Author’s response to reviews

Title: Updated clinical guidelines experience major reporting limitations.

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Reviewer 1

1. INTRODUCTION

Readers would benefit from a more elaborate description of the context and background to provide essential details to those who are not familiar with guidelines and guideline development, and not aware of CheckUp. This content will help to rationalize the purpose of this study.

Authors might consider the following structure:

- Paragraph #1 what are guidelines and why do they need updating.

We have included now a definition of clinical guidelines (CGs).

The text now reads: “Clinical Guidelines (CGs) are defined as ‘statements that include recommendations intended to optimise patient care, that are informed by systematic reviews of evidence and an assessment of the benefits and harms of alternative care options’ [1]. Scientific knowledge is in constant evolution [2,3]; therefore, surveillance of the new evidence is required to ensure the trustworthiness of clinical guidelines (CGs) [4-8].”
2. INTRODUCTION

- Paragraph #2 brief review of existing guideline updating processes and their pros/cons.

We have included now a definition of updating process.

The text now reads: “Updating CGs is an iterative process with a systematic and explicit methodology that involves identifying and reviewing new evidence not included in the original version of a CG [9].”

We believe that the pros/cons of updating processes are out of the scope of our study.

3. INTRODUCTION

- Paragraph #3 describe previous work on CheckUp including the tool and how it is to be used and its purpose, i.e. to improve quality of the guideline as a whole or quality of the reporting of the update process?

We have included a definition of CGs reporting process and the aim and uses of CheckUp.

The text now reads: “The reporting of updated CGs is a process within an updating strategy that communicates users about the methods and changes in an updated CG [9]. So far, there is limited guidance on the reporting of the updating process [19]. To address this gap, we recently developed the Checklist for the Reporting of Updated Guidelines (CheckUp) [20]. The aim of CheckUp is to evaluate the completeness of reporting in updated CGs [20]. CheckUp can be used 1) to inform about strategies for updating CGs and their reporting requirements (CG developers), 2) to assess the reporting of updated CGs (interested CG users), and 3) to complete as a publication requirement of updated CGs (editors of scientific journals that publish CGs) [20]. Although CheckUp has been already included in some methodological handbooks and methodological studies [21,22], it has not been yet formally implemented.”

4. INTRODUCTION

- Paragraph #4 identify the need this study addresses, the purpose of the study (to address that need) and the overall implications (value and/or application of the findings)

We have included the potential implications of our study. We considered that “need this study addresses” (justification) and “purpose of the study” (aim) are already covered.

The text now reads: ”To our knowledge, updated CGs have not been systematically reviewed to assess the completeness of reporting the updating process. An overview of the current status
could be informative for the CG community. Therefore, the objectives of our study were: 1) to assess the completeness of reporting the updating process of updated CGs using CheckUp, and 2) to explore the inter-observer reliability of CheckUp.”

5. METHODS

- Start with a section labelled Research Design, specify the overall approach and method along with references (for example, content analysis?) and specify that ethics review and approval was not needed because data were publicly available.

We have included the new section “2.1. Study design” with an overview of methods.

The text now reads: “We conducted a systematic assessment of the reporting of the updating process in a sample of updated CGs using CheckUp. We followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guideline to the extent it was applicable to our study [23].”

Regarding “ethics review”, we considered that the manuscript already covered it in “Declarations - Ethics approval and consent to participate” section of the manuscript.

6. METHODS

- Specify why the year 2015 was chosen

We have included the rationale for searching CGs published in the year 2015.

The text now reads: “We included all updated CGs published in 2015 (as the most recent year prior to publication of CheckUp) which met the following criteria…”

7. METHODS

- What was the sampling framework for guidelines?

We have included all updated CGs that were:

- Published in 2015,

- That met the inclusion criteria, and

- That were identified in MEDLINE, G-I-N library and/or National Guidelines Clearinghouse.
8. METHODS

- Specify what data were collected/extracted, i.e. title, country, clinical topic etc.

We have included more information about the data extraction regarding the guideline characteristics.

The text now reads: “Furthermore, we collected the following information regarding: 1) the institution that updated the CG (name, country, and type of organisation), 2) the scope of the updated CG (diagnosis, management, prevention, screening, or treatment), and 3) the health topic of the updated CG.”

9. METHODS

- Specify that guideline characteristics and CheckUp scoring were reported with summary statistics

We have included the concept of summary statistics.

The text now reads: “We calculated summary statistics to provide quantitative information about the institution that updated CGs, updated CGs and CheckUp scores.”

10. RESULTS

- Can you provide reasons for full-text exclusions (as one would for a systematic review)?

We have included the reasons for full-text exclusions in the file supplementary data 2.

11. DISCUSSION

Authors invite CheckUp users to submit comments on its use - specify how they are to do so

We have included this suggestion.

The text now reads: “Finally, we invite users to comment on the items and the usability of CheckUp contacting the corresponding author of this publication.”
Reviewer 2

12. At the core of the science of implementation is the evidence that the existence of an effective intervention does not ensure the use of the effective intervention. Therefore, at a minimum, it would be important to acknowledge the findings related to the barriers to adherence to clinical guidelines and protocols in health. (I have included a few references below.)

We have included this suggestion in the discussion section of our manuscript.

The text now reads: “When updating CGs, developers need to pay special attention to the implementation implications of the changes introduced in updated CGs [96]. This can be done by exploring facilitators and barriers, developing supporting materials or by providing audit criteria [97]. Recently, GRADE has published Evidence to Decision frameworks to support developers to systematically consider this aspect and other criteria [98]. As living CGs become more common practice [99], developers will need to assess to what extent more frequent changes in recommendations impact their implementability and optimisation of patient care.”

13. To strengthen the relevance of this research to the field of implementation, does this process improvement address one of the identified barriers to adherence?

For instance, how might this research complement or contrast the findings from Gagliardi and Brouwers?


“Providers and patients are most likely to use and benefit from guidelines accompanied by implementation support. Guidelines published in 2007 and earlier assessed with the Appraisal of Guidelines, Research and Evaluation (AGREE) instrument scored poorly for applicability, which reflects the inclusion of implementation instructions or tools. The purpose of this study was to examine the applicability of guidelines published in 2008 or later and identify factors associated with applicability.”

We have included this suggestion in the discussion section (see comment 12).

14. With the adherence challenges fully acknowledged, then perhaps, the authors can build a case for

1) the importance of CGs reflecting the most up-to-date evidence
2) the improved process of reporting updated CGs, and

3) how the reporting of updated CGs will promote more consistently high quality health care.

We will try to answer the reviewers’ comment point by point:

1) Included in the first paragraph of the introduction section (see comment 1).

2) Included in the fourth paragraph of the introduction section (see comment 4).

3) Included in the discussion section (see comment 12).

15. In addition, for the non-health professional, it would be helpful to provide a more detailed description of the current/typical approach to reporting updated guidelines. Most non-health professionals will not have the context to quickly engage with this research. (These readers will be curious about things like: Who manages the process of reporting of updated guidelines currently? To whom does one report updated guidelines?, etc.) Furthermore, it would be helpful to describe AGREE II at the beginning of the paper, since you reference it by name at the end of the article, however, no additional information is provided.

We have included this suggestion in the introduction section (see comment 3).

16. Finally, would it be possible to expect that future research, based on the use of CheckUp, could

- test the extent to which a high CheckUp score correlates with higher levels of adherence to the CG?

- demonstrate the correlation between CheckUp scores and the quality of clinical care?

If not one of these outcomes, how would the authors expect the consistent use of the CheckUp to impact health care practice and health care outcomes?

We have included this suggestion in the discussion section (see comment 12).
17. You are probably already very familiar with these references (and others) related to adherence, but I thought I would drop a few into this document, for easy reference:


We have referred to two systematic reviews of studies that assessed CGs using the AGREE instrument [AlonsoCoello2010, Armstrong2017].

Reviewer 3

18. A slightly longer introduction about evidence for the need for the tool would have framed it better for a IS audience. It is not hard to make a clearer case for clinicians are finding it harder than ever to keep up with new clinically actionable research. At the same time, resources such as updated CGs specifically designed to help to do this are often viewed with scepticism by clinicians. The reasons for this are multifaceted but one, it could be argued, is the lack of a standard methodology to develop and update CGs.
We have modified the introduction section (see reply to comment 1-4).

19. This tool may go some way to demonstrate / test the rigour used in updating particular clinical guidelines and if used by the developers themselves, could bring a welcome standardisation to the work.

I am not convinced that the tool will be used by clinicians as suggested in the second paragraph of 4.5 as it is too labour intensive.

I would think that professional bodies who write and update CGs would be the natural target and, as you say, for them it could provide a gold standard.

We have modified “CGs users” to “interested CGs users”.

20. It appears to be a very straightforward process and I congratulate the authors on a comprehensive yet fairly easy to use tool. The 10-point scale is useful. The inter-observer reliability is excellent so I wonder at your caution that three reviewers be used. Maybe a sentence explaining why?

We included three reviewers for convenience. Although we considered: 1) to observe variability between measurements and 2) to include the minimum effective number of raters [Saito 2006].

21. I had trouble reading Figure 2 as the resolution on screen was too low.

Figure 2 is uploaded again. This should have corrected the low resolution.