

# Clinical guidelines 2

## – Developing the guidelines

Physical therapists want to do their best for their patients, which means offering interventions known, through high quality research, to be effective. Clinical guidelines are a useful practical tool to help this process.

This Keynotes by Philip van der Wees and Judy Mead describes how to develop clinical guidelines which will create a common basis for development in physical therapy. It is the second in a series of Keynotes on developing and implementing clinical guidelines. It is based on a methodology for clinical guideline development adopted by the European Region of WCPT.<sup>[1]</sup>

It aims to assist WCPT Member Organisations (MOs) and their members to:

- understand clinical guidelines development, so that they can participate in developing uni/multi-disciplinary guidelines
- provide a standard methodology for clinical guideline development groups
- adapt guidelines, developed in other countries, to their own national or local situation
- stimulate international collaboration in guideline development.

The framework has six main phases, based on the work of several international programmes (further details on the WCPT website at [www.wcpt.org/programmes/ebp/guidelines.php](http://www.wcpt.org/programmes/ebp/guidelines.php)). In each phase we describe the steps to take. The AGREE instrument, which is an appraisal tool for clinical guidelines, provides an excellent reference by describing what to look for in a 'good' guideline <http://www.agreecollaboration.org/>

The phases are:

1. Organisation and structure
2. Preparation
3. Guideline development
4. Validation
5. Dissemination and Implementation
6. Evaluation and revision

### 1. Organisation and structure

The structure for developing clinical guidelines varies for each programme, although most are directed by a central organisation. An international survey has found that programmes are mainly carried out by governmental agencies or professional societies, based on a structured programme.<sup>[2]</sup> Some central coordination in developing clinical guidelines is a good thing, although individual groups may also develop guidelines, which may be endorsed by the professional body.

A Guideline Development Group (GDG) actually develops the guideline. This should consist of people with clinical skills/expertise and people with expertise in guideline methodology. It is important to include expertise from different clinical schools of thought, and relevant stakeholders and patients (or representatives). Stakeholders and patients can also be included in a reference group or specific focus groups.

### 2. Preparation

When deciding on a topic, there should be an expectation that change is possible and desirable. There should also be an expectation that it is possible to improve daily practice, quality of care and/or patient outcomes.

The first draft of a scoping document will include details of the aspects of care the guideline will cover, background epidemiology, population, healthcare settings, interventions and treatments that will be included and relevant outcomes for determining clinical and, if possible, cost effectiveness.

### 3. Guideline development

One of the most crucial phases in clinical guideline development is systematically identifying relevant evidence on which to base recommendations for practice. The process must be carried out in such a way as to minimise bias.

There should be an explicit search strategy to identify literature, selected according to defined inclusion and exclusion criteria and summarised using methodological standards, where these are applicable. It is recommended that the following databases are searched: Cochrane Library, PEDro database, CINAHL, MEDLINE.

Then the evidence has to be assessed and synthesised. This should be done systematically, by assessing the methodological quality (content analysis) and summarized in a review of the evidence (qualitative analysis). The Cochrane Collaboration produces robust systematic reviews (qualitative analysis) and meta-analyses (qualitative and quantitative analysis) that can save a lot of work in assessing the literature.

Weighing the evidence is important so that the GDG and users of the guideline can understand the relative

importance (weight) of the evidence. Usually, hierarchies are used, which reflect how successful research methods are at identifying the effectiveness of interventions. For example:

Level 1: randomised controlled trials (RCTs) and good systematic reviews of RCTs

Level 2: case-control or cohort studies and good systematic reviews of them

Level 3: non-analytic studies like case reports or case series

Level 4: expert opinion

Once the evidence is identified, the whole GDG must formulate recommendations. These need to take account of the strength of the evidence, its clinical relevance to practice or service delivery, and how acceptable it is to patients. Recommendations in guidelines are usually subject to a system of grading (A-D), based directly on the level of evidence.

However, the hierarchy of evidence and the grading of recommendations is currently being debated by the international guideline community. Since many different grading systems exist and are becoming more and more complicated, a working group within the Guidelines International Network (G-I-N) is currently trying to devise a better system.

## 4. Validation

In the validation phase the draft guideline should be tested or reviewed. The draft guidelines can be sent to potential users to test practicality and clarity, and how acceptable the recommendations are. Patients and stakeholders can also review the draft guideline. The comments should be used by the GDG to adjust the guideline. An external review by an (independent) committee of experts in guideline development is recommended. The AGREE instrument is a useful tool to check the rigour of the development process.

## 5. Dissemination and implementation

For the dissemination and implementation of guidelines a standard strategy can be developed, which can then be tailored to the specific requirements of the individual guideline. What constitutes successful implementation can be identified during the guideline development. After defining the implementation plan, projects can be carried out in a number of sites to facilitate implementation.

Several systematic reviews or overview studies have been published concerning the effectiveness of implementation strategies,<sup>[3-8]</sup> but there is currently no consensus on what constitutes the best strategy. It is clear that sending guidelines to potential users in itself has no effect.

Actual change of practice is possible, but requires a rigorous and tailored strategy with different activities, targeted at potential users.

## 6. Evaluation and Revision

The guideline document should include a date on which it will be reviewed in the light of new evidence that might be available. An acceptable timeframe for a review would be five years.

When an update of the guideline is undertaken, the original scope of the guideline and clinical questions should be reviewed to see whether they are still valid. Based on the collected material (new evidence, change of practice, additional feedback) the recommendations from the original guideline need to be reviewed and revised if necessary.

Philip van der Wees is Head of Quality, Research and Education at the Royal Dutch Society for Physical Therapy. Judy Mead retired as Head of Research and Clinical Effectiveness from the Chartered Society of Physiotherapy, UK, in 2005.

## Reading List

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