

**EDITORIAL**

DOI: 10.17126/joralres.2015.045

Clinical practice is a routine activity, however it usually implies a degree of variability not only related to the subject being treated, but also to the health professionals who are providing the treatment. As a result, clinicians at the same health center often diagnose and treat patients differently even if they seem to suffer from similar conditions. This situation may even happen to the same patient when seeking a “second opinion”. These extreme differences in opinion may create an obstacle for the comparison and evaluation of outcomes and results by clinicians, health teams and health centers.

While patients may differ in a number of parameters and the same disease entity may show various clinical manifestations, there are tools developed from evidence-based clinical practice (EBCP), that are useful to establish some guidelines which can help in decision making, consequently variability in diagnosis should not be a permanent problem.

As a result, the so-called clinical practice guidelines (CPGs) were developed. They are generally defined as a set of recommendations based on a systematic review of current best evidence and the assessment of risks and benefits of the various options available for the diagnosis and treatment of patients, in order to optimize health care. That is, they are instruments designed with the aim of standardizing the performance of health professionals and improving the quality of health care.

Unfortunately, there is a widespread tendency to develop CPGs without considering some methodological aspects inherent to information that supports the new health technology policies that will be implemented, the opinion of those who are in charge of implementing them, the users, the costs involved in the implementation, the benefit expected from them, etc.<sup>1</sup>.

This problem has become so prevalent especially in Latin America, where instead of having CPGs based on

**The role of clinical practice guidelines in the daily work of health professionals.**

the best available evidence (therefore being revised and updated regularly, at least every four years), what is actually available is procedural rules or manuals, which are generally more useful to health authorities in office than to all other actors involved in their implementation and application.

CPGs should have some basic requirements, among which we find: their rigorous development (detailed information on the process used to gather and synthesize the evidence, the methodology used for making recommendations and for subsequent updates; which are the reasons why the best CPGs are those based on systematic reviews of good evidence, strength of recommendation, and on a patient-oriented approach.

Other key features are the precision of the language used and the format of the CPG, and the potential applicability of the CPG, with special emphasis on possible discrepancies regarding further implementation, cost, etc. Another key feature is that they must have a transparent development process, identifying potential conflicts of interest by the group responsible for developing the CPG, that is, being free from editorial constraints. Finally, they must be able to provide flexibility in different clinical situations<sup>2</sup>.

For this reason, proposals for assessing the methodological quality of CPGs have been devised. One is the “AGREE Instrument” (Appraisal of Guidelines Research & Evaluation); an international and collaborative tool created in 2003; methodologically updated and improved in 2013, resulting in AGREE II, comprising 23 items grouped in 6 quality domains (scope and purpose, stakeholder involvement, rigor of development of the CPGs, clarity of presentation, applicability, and editorial independence). AGREE II has been subjected to studies that measure its validity and reliability<sup>3</sup>.

The development of CPGs based on proposals as this



one will certainly help to improve existing tools. And although current tools are of great value for decision-making in the health field and have become a valuable support for the evaluation and eventual acquisition of health technology, they have progressively fallen into disrepute. It is not necessary to be an expert to realize that CPGs (at least those applied in Chile) are (with few exceptions), unreliable, permissive, lacking appropriate methodology and specific purposes, unclear about their applicability, lacking participation of interest groups, and in some cases without sufficient editorial independence to avoid potential conflicts of interest.

However, not all the initiatives have poor performance, there are a number of organisms working seriously and continuously to develop CPGs based on the best current evidence. An example of this is GuíaSalud; an

initiative of the Spanish government, which allowed to create the Catalogue of Clinical Practice Guidelines in 2004 and the Program of CPG of the National Health System in 2006. These initiatives allow users to have access to updated information on various topics at [guiasalud.es](http://guiasalud.es) Web site<sup>4</sup>. The same happens with other renowned agencies in the field, such as: New Zealand Guidelines, Scottish Clinical Guidelines, EBM Guidelines, Health Services/Technology Assessment Text (HSTAT), National Institute for Health and Clinical Excellence (NICE), etc., whose email addresses are available on various Internet sites, such as [rafabravo infodoctor](http://rafabravo.infodoctor.org)<sup>5</sup>.

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