark example of the challenges involved in the adoption of clinical recommendations made even by authoritative medical bodies is that, despite significant publicity and support among participating healthcare organisations for the *Choosing Wisely* campaign in the US to reduce 'low value' interventions in healthcare, a recent study found that the campaign had resulted in a reduction in usage in only two of seven services identified as low-value.[5]

To appropriately evaluate the impact of clinical guidelines, the following elements must be considered:[6]

- How well are the guidelines known and to what extent are they valued?
- To what extent are the recommendations applied?
- To what extent are the recommendations effective if applied?

If guidelines fall short on any one of these elements, their benefits are effectively undermined.[7] For example, even where guidelines provide good information, there can be barriers to their adoption due to a clinical practice being entrenched whether this is due to cultural or financial factors or a combination of both. Thus clinician 'buy in' is essential. Another example is that problems with guidelines accessibility have been identified as a key implementation barrier, particularly in rural and regional areas.[8]

For these reasons, the College recommends that the draft document be expanded, to consider strategies for improving the implementation of clinical guidelines once they are developed. The College believes that a focus on a small number of high quality clinical guidelines rather than a broad based approach to guideline development may assist clinicians in implementation.

Recommendation 6: That the guidelines be made readily available in a variety of formats

When asked about their preferred means of accessing clinical guidelines, 56% of survey respondents nominated online format, whilst 44% said they preferred to access guidelines in Pdf format (for easy printing). Respondents reported accessing guidelines using desktop and laptop PCs, as well as Smartphones (both Apple and Android).

Notably, no respondents nominated book format as their preferred means of accessing clinical guidelines.

Nonetheless, a number of survey respondents noted that they presently experience considerable difficulty in accessing clinical guidelines solely in online format. First, in some hospitals, the IT and wi-fi access is sporadic, and clinicians may have problems connecting to the internet. Second, IT firewalls and capacity limitations in public hospitals may prevent clinicians from accessing long, but useful, guidelines. Third, even when guidelines are stored on the hospitals' internal intranet, they are often difficult to locate.

For these reasons, it is important that clinical guidelines are developed in such a way as to be easily accessible and readily available, given the current IT infrastructure in public hospitals. We recommend that guidelines be available in a variety of formats (Pdf, online, mobile format), so that if clinicians are unable to access them in one format (e.g. online), they can access them in another way (e.g. via printed Pdfs). The guidelines must also be available in a patient and carer friendly format, to support the meaningful involvement of our clients in their care.

Recommendation 7: That guidelines are available from a single, professionally curated website, which is regularly updated and well-publicised

This comment builds on Recommendations 5 and 6. In order for guidelines to be implemented, it is imperative that such guidelines can be easily located. Survey respondents remarked that they often have considerable difficulty in locating the most up to date and relevant clinical guidelines, which is both frustrating and time consuming. In addition, the Fellows and Trainees noted that there are often different guidelines available, and these sometimes conflict in their recommendations for best practice.

We note that the NHMRC has developed the "Australia's Clinical Practice Guidelines Portal", and commend this initiative.

We also recommend that all guidelines have a "sunset clause", specifying a date after which the guideline must be formally evaluated and reviewed. As guidelines usually only remain relevant for 2 or 3 years after publication, we recommend a "sunset clause" no greater than 3 years.

Recommendation 8: That clinical guidelines should not be considered in isolation

As one respondent noted, one of the major challenges associated with clinical guidelines is that they are sometimes used to treat people who would not have qualified for the original clinical trials, such as very elderly individuals, or clients with multiple co-morbidities. Applying the clinical guidelines in these settings is not evidence based, and may, in fact, place the patient at risk of harm. In other words, clinical guidelines need to be contextualised to the individual patient.

For this reason, we recommend that when publishing clinical guidelines, appropriate caveats be included, so that clinicians are made aware of the contextual elements.

General comments

Recommendation 9: That the draft document be rewritten in Plain English

Survey respondents noted that in parts, the draft document is unclear and difficult to understand, with confusing terminology, use of acronyms, and typographical/grammatical errors. This is problematic, as a difficult document is likely to deter clinicians and policymakers from reading and engaging with the ideas.

For this reason, we recommend that the document be revised, to increase its readability.

References

[1] Cabana MD, Rand CS, Powe NR, et al. (1999) Why Don't Physicians Follow Clinical Practice Guidelines? A Framework for Improvement. *JAMA*. 282(15):1458-1465. doi:10.1001/jama.282.15.1458

[2] National Health and Medical Research Council (2015). *Consumer and community involvement.* Available at https://www.nhmrc.gov.au/research/consumer-and-community-involvement Accessed 27/01/16.

[3] National Health and Medical Research Council (2014) Annual Report on Australian Clinical Practice Guidelines. Canberra: National Health and Medical Research Council.

[4] Grimshaw JM, Thomas RE, MacLennan G, Fraser C, Ramsay CR, Vale L, Whitty P, Eccles MP, Matowe L, Shirran L, Wensing M, Dijkstra R, Donaldson C. (2004). Effectiveness and efficiency of guideline dissemination and implementation strategies. *Health Technol Assess*.8(6):iii-iv, 1-72.

[5] Rosenberg A, Agiro A, Gottlieb M, Barron J, Brady P, Liu Y, Li C, DeVries A (2015). Early trends among seven recommendations from the Choosing Wisely campaign. *JAMA Intern* Meddoi:10.1001/jamainternmed.2015.5441.http://archinte.jamanetwork.com/article.aspx?articleid=2457401.

[6] Burgers J, Smolders M, Weijden van der T, Davis D, Grol R (2013) Clinical practice guidelines as a tool for improving patient care. In *Improving Patient Care: The Implementation of Change in Health Care*, Second Edition (eds R. Grol, M. Wensing, M. Eccles and D. Davis), John Wiley & Sons, Ltd, Oxford, UK. doi: 10.1002/9781118525975.ch6.

[7] Francke AL, Smit MC, de Veer AJE, Mistiaen P (2008). Factors influencing the implementation of clinical guidelines for health care professionals: A systematic meta-review *BMC Medical Informatics and Decision Making* 8:38 DOI: 10.1186/1472-6947-8-38

[8] Cohn SL, Gautam B, Preddy JS, Connors JR, Kennedy SE. (2015). Barriers to the use of paediatric clinical practice guidelines in rural and regional New South Wales Australia. *Aust J Rural Health* doi: 10.1111/ajr.12190.