

# Guidance for Guidelines

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Clinical practice guidelines are systematically developed statements that aim to help physicians and patients reach the best health care decisions. Good guidelines have many attributes, including validity, reliability, reproducibility, clinical applicability and flexibility, clarity, development through a multidisciplinary process, scheduled reviews, and documentation.<sup>1</sup> More than 2000 guidelines are currently represented in the National Guideline Clearinghouse ([www.guideline.gov](http://www.guideline.gov)). Medical specialty societies are their most common sponsors.

Guidelines rely on both evidence and opinion; they are neither infallible nor a substitute for clinical judgment. They do, however, go beyond systematic reviews to recommend what should and should not be done in specific clinical circumstances. Some are widely respected; they have helped to standardize care, diminish local variation, and improve health outcomes. However, the quality of guidelines varies considerably. Among the efforts in the United States that are generally considered successful are those of the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices, and the National Academies, as well as the treatment guidelines for sexually transmitted diseases issued by the Centers for Disease Control and Prevention. Efforts outside the United States include those of the World Health Organization and the National Institute for Clinical Excellence (NICE), in the United Kingdom.

Guidelines may be controversial for many reasons; they have been criticized for recommending too little and for recommending too much. A dramatic example of political controversy occurred in 1995, when the House of Representatives voted to effectively stop funding the Agency for Health Care Policy and Research;

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House members had been lobbied by spinal surgeons who objected to agency-sponsored guidelines for managing acute back problems, which they viewed as biased against surgical therapy.<sup>2</sup> The agency, now called the Agency for Healthcare Research and Quality (AHRQ), was ultimately preserved, but with a substantially diminished budget — and it ended its guidelines program, having issued 19 guidelines between 1992 and 1996. Subsequently, the quality of guidelines in the fields the agency had covered declined: a RAND study found that later guidelines were “of substantially worse methodological quality and ignore key features important to guideline development.”<sup>3</sup>

Other guidelines have been

criticized for contradicting dogma or for providing reasons for insurers to deny coverage for specific drugs or devices. In 1997, Richard Klausner, then the director of the National Cancer Institute, and others were outraged when a National Institutes of Health (NIH) consensus development panel declined to recommend routine mammograms for women in their 40s. Recently, the Infectious Diseases Society of America’s guidelines for diagnosing and treating Lyme disease have been challenged for being overly restrictive and facilitating the denial of insurance coverage for some therapies.

Guidelines have also been questioned when pharmaceutical and medical-device companies with a financial stake in the outcome provide substantial funding for their development and implementation. When members of guideline committees also have substantial financial associations with industry, further questions inevitably arise. Some argue that public disclosure of sponsorship and of the financial associations of committee members, along with rules to prevent sponsors from influencing the selection of panel members and the content of guidelines, are adequate safeguards. Others maintain that practice recommendations will invariably be viewed with skepticism unless corporate sponsorship and experts with financial ties are completely avoided.

At present, the financial ties between guidelines panels and industry are extensive. A survey of

685 disclosure statements by authors of guidelines concerning medications found that 35% declared a potential financial conflict of interest.<sup>3</sup> In 2006, Eli Lilly was criticized for providing the impetus for the development of practice guidelines for sepsis treatment and coordinating the process with a marketing campaign for Xigris (recombinant human activated protein C). And Amgen and other companies that manufacture or market recombinant erythropoietin, as well as DaVita, a large company that provides dialysis services, have been criticized for their close relations to the development of the National Kidney Foundation's guidelines for managing anemia in chronic kidney disease. An alternative approach is government sponsorship, although it does not ensure that committee members are independent of commercial interests. In 2004, the National Cholesterol Education Program updated its guidelines for the detection, evaluation, and treatment of high blood cholesterol in adults. It was subsequently disclosed that most of the committee members had extensive financial connections to the manufacturers of statins, which stood to gain from increased use of these drugs.

There are various approaches to improving the quality of guidelines and minimizing the potential for inappropriate influences. Since 1999, NICE ([www.nice.org.uk](http://www.nice.org.uk)) has provided guidance on appropriate clinical practice within the National Health Service.<sup>4</sup> NICE is an independent organization with an annual budget of about \$50 million; between 2003 and November 2006, it published 39 clinical guidelines, as well as

many technology appraisals and guidance documents for interventional procedures. Some NICE guidance has been controversial. Recently, for instance, Pfizer and Eisai, a Japanese biotechnology company, asked a British court to block guidance that would re-

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strict the use of certain drugs for Alzheimer's disease. The organization has taken steps to avoid situations arising from potential conflicts of interest, requiring members of its advisory bodies to declare their financial and other interests. According to a 2004 statement from NICE, "if a conflict of interest is identified, the individuals are required to stand down and do not take part in the relevant decision-making process for that project."

In the United States, the NIH Consensus Development Program ([www.consensus.nih.gov](http://www.consensus.nih.gov)), which was started in 1977, sponsors evidence-based assessments of important medical issues. At present, each assessment includes a systematic literature review, prepared through the AHRQ; a public conference that features

research presentations; and a consensus statement that is disseminated widely. The public conferences use a system of jurors and witnesses, according to Barry Kramer, the director of the NIH's Office of Medical Applications of Research, which coordinates the program. Panel members can have neither financial nor other potential conflicts, and panels are independent of both the NIH and the Department of Health and Human Services. The consensus statements reflect the conclusions of the panels, not those of the institutes. The conference speakers, by contrast, may have industry ties, but if they do, those ties are disclosed. The process, despite its rigor, has limitations. It takes about 18 months from conception to completion, and each assessment costs about \$500,000; only three or four conferences are held each year.

Although the AHRQ ([www.ahrq.gov](http://www.ahrq.gov)) does not prepare guidelines, it sponsors about 20 to 25 systematic reviews each year. These reviews provide public and private organizations, such as the Centers for Medicare and Medicaid Services, the NIH, and specialty societies, with the scientific foundation for developing and implementing guidelines. Some reviews compare the effectiveness of drugs or medical tests, such as therapies for low bone density or noninvasive diagnostic tests for breast abnormalities. The researchers can have no financial associations related to the subject. The AHRQ, however, receives many more proposals for reviews than it can fund.

Medical specialty societies and other professional organizations have diverse policies for corpo-

rate sponsorship of guidelines and the financial associations of committee members. Some do not allow direct sponsorship, although they may accept support for their overall budget. There appears to be a trend toward more complete disclosure — both to the sponsoring society and to readers of the guidelines — of financial, personal, and professional relationships with industry. Yet little is known about specific practices, such as the procedures for selecting and supervising panels (are committee chairs and the officials who select them permitted to have associations with affected companies?) and the rules for responding to potential conflicts of interest (including situations in which members must recuse themselves).

Clinical practice guidelines

would serve patients and physicians best if they were prepared with the necessary financial and methodologic support to ensure their quality; the guidelines would inspire the most confidence if independent experts developed them without funding from industry or others with self-interest in the outcome. One approach would be to expand the NIH Consensus Development Program so that it could take on more subjects. Or Congress might require that the AHRQ once again support guideline development. Alternatively, the United States could create its own version of NICE, or a new agency to oversee and publish comparisons of the clinical effectiveness of different treatments and interventions.<sup>3,5</sup> To succeed, however, any entity would need independence and financial

security: when powerful interests take issue with guidelines, challenges will be inevitable.

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