The Malaysian Medical Association's Position Paper on Clinical Practice Guidelines

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Abstract

Healthcare policy makers, healthcare professionals, medical professional societies, non-governmental organisations, patients, and their carers in search of the best evidence to inform clinical decisions have come to rely on systematic reviews of comparative effectiveness research. Clinical practice guidelines (CPGs) are meant to be guides for clinical practice based on the best available evidence at the time of development. This position paper on CPGs by the Malaysian Medical Association (MMA) is to summarise our viewpoint with regard to the development of a CPG especially concerning its methodology and implementation.

Introduction

Clinical Practice Guidelines (CPGs) are defined as "statements that include recommendations intended to optimize patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options" (Institute of Medicine, 2011 & Ministry of Health, 2015). They should be aids to, not substitutes for, clinical judgment and it should be emphasised that they provide guidance, rather than instructions or commands. Prior to 2000, there was a lack of emphasis on the quality of evidence and strength of recommendations in CPGs. With the introduction of GRADE (Grading of Recommendations, Assessment, Development and Evaluations) (Guyatt GE et al., 2008) with its working group established in 2000 and the AGREE (Appraisal of Guidelines for Research and Evaluation) instrument in 2003 (AGREE Collaboration, 2003), assessment of a CPG in terms of the quality of evidence and the strength of recommendations has become a standard approach. This position paper on CPGs by the MMA is to summarise our viewpoint with regard to the development of a CPG, especially concerning its methodology and implementation.

The main purpose of guidelines is to achieve better health outcomes by improving the practice of health professionals and by better informing consumers about treatment options. The main reasons for development of clinical practice guidelines are:

1. They are tools to address the issue of unjustifiable variations in clinical practice for various clinical conditions.
2. In an environment of increasing availability of new and often competing treatment options, they assist clinicians in making the right decision, one which is appropriate, effective, and reasonably cost-effective.
3. They attempt to make the best use of available resources to achieve the best possible outcome.
4. They can be looked upon as a standard for clinical practice.

Much funding and resources are expended on basic and clinical research, but research findings are often not systematically applied in clinical practice although they provide evidence that a new treatment or intervention is more effective and gives an improved outcome. CPGs attempt to synthesize these research findings by systematic reviews resulting in recommendations about treatment of specific conditions.

Consensus statements have been used for many areas of clinical practice, but these are based on expert opinions and are less rigorous in their development process than CPGs. The development of evidence-based CPGs is under the purview of the Health Assessment Technology Assessment Section, Ministry of Health Malaysia. The full list of published CPGs and those being developed/updated is available on the Ministry of Health website (https://www.moh.gov.my/index.php/pages/view/3962).

Development of Clinical Practice Guidelines

The most scientific approach is the development of evidence-based guidelines which link recommendations to the quality of the underlying evidence. It involves systematically identifying and synthesising the available scientific evidence. Given the volume of research activity and scientific publication, this is obviously a daunting task and very time consuming. The International Cochrane Collaboration, set up in 1992, has a register of scientific research in health care, and can be accessed to assist in systematic and quantitative reviews on selected clinical topics. Research evidence should be graded according to the rigorous nature of the study design and hence, the validity of their conclusions. The highest level of evidence is assigned to randomised controlled trials which have the most rigorous study design. Other studies are regarded as lower levels of evidence since the study designs allow greater potential for bias. Evidence obtained from expert committee reports or opinions and/or clinical experiences of respected authorities is considered the lowest level of evidence. Evidence is presented in an open and evaluable form, and this approach de-emphasises' intuition, unsystematic clinical experience and pathophysiologic rationale as sufficient grounds for clinical decision making. Clinical practice guidelines should be developed through the following process:

1. The professional organisation specifies the problem and defines the issues involved.
2. Existing guidelines are identified and assessed. If existing guidelines are applicable to the current circumstances. or can be adapted, new guidelines may not be necessary.
3. A knowledgeable, multidisciplinary panel of experts and representatives from key affected groups is convened.
4. The scope and target audience are defined.
5. Health outcomes are identified.
6. An evidence-based literature search is made, and scientific evidence is appraised and synthesised.
7. The guidelines are drafted explicitly using evidence to support recommendations. The quality of evidence is systematically graded and summarised using a framework such as GRADE (Grading of

Recommendations, Assessment, Development and Evaluations).

8. The draft is subjected to review by internal and external reviewers. The methodological quality of guidelines can be assessed with an instrument such as AGREE II (The AGREE Next Steps Consortium, 2009).
9. Clear explanation of the relationships between alternative care options and health outcomes are provided, with ratings of both the quality of evidence and the strength of the recommendations.
10. The guidelines must be kept updated to maintain the validity of recommendations as new evidence emerges.

Dissemination and Implementation of Guidelines

To influence clinical decision making, guidelines must be brought to the attention of users and adopted by them. Publication of guidelines in medical journals is the least effective method of implementation. The intended users must be identified and reached through professional bodies, local health or hospital authorities, direct mailing of handbooks, conferences, and seminars. Implementation of guidelines requires strategies to facilitate change in behavior. Educational activities such as seminars focusing on specific guidelines with active involvement of potential users are effective. Patient specific reminders at the time of consultation, e.g., attachment of guidelines to medical records, inclusion of guidelines on a desktop computer or specially designed clinical records are also effective. The use of guidelines in audits can also increase the likelihood of adoption. In the process of implementation, issues may arise with the organisation of care, a lack of coordination between groups of health care providers, and other administrative problems. These issues need to be resolved by the relevant health care authorities to allow effective implementation.

Conclusion

Clinical guidelines are considered the gold standard in providing evidence-based recommendations for guiding clinical decision-making, improving patient outcomes, and shaping health policy. The potential for guidelines to influence the quality and outcome of patient care is considerable. Well-developed clinical practice guidelines effectively disseminated and implemented can go a long way in ensuring appropriate and quality health care for the community.

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