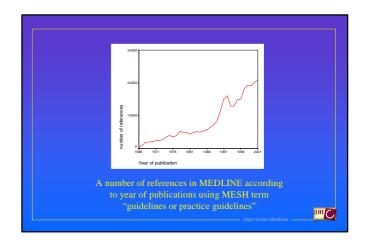


Systematically developed statements
to assist practitioner and patient
decisions about appropriate health
care for specific clinical circumstances.

IOM 1992



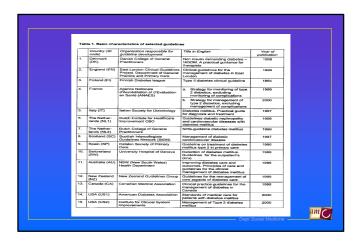
## Three generations of practice guidelines Ø based on consensus conferences Ø based on EBM Ø based on EBM and CEA

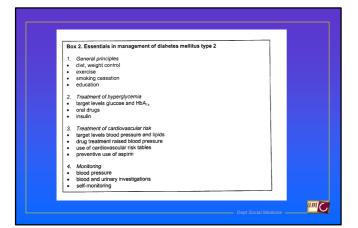
## Reasons for CPP development Ø professional (professionalization) Ø manager (planning and control) Ø financier (efficiency, cost control) Ø government (accountability, priority setting regulated markets) Ø patient / citizen (empowerment, transparency, consumer choice)

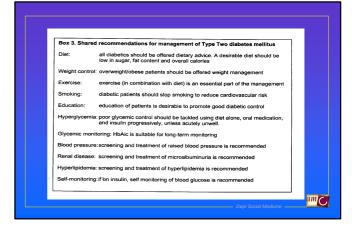
Inside guidelines: comparative analysis of recommendations and evidence in diabetes guidelines from 13 countries

Jako S Burgers
Julia V Bailey
Niek S Klazinga
Akke K van der Bij
Richard PTM Grol
Gene Feder,
for the AGREE Collaboration

Diabetes Care; 2002;25;11:1933-1939







Box 4. Recommendations with 'minor' variation

BMI used to define obesity: Range 25 - 30.

Target HbA<sub>1c</sub>: Range 6.5 - 7,5%

Metformin as first choice oral treatment in obese

Addition of a second oral agent to maximum doses of an initial agent

Sulphonylureas or biguanides in patients of normal BMI

Use of ACE inhibitors in those with hypertension and renal disease

Aspirin use in secondary prevention of cardiovascular disease

Box 5. 'Major' variation between recommendations

Length of trial of diet and exercise before oral treatment: range 2 - 9 months

Use of alphaglucosidase inhibitors: widely varying indications for this medication

Combination of insulin and oral medication: widely varying combinations suggested. No consensus on the value or indications for combination treatment.

Target BP: range <130/85 < 160/90

First line medication for raised BP: no consensus on a first-line drug; wide choice given

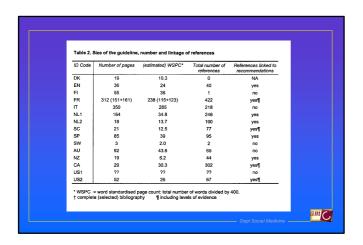
Aspirin use as primary prevention in 'high risk': widely differing opinions on its value

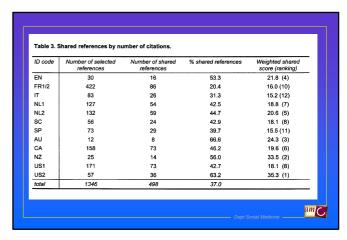
Targets for lipid control: widely differing targets given (e.g. total cholesterol 4.5 - 6.5 mmol/l)

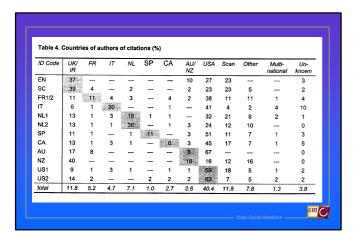
Frequency of monitoring: e.g. HbA<sub>1c</sub> 1-4 /year

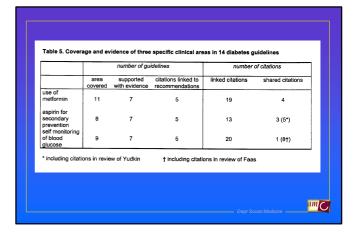
Self-monitoring of blood glucose: contradictory if controlled with diet or oral medication

Routine annual ECG: recommended or not









## Potential bias Ø Selection workgroup members Ø Selection central questions Ø Conceptualizations of diseases Ø Searching literature Ø Judging literature Ø Phrasing recommendations Ø Guideline by-products (leaflets, review-criteria, indicators

The potential use of formalized EBM/CEA based statements for patient/physician decision making

Ø in bridging the research/practice gap (is there a difference between efficacy and effectiveness?)

Ø in clinical decision making (personalizing the decision tree)

Ø in structuring and monitoring clinical working processes (from decision making to flow-charts and formalization of tasks and responsibilities)

Ø in accountability (do CPG's create trust?)

Ø in priority setting (can justice be done?)

## Topics to be addressed in national guideline development programs

- ownership
- evidence-base
- participation of different parties
- legal context
- link with local standards, audit, indicators and CME
- quality of guidelines (AGREE)
- international cooperation

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