Guidelines Under Fire Again!

John Chalmers

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In an editorial in this issue of *Hypertension*, copublished in *The Journal of Hypertension*, a group of luminaries in our field, led by Franz Messerli, takes issue with aspects of the recent Clinical Practice Guidelines published in the Annals of Internal Medicine, on behalf of the American College of Physicians (ACP) and the American Academy of Family Physicians (AAFP).[1–3] A similar critique was made by Messerli in a letter to the editors of *Hypertension* in 2014 in relation to a Science Advisory issued by the American Heart Association, the American College of Cardiology, and the Center for Disease Control in 2014.[4,5]

The editorial makes salient points, but the dominant criticism is that the authors of the ACP/AAFP guidelines, 6 in total, lack the expertise expected of authors of major guidelines as judged by the number of publications on the subject in question (in this instance, on hypertension) by recognition as a hypertension specialist certified by the American Society of Hypertension, by membership of relevant societies such as the American Society of Hypertension, or the Council for Hypertension of the American Heart Association, and by membership of editorial boards of relevant scientific journals. In these respects, the editorial compares the expertise of the authors of the Eighth Joint National Committee (JNC 8) with those of the ACP/AAFP guidelines and finds the latter to be markedly less expert.[3,6]

Two major trends have affected the composition and the recommendations of guideline committees over the past 3 decades. One has been the constant call to reduce the influence of conflicts of interest, particularly with respect to relationships of committee members with pharmaceutical companies. This has led some major organizations responsible for guidelines, to reduce or avoid many experts, including well-reputed clinical trialists with significant pharma support, from membership of guideline committees, as we see with the recent guidelines issued by the ACP/AAFP.[3] The other strong trend has been the progressive observance of evidence-based medicine with increasing insistence that recommendations for treatment should be based on evidence from high-quality randomized trials. These 2 trends received major endorsement and reinforcement, particularly in the United States, from 2 major reports published in 2011 by the Institute of Medicine of the National Academies in the United States, one on *Clinical Practice Guidelines We Can Trust* and the other on *Finding What Works in Health Care: Standards for Systematic Reviews*.[7,8]

Although one cannot but agree with the principles espoused, it must be admitted that rigid adherence to these recommendations can pose problems. The difficulty is well summarized in a report issued by the American College of Cardiology/American Heart Association Taskforce on Practice Guidelines in 2014,[9] which comments: "It is precisely when evidence is lacking or controversial that clinicians need the most guidance," and that there is "a natural tension between the needs of clinicians for comprehensive clinical advice from seasoned experts and for a clear delineation of diagnostic and therapeutic measures for which strong evidence exists."[9]

But this issue is not only a problem for the clinician seeking guidance, it also poses a major problem for guideline committees which may be forced to choose between not providing the advice that clinicians most wish to receive on a controversial issue and issuing recommendations based on a weak evidence base that may need retraction or revision at a later date. Defining the evidence base for a particular set of guideline recommendations can clearly be an issue, as we witnessed with the dissenting report from some panel members appointed to JNC 8[6,10] and are possibly witnessing in relation to the controversy over the recent ACP/AAFP guidelines.[1–3] Thus, it seems that 1 element of the disquiet experienced by the authors of the editorial led by Messerli[1,2] relates to disagreement with the thrust of the recommendations for target systolic blood pressure and the failure to consider the results of SPRINT (Systolic Blood Pressure Intervention Trial) in reaching the recommendation of the ACP/AAFP.[3,11,12]

On the other hand, it must be said that expertise lies in the eye of the beholder. To many people, including myself and the authors of the editorial led by Messerli,[1,2] who are actively engaged in research, who publish regularly in scientific journals and are invited to speak at scientific meetings, expertise may seem to reside in the realms of research and to be measured through the criteria that are commonly applied for assessing research performance and track record. But there is another world, inhabited by clinicians and practitioners both in primary care and in hospital practice, and often working alongside us. This world too has many very erudite practitioners, often those we like to have care for close friends or members of our family when they are ill, and they too can have very considerable expertise in the same disorders that we like to write about. These internists, physicians, family doctors,

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and surgeons are often the very best teachers in our medical schools and our residency programs and the most sought-after mentors. They may also have major roles in the design, planning, and delivery of teaching programs, in the workings of their institutions or professional organizations, and in activities such as examining for American Boards of Family Medicine, Internal Medicine or a variety of specialties. And they may be regarded as experts on particular topics or disorders, by a wide array of colleagues, at local level, at regional level and even at national level. I am not in a position to judge the merits of the authors of the ACP/AAFP guidelines in those terms, but it is possible that some at least would qualify for the term expert in the field of hypertension. Others could qualify for the term expert through their experience and expertise in the process of guideline development, or in areas such as assessment of research proposals from an ethical perspective.

It does, however, seem a pity that the ACP and the AACP did not chose to include some colleagues who also qualify as experts through their performance in research or in the terms described in the accompanying editorial.

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References

1. Messerli FH, Hofstetter L, Agabiti-Rosei E, et al. Expertise: no longer a sine qua non for guideline authors? *Hypertension*. 2017;70:235–237. doi: 10.1161/HYPERTENSIONAHA.117.09470.
2. Messerli FH, Hofstetter L, Agabiti-Rosei E, et al. Expertise: no longer a sine qua non for guideline authors? *J Hypertens*. 2017;35:1564–1566. doi: 10.1097/HJH.0000000000001435.
3. Qaseem A, Wilt TJ, Rich R, Humphrey LL, Frost J, Forciea MA; Clinical Guidelines Committee of the American College of Physicians and the Commission on Health of the Public and Science of the American Academy of Family Physicians. Pharmacologic treatment of hypertension in adults aged 60 years or older to higher versus lower blood pressure targets: a clinical practice guideline from the American College of Physicians and the American Academy of Family Physicians. *Ann Intern Med*. 2017;166:430–437. doi: 10.7326/M16-1785.
4. Messerli FH. Hypertension guidelines: political correctness trumping expertise? *Hypertension*. 2014;63:e81. doi: 10.1161/HYPERTENSIONAHA.113.03056.
5. Go AS, Bauman MA, Coleman King SM, Fonarow GC, Lawrence W, Williams KA, Sanchez E; American Heart Association; American College of Cardiology; Centers for Disease Control and Prevention. An effective approach to high blood pressure control: a science advisory from the American Heart Association, the American College of Cardiology, and the Centers for Disease Control and Prevention. *Hypertension*. 2014;63:878–885. doi: 10.1161/HYP.0000000000000003.
6. James PA, Oparil S, Carter BL, et al. 2014 evidence-based guideline for the management of high blood pressure in adults: report from the panel members appointed to the Eighth Joint National Committee (JNC 8). *JAMA*. 2014;311:507–520. doi: 10.1001/jama.2013.284427.
7. Graham R, Mancher M, Miller Wolman D, Greenfield S, Steinberg E, eds; Institute of Medicine (US) Committee on Standards for Developing Trustworthy Clinical Practice Guidelines. *Clinical Practice Guidelines We Can Trust*. Washington, DC: National Academies Press (US); 2011.
8. Eden J, Levit L, Berg A, Morton S, eds; Institute of Medicine (US) Committee on Standards for Systematic Reviews of Comparative Effectiveness Research. *Finding What Works in Health Care: Standards for Systematic Reviews*. Washington, DC: National Academies Press (US); 2011.
9. Jacobs AK, Anderson JL, Halperin JL, et al; ACC/AHA Task Force Members. The evolution and future of ACC/AHA clinical practice guidelines: a 30-year journey: a report of the American College of Cardiology/American Heart Association Task Force on practice guidelines. *Circulation*. 2014;130:1208–1217. doi: 10.1161/CIR.0000000000000090.
10. Wright JT Jr, Fine LJ, Lackland DT, Ogedegbe G, Dennison Himmelfarb CR. Evidence supporting a systolic blood pressure goal of less than 150 mm Hg in patients aged 60 years or older: the minority view. *Ann Intern Med*. 2014;160:499–503. doi: 10.7326/M13-2981.
11. Wright JT, Williamson JD, Whellon PK, Snyder JK, Sink KM, Rocc MV, et al. A randomised trial of intensive versus standard blood pressure control. *N Engl J Med*. 2015;373:2103–2116.
12. Williamson JD, Supiano MA, Applegate WB, et al; SPRINT Research Group. Intensive vs standard blood pressure control and cardiovascular disease outcomes in adults aged ≥75 years: a randomized clinical trial. *JAMA*. 2016;315:2673–2682. doi: 10.1001/jama.2016.7050.

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