



Clinical Practice Guidelines

What are clinical practice guidelines?

Clinical practice guidelines (CPGs) have been defined as “...systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances” [1] or ‘statements that include recommendations, intended to optimise patient care, that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options’ [2]. The overall goal of CPGs is to provide recommendations on how healthcare and other professionals should care for people with specific conditions [3]. This fact sheet will focus on CPGs for the treatment of people with pain.

Why are they important:

People with pain, clinicians and policy makers are faced with a confusing range of possible treatment options, all backed by enthusiastic advocates. The evidence base is growing rapidly but the quality of that evidence is highly variable. We know that the amount, type and quality of care offered to people with pain can be highly variable. CPGs are important tools for trying to systematically bring together the best evidence to make clear recommendations to guide clinical care and provision. By recommending effective evidence-based interventions and discouraging interventions lacking in scientific support, CPGs seek to optimize the quality of care, while reducing the waste and the potential harm associated with ineffective or unsafe interventions [4].

Who develops them and why does that matter?

CPGs are often developed by government backed agencies such as the National Institute for Health and Care Excellence (NICE) in the UK, or by professional/special interest organisations. Examples include the American College of Physicians or the Neuropathic pain special interest group of IASP (NeupSIG). Whatever type of organisation develops them, there is a need for clinical guideline processes to include full representation across the multiple clinical disciplines that are involved in patient care and critically from people with lived experience of the condition. Where this is not ensured there is danger that the guidelines might reflect the interests of a particular professional group, rather than best clinical practice, and that recommendations may not really reflect the needs of people living with, or caring for people with pain. There is also a need for full transparency around possible conflicts of interest in the guideline development team, including both professional and industry interests and relationships [5].

How should they be developed and how can I spot a trustworthy CPG?

Developing a CPG should be a systematic and transparent process. This should involve developing and defining a clear scope for the guideline and methodology before searching the evidence; convening a guideline development group (committee) with appropriate knowledge, skills, and representation; conducting systematic reviews specific to the questions outlined in the scope and



finally considering the evidence and translating them into recommendations. When developing the scope and the final guideline there should be a process of consultation with all important stakeholders, including people with pain. CPGs should clearly communicate their recommendations and the certainty of the evidence used to generate them.

You can use the AGREE-II tool to help evaluate the quality of CPGs [6]. It asks questions about the scope and purpose of the guideline, the quality of stakeholder involvement, the rigour of development, the clarity of presentation, the applicability and the editorial independence of a guideline and timelines for review.

Why might different guidelines on the same topic disagree?

There are a number of reasons why different guidelines around the same topic sometimes produce conflicting recommendations. These might include differences in the population of interest and the local setting, differences in the specific date and scope of the evidence searches, leading to different studies being included; variation in methodological thresholds around what represents convincing evidence of clinical effectiveness, and differences in interpretation of the same evidence by different guideline committees [4,7]. The potential for conflicting recommendations between guidelines decreases as the volume and quality of evidence increase. In fact, inconsistency of recommendations across guidelines may be a warning sign for weak evidence [4].

Why don't they always change practice?

Publishing a CPG does not guarantee that clinical practice will change. There are lots of examples where guideline recommendations are not widely followed [8], because multiple potential barriers prevent change of practice [9,10]. These can include clinicians' knowledge and understanding of the guideline, their willingness to accept its recommendations (often in the face of deeply held beliefs, clinical experience, preferences and vested interests), local issues related to the feasibility of implementing CPG recommendations and the culture of the organisation, the accessibility and credibility of the guideline itself [9-13] and the acceptability, or lack thereof, of the guideline recommendations to patients [14].

How might we implement them:

Changing clinical practice is a complex process and there is not a strong body of evidence supporting any particular strategy [15,16]. Careful consideration needs to be given to how to best implement the recommendations of CPGs. This likely requires a detailed understanding of the local clinical setting and the diversity of the local patient community, an assessment of local resources needed to support implementation, adequate training and support for clinicians, partnership with the patient populations and an ongoing process of evaluation and adaptation. There is a pressing need for more research into effective implementation in the field of pain treatment.

Conclusion

CPGs are an important tool in delivering evidence-based practice. They can potentially help us to improve the quality, consistency and efficiency of clinical care, deliver a better experience for



patients and improve efficiency in our clinical systems. Users and leaders planning to implement CPGs should approach them critically, and consider both who developed them and whether the process of development met established indicators of quality.

References

1. Field MJ, Lohr KN. Clinical practice guidelines: directions for a new program. Washington, DC: National Academy Press; 1990.
2. Graham R, Mancher M, Miller, Wolman D. Clinical practice guidelines we can trust. Washington DC: Institute of Medicine. National Academies Press; 2011.
3. National Institute for Health and Care Excellence. <https://www.nice.org.uk/process/pmg6/resources/how-nice-clinical-guidelines-are-developed-an-overview-for-stakeholders-the-public-and-the-nhs-2549708893/chapter/nice-clinical-guidelines> . Accessed 23/11/21
4. O'Connell NE, Ward SP. Low Back Pain: What Have Clinical Guidelines Ever Done for Us? J Orthop Sports Phys Ther 2018;48(2):54-57. doi:10.2519/jospt.2018.0602
5. Spithoff S, Leece P, Sullivan F, Persaud N, Belesiotis P, Steiner L (2020) Drivers of the opioid crisis: An appraisal of financial conflicts of interest in clinical practice guideline panels at the peak of opioid prescribing. PLoS ONE 15(1): e0227045.
6. Brouwers M, Kho ME, Browman GP, Burgers JS, Cluzeau F, Feder G, Fervers B, Graham ID, Grimshaw J, Hanna S, Littlejohns P, Makarski J, Zitzelsberger L for the AGREE Next Steps Consortium. AGREE II: Advancing guideline development, reporting and evaluation in healthcare. Can Med Assoc J. 2010. doi:10.1503/cmaj.090449
7. O'Connell NE, Cook CE, Wand BM, Ward SP. Clinical guidelines for low back pain: a critical review of consensus and inconsistencies across three major guidelines. Best Pract Res Clin Rheumatol. 2016;30:968-980. <https://doi.org/10.1016/j.berh.2017.05.00>
8. Foster NE, Anema JR, Cherkin D, Chou R, Cohen SP, Gross DP, Ferreira PH, Fritz JM, Koes BW, Peul W, Turner JA, Maher CG; Lancet Low Back Pain Series Working Group. Prevention and treatment of low back pain: evidence, challenges, and promising directions. Lancet 2018 ;391(10137):2368-2383. [https://doi:10.1016/S0140-6736\(18\)30489-6](https://doi:10.1016/S0140-6736(18)30489-6)
9. Slade SC, Kent P, Patel S, Bucknall T, Buchbinder R. Barriers to primary care clinician adherence to clinical guidelines for the management of low back pain: a systematic review and metasynthesis of qualitative studies. Clin J Pain. 2016;32:800-816. <https://doi.org/10.1097/AJP.0000000000000324>
10. Fischer F, Lange K, Klose K, Greiner W, Kraemer A. Barriers and strategies in guideline implementation—a scoping review. Healthcare (Basel). 2016;4:36. <https://doi.org/10.3390/healthcare4030036>
11. Bishop FL, Dima AL, Ngui J, et al. “Lovely pie in the sky plans”: a qualitative study of clinicians’ perspectives on guidelines for managing low back pain in primary care in England. Spine (Phila Pa 1976). 2015;40:1842-1850. <https://doi.org/10.1097/BRS.0000000000001215>



12. Bishop PB, Wing PC. Compliance with clinical practice guidelines in family physicians managing worker's compensation board patients with acute lower back pain. *Spine J.* 2003;3:442-450. [https://doi.org/10.1016/S1529-9430\(03\)00152-9](https://doi.org/10.1016/S1529-9430(03)00152-9)
13. Figg-Latham J, Rajendran D. Quiet dissent: the attitudes, beliefs and behaviours of UK osteopaths who reject low back pain guidance – a qualitative study. *Musculoskelet Sci Pract.* 2017;27:97-105. <https://doi.org/10.1016/j.math.2016.10.006>
14. Spitaels D, Vankrunkelsven P, Desfosses J, et al. Barriers for guideline adherence in knee osteoarthritis care: a qualitative study from the patients' perspective. *J Eval Clin Pract.* 2017;23:165-172. <https://doi.org/10.1111/jep.12660>
15. Mesner SA, Foster NE, French SD. Implementation interventions to improve the management of non-specific low back pain: a systematic review. *BMC Musculoskelet Disord.* 2016;17:258. <https://doi.org/10.1186/s12891-016-1110-z>
16. Suman A, Dikkers MF, Schaafsma FG, van Tulder MW, Anema JR. Effectiveness of multifaceted implementation strategies for the implementation of back and neck pain guidelines in health care: a systematic review. *Implement Sci.* 2016;11:126. <https://doi.org/10.1186/s13012-016-0482-7>

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