Explicit Priority Setting in Clinical Guidelines : The Next Frontier?

Peter Langhorne

Stroke 2007, 38:2037: originally published online May 31, 2007
doi: 10.1161/STROKEAHA.107.487231
Stroke is published by the American Heart Association. 7272 Greenville Avenue, Dallas, TX 72514
 Print ISSN: 0039-2499. Online ISSN: 1524-4628

Editorial

Explicit Priority Setting in Clinical Guidelines
The Next Frontier?

Peter Langhorne, PhD, FRCP

See related article, pages 2185–2190.

The last 15 years have seen great improvements in the development of clinical practice guidelines. There are now rigorous methods for conducting systematic reviews of the relevant scientific evidence and for grading the strength of that evidence.[1] However, it is in the next step of the process (generating and implementing recommendations for practice) that difficulties frequently arise. The grade of scientific evidence cannot simply dictate the priorities for clinical practice because of the crucial role of several other considerations. Judgements about the implementation of evidence will include judgements about patient needs, the size and value of treatment effects, and the most appropriate use of resources within a particular healthcare system (and society in general). It is for these reasons that clinical practice guidelines should be developed within the social and cultural context in which they will be applied. In guideline development, this priority setting process has usually reflected the assembled views of the guideline panel and has not been carried out in an explicit manner. Once guidelines come to be implemented in clinical practice, priorities often reflect the intuitive decision-making of clinicians and healthcare managers.

The article by Norrving et al[2] outlines a novel approach to priority-setting during the development of the Swedish national stroke guidelines. They established a series of committees with a broad representation of many stakeholders including patient representatives. The approach is to be commended because it attempted to make transparent a series of decisions, which are frequently implicit.

Inevitably a number of questions arise. Despite the emphasis on transparency, it is not always clear exactly how some decisions are arrived on. The reliability of the methods used need to be tested in other settings. This is particularly important when rationing decisions may be taken based largely on economic considerations. Overall, the Swedish guideline development group have taken an important step in trying to establish a transparent and reliable approach to setting priorities. However, I suspect we are nearer the beginning of this journey than the end.

Disclosures

None.

References

1. Atkins D, Best D, Briss PA, Eccles M, Falck-Ytter Y, Flottorp S, Guyatt GH, Harbour RT, Haugh MC, Henry D, Hill S, Jaeschke R, Leng G, Liberati A, Magrini N, Mason J, Middleton P, Mrukowicz J, O'Connell D, Oxman AD, Phillips B, Schunemann HJ, Edejer TT, Varonen H, Vist GE, Williams JW Jr, Zaza S; GRADE Working Group. Grading quality of evidence and strength of recommendations. *BMJ.* 2004;328:1490.
2. Norrving B, Wester P, Sunnerhagen KS, Terént AS, Sohlberg A, Berggren F, Wester P-O, Asplund K; for the Stroke Guidelines Working Group, National Board of Health and Welfare, Stockholm, Sweden. Beyond conventional stroke guidelines: setting priorities. *Stroke.* 2007;38: 2185–2190.

KEY WORDS: clinical ■ clinical guidelines ■ clinical trials ■ evidence-based practice ■ outcomes

The opinions in this editorial are not necessarily those of the editors or of the American Heart Association.

From the Academic Section of Geriatric Medicine, University of Glasgow, Glasgow, UK.

Correspondence to Peter Langhorne, Academic Section of Geriatric Medicine, University of Glasgow, Level 3, Centre Block, Royal Infirmary, Glasgow, UK G31 02ER. E-mail pl11m@clinmed.gla.ac.uk

(*Stroke.* 2007;38:2037.)

***Stroke* is available at http://www.strokeaha.org**
DOI: 10.1161/STROKEAHA.107.487231