

The future of European Nephrology ‘Guidelines’—a declaration of intent by European Renal Best Practice (ERBP)

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Keywords: ERBP; guidelines

Introduction

The disparities of medical practice, together with a growing number of possible interventions, have increased the demand for well-conceived guidance for practitioners [1]. However, this development is hampered by the number and quality of scientific studies that test medical hypotheses, which are often unsatisfactory. This is especially true in nephrology, where well-conducted controlled trials are rare [2]. Because patients with renal failure are generally excluded from controlled studies in the general population [3], the development of sufficiently well-founded guidance in nephrology has always been difficult.

With the development of European Best Practice Guidelines (EBPG), the European Renal Association–European Dialysis and Transplantation Association (ERA–EDTA) has created its own guidance-generating process. Similar initiatives have also arisen in the USA (Kidney Disease Outcome Initiative—K/DOQI), Australia (Caring for Australasians with Renal Impairment—CARI), Canada

(Canadian Society of Nephrology—CSN), the UK (United Kingdom Renal Association—UKRA), as well as at several other locations around the world. These institutions have generated a plethora of often parallel recommendations on similar topics but sometimes with different messages [4].

The question can be asked: ‘Is there still a place for an institution generating European nephrology guidance?’ If there is, how should such an initiative be managed to conform with current demands? To answer these questions, the Council of ERA–EDTA set up a commission that convened three times in the course of 2008–09.

The present text is a distillation of the discussions, reflections and final conclusions of this commission. It is an *ad hoc* document, reflecting the current status. In the future, concepts and attitudes might change, as medical thinking is influenced by changes in practice, needs, general philosophy, ethics and political/financial conditions.

Potential future of European nephrology guidance

The nephrology guidance landscape was thoroughly modified with the advent of the Kidney Diseases Improving Global Outcome (KDIGO) initiative, a body that

Table 1. Documents generated up till now by the European Best Practice Guidelines (EBPG)

Topic	Year
EBPG	
Anaemia	1999
Transplantation (pre-transplantation)	2000
Ca/P algorithm ^a	2001
Haemodialysis (first wave)	2002
Transplantation (post-transplantation)	2002
Anaemia (update)	2004
Peritoneal dialysis	2005
Haemodialysis (second wave)	2007
ERBP	
Anaemia ^b	2008
Hepatitis C ^b	2008

^aNo real 'guidelines' but series of algorithms, generated by European experts, not under the responsibility of ERA–EDTA.

^bPosition statement.

establishes global nephrology guidelines on a worldwide basis [5]. However, the number of topics and necessary updates is too large to be dealt with by KDIGO alone. KDIGO have therefore installed a coordination task force having representation from all other major guidance initiatives. It was originally thought that KDIGO would cover the whole spectrum, producing new and updated nephrology guidelines on any theme considered suitable. In 2006, the KDIGO Board of Directors decided to concentrate on selected topics only. This opened up a new opportunity for existing guidance bodies, both European and other, to take a more active role in the formulation of nephrology recommendations.

History of European nephrology guidance initiatives

The ERA–EDTA has produced nephrology guidance documents since 1999 on the treatment of renal anaemia; haemodialysis; peritoneal dialysis and transplantation (Table 1) [6]. Clinical nephrology recommendations have not yet been generated. Whereas guidance produced by other bodies (e.g. K/DOQI) has often been restrictive and focused on specific themes, the design of European guidance, in general, has been more comprehensive, at the expense of taking a position in areas where the evidence was weak. EBPG produced only one update, in 2004, on anaemia. EBPG has also collaborated with K/DOQI on bone metabolism; hypertension in CKD; cardiovascular disease in dialysis and anaemia (2006 update) and with KDIGO on hepatitis C [7]. Also to be noted is that K/DOQI invited several European experts who, in the final drafts, were referred to as 'liaison' members to the work groups. Several European experts are collaborating with KDIGO on the upcoming guidelines on bone and mineral metabolism and on the care of the kidney transplant recipients.

Outline of further action

Before starting a specific action, a think tank of 20 European experts in guidance development was appointed by

the ERA–EDTA Council to develop over a ± 1 -year period a further plan for the future. The group was mainly composed of the physicians who are the most affected by these documents, i.e. nephrologists, including a paediatric nephrologist and renal epidemiologists. Several members had previously participated in the development of EBPG on anaemia, haemodialysis, peritoneal dialysis or transplantation; some of the participants had also been involved in the development of K/DOQI and KDIGO guidelines (Table 2), whilst others serve on the ERA–EDTA Council. During the course of its activity, the group was extended by several non-nephrologists, i.e. a clinical scientist, a renal nurse and a patient who also worked for 33 years as a general practitioner (Table 2).

Although a further extension of the group by non-nephrologists (e.g. by an ethicist) was considered, this was eventually deemed unnecessary at the current time. If there is a need, *ad hoc* advice will be sought from specific experts.

The group mentioned above will serve as Advisory Board, meeting on a regular basis several times a year to consider potential topics, the need for updates and adaptations to existing documents and their implementation. This Advisory Board should take decisions about further action based on existing and new evidence. This Board should appoint extended scientific area work groups (involving experts in a specific field) (see the 'Composition of work group' section). Members of this Advisory Board should be selected by the Council of ERA–EDTA based on their specific competences and CVs. The Board composition should be based on an alternating rotation system after a pre-set number of years, which should be specified in the Board's bylaws.

The Board should also appoint specific watchdogs (see the 'Literature watch' section), who could be defined as area experts to advise the Board about new relevant data in specific fields and the need to, or possibility of, generate new recommendations.

A change in scope and philosophy

At the very beginning of the discussions of the Advisory Board, the lack of knowledge and evidence due to a shortage of randomized controlled trials (RCTs) was acknowledged [6]. Such uncertainty creates a problem for the production of new 'guidelines' and necessitates a search for clear definitions and alternative formats, to avoid confusing those who may otherwise consider the statements as too strong if they are based on rather weak evidence. Offering guidance should be done with sufficient transparency such that deficits, due to lack of evidence, are acknowledged.

On the other hand, the need to offer guidance in areas where there is not much evidence is also recognized. ERA–EDTA has a responsibility to offer guidance from experts to clinicians especially in those areas. The latter category of guidance can be offered in a format that differs from traditional 'guidelines'. The Advisory Board decided that the best way for this to be done was to implement 'recommendations' and 'position statements' in new formats summarizing the state of the art for a specific topic, where the available evidence and/or expertise are translated into a broad European perspective. To emphasize this change in

Table 2. Members of the ERBP Advisory Board, together with their expertise, experience with other guideline bodies and nationalities

	KDIGO	K/DOQI	EBPG	Other	Expertise	Country
Abramovicz Daniel			X		TP	Belgium
Cannata Jorge	X		X		Gen	Spain
Cochat Pierre			X	Paediatrician	Gen/TP	France
Covic Adrian ^a	X			East Europe	HD	Rumania
Eckardt Kai-Uwe	X	X	X		Anaemia	Germany
Fouque Denis	X	X	X		Gen	France
Heimbürger Olof			X		PD	Sweden
Jenkins Simon				Patient		UK
Lindley Elizabeth	X			Clinical scientist	Gen/HD	UK
Locatelli Francesco	X	X	X		Gen/Anaemia	Italy
London Gérard ^b					Gen/HD	France
MacLeod Alison	X	X	X	Guideline methodologist	Gen	UK
Marti Anna				Renal nurse	HD	Spain
Spasovski Goce				Eastern Europe	Gen/HD	FYROM
Tattersall James	X		X		HD	UK
Van Biesen W					PD	Belgium
Vanholder R	X	X	X		HD	Belgium
Wanner Christoph	X	X	X		HD	Germany
Wiecek Andrej	X		X	Eastern Europe	Gen/HD	Poland
Zoccali Carmine	X	X			Gen	Italy

TP: transplantation; Gen: general nephrology; PD: peritoneal dialysis; HD: haemodialysis.

^aEx officio as Secretary Treasurer of ERA-EDTA.

^bEx officio as President of ERA-EDTA.

scope, it was decided to modify the name from EBPG to ERBP (European Renal Best Practice) [6].

The structure is functioning under the ERA-EDTA, with an Advisory Board (see the 'Outline of further action' section) that serves as one of the Advisory Boards of ERA-EDTA. The Advisory Board decides the topics on which statements should be made, the format (i.e. recommendation, guideline, position statement or other) appointments the chairmen of the work groups that are going to address a particular topic, and reviews the final draft before its submission. In addition, the Advisory Board is in contact with other guidance bodies such as KDIGO to facilitate the harmonization of initiatives, and also, via the liaison task force of KDIGO, with K/DOQI, CARI, CSN and UKRA (Figure 1).

Definitions

There has been extensive discussion within both the ERBP Advisory Board and the KDIGO Executive Committee and Board of Directors about the terminology used in guidance documents and the methodology used to grade the quality of evidence and strength of recommendations. Tables 3 and 4 summarize the definitions and interpretations as they stood in January 2009. Worldwide the methodology is evolving, so it is possible that there will be further adaptations.

Quality of evidence

Evidence should be graded according to the GRADE system [8]. KDIGO have decided to use A, B, C and D to describe the four grades of evidence quality, based on a GRADE document published in 2008 (Table 3) [9].

The following parameters should be considered: (1) the quality of evidence; (2) the balance of health benefits and harms; and (3) the balance of net financial benefits and

Table 3. Grading of quality of evidence

KDIGO grade for quality of evidence	GRADE grade for quality of evidence	Meaning
A	High	We are confident that the true effect lies close to our estimate of the effect
B	Moderate	The true effect is likely to be close to our estimate of the effect, but there is a possibility that it is substantially different
C	Low	The true effect may be substantially different from our estimate of the effect
D	Very low	Our estimate of the effect is just a guess, and it is very likely that the true effect is substantially different from our estimate of the effect

costs; the latter element becomes increasingly important as resources become more and more limited.

Strength of guidance statements

The strength of a guidance statement indicates the extent to which one can be confident that adherence to the recommendation will do more good than harm. The level of confidence depends not only on the quality of the evidence but also on the judgment of the experts in the work group [9]. Only two statement strengths have been defined by KDIGO (Table 4), with Level 1 referring to 'strong' recommendations.

When judgment is brought in, high-quality evidence does not always lead to Level 1 guidance statements and vice versa. In situations where there is high-quality evidence

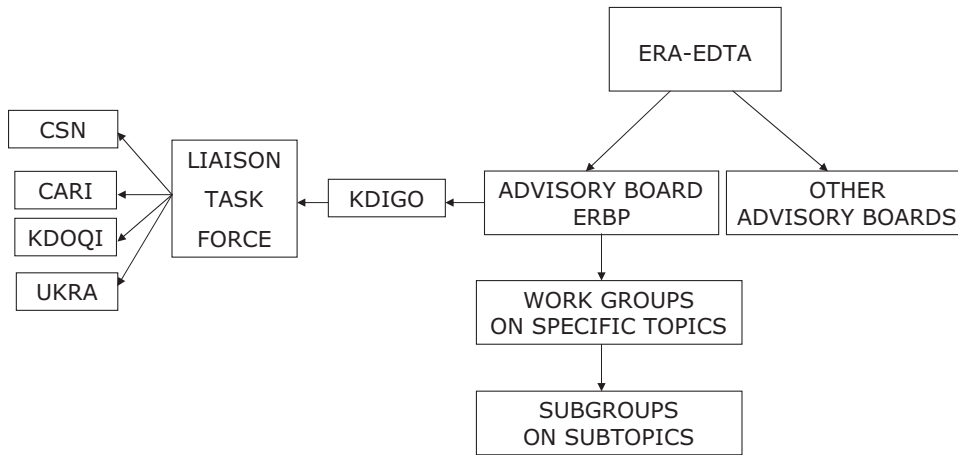


Fig. 1. Structure of ERBP and its Advisory Board, and their relation to ERA–EDTA and other guidance generating bodies.

Table 4. Grading of strength of recommendation

KDIGO grade	Implications		
	Patients	Clinicians	Policy
Level 1 ‘We recommend...’	Most people in the situation will want the recommended course of action and only a few will not	Most patients should receive the recommended course of action	The recommendation could be adopted as a policy
Level 2 ‘We suggest...’	The majority of people in the situation would want the recommended course of action, but a substantial minority would not	Different choices will be appropriate for different patients. Patients will need help to arrive at a management decision consistent with their values and preferences	There is a need for substantial debate and involvement of stakeholders

that an intervention would be effective, but the intervention has frequent and/or serious side effects, the strength of the guidance statement may be moved to Level 2 (‘weak’).

Lower quality evidence, based on good clinical practice or widespread experience that is unlikely to be tested by an RCT, could lead to a Level 1 guidance statement if the work group members judge the intervention to be beneficial, and if the risk involved is low enough to allow the intervention to be used unconditionally in most cases (e.g. the use of dialysis to treat end-stage or acute renal failure; the use of anticoagulants in haemodialysis).

When the strength of the guidance statement and the evidence quality are combined, there are eight grades (1A to 2D). KDIGO are intending to use this system based on symbols, rather than words. The ERBP Advisory Board felt that the guidance statements should give both the overall grade and an explanation of the grade for each statement in words. For example: ‘Grade 2D (weak recommendation; low-quality evidence)’.

Within the KDIGO system, it is also possible to make an ‘ungraded’ statement. The wording for these statements is likely to be ‘It would be reasonable to...’ rather than ‘We recommend/suggest...’. ERBP accepts this ninth grade as well. To avoid confusion, it is, however, recommended to only use this kind of statement exceptionally.

To emphasize the difference between graded and ungraded statements, the former should be boxed, but with

Level 1 statements in bold, and ungraded statements should be unboxed bullet points.

Guidance documents

Currently, KDIGO are using the word ‘guideline’ to refer to the document (the ‘book’) containing all statements, regardless of the overall grade. Where insufficient evidence is available, the ERBP Advisory Board prefers to refer to the document as ‘best practice recommendation’ rather than ‘best practice guideline’ unless all statements contained are of Level 1.

Both KDIGO and the ERBP Advisory board are using a ‘position statement’ to describe a document that relates to best practice but is not based on a systematic literature review and a stringent process of synthesis, evaluation and external review by the group producing the document. Examples of ERBP position statements are the commentary on renal anaemia and the endorsement of the KDIGO guideline on hepatitis [10,11].

Direct activities

Adaptations of existing ‘guidelines’

The existing ‘guidelines’ should be adapted to match major new evidence. This not only implies the updating of current

guidance texts but also the development of a strategy to screen for evidence that is important enough to justify *ad hoc* changes (see the ‘Literature watch’ section—watchdog function). Recent examples of guidance documents that might need modification are the target haemoglobin levels for renal anaemia treatment where published evidence [12–14] was the subject of a specific ERBP position statement [10] and the example of biocompatibility and dialyser flux in haemodialysis, which might need reformulation after the results of the MPO study have been published [15]. For keeping existing guidance texts up to date, the most convenient option is to delegate this task to the group or members of the Advisory Board who have been responsible for the corresponding previous guideline, at the behest of the ERA–EDTA Council. If considered necessary, they should work in conjunction with experts in the field who are not Board members.

The ERBP Board’s priority must be to update existing ‘guidelines’ rather than create new recommendations, since maintaining outdated ‘ghost guidelines’ is not desirable.

Potential candidates for updating in the near future are as follows:

Transplantation. Transplantation recommendations were published by EBPG in 2000 and 2002 [16,17]. Since that time, much new evidence in this area has been generated. It has been taken into account that KDIGO is currently drafting transplantation guidelines. ERBP plans to write a position statement on the KDIGO document when it is published and to focus its recommendations on topics that will not be included by KDIGO, such as pre-transplantation work-up, both of donor and recipient; living donation; extended, non-heart beating donors; and pre-emptive transplantation. The American Transplantation Society (AST) should also be contacted to avoid overlap.

Haemodialysis. Haemodialysis recommendations were published by ERBP in 2002 and 2007 [18–22]. Especially the first wave might require updating, but probably only on selected topics such as dialysis water quality. Reformulation of other topics might be needed once new RCTs appear, such as the MPO study [15] for the adequacy of dialysis; the AURORA study and the SHARP study [23] for cardiovascular disease; or the IDEAL study [24] for the start of dialysis.

The topic on the ‘start of dialysis’ might be extended to cover the process of delivering care to patients with CKD stages 3 and 4, including the choices of available dialysis modalities, ethical considerations and the approach to older patients (see the ‘Coverage of new topics’ section).

Anticoagulation. Until now, EBPG has been focusing only on anticoagulation during haemodialysis [18]. However, also anticoagulation of dialysis patients for other reasons (e.g. in relation to cardio-vascular disease or to maintain vascular access function), anticoagulation in the earlier stages of CKD and central vein catheter locks might be taken into consideration.

Peritoneal dialysis. PD recommendations were published by EBPG in 2005 [25]. There is not much evidence in this

area. In keeping with the section above entitled ‘A change in scope and philosophy’, it is thought that the previous ‘guidelines’ would better be replaced by a position statement that refers to the 2005 documents.

Literature watch

In view of the definition of evidence quality and recommendation strength, a ‘literature watch service’ (watchdogs) for different topics has been established. Topics will be distributed among Advisory Board members. They will perform an ongoing screen for studies that ‘are likely to change the view/attitude towards a certain problem’ and that might engender a reason to adapt/update recommendations or generate position statements. The results of such screening activity will be posted through the *Nephrol Dial Transplant*-Educational literature survey.

Coverage of new topics

A second potential task is to start covering topics that have never been dealt with by European guidance bodies. This is especially true for clinical nephrology topics that fall outside the area of renal replacement therapy, e.g. IgA nephropathy, nephrotic syndrome, etc. But the decision about which topics to address should be made by the Council, advised by the Advisory Board. The decision to cover a given topic should be made after reviewing existing guidance documents from other bodies (CARI, UK, CNS, K/DOQI) to avoid overlap, and through the use of harmonization with those organizations to prevent parallel efforts. The coordination and liaison initiative from KDIGO [26] might be the correct forum to facilitate decisions in this regard.

However, updating the existing ‘guidelines’ generated in the past remains the priority. New ‘guidelines’ or recommendations should only be considered if the allotted budget allows room for new incentives.

Composition of work groups

The structure generating the documents containing the statements should consist of a number of work groups. Each work group, with a maximum membership of 16, should have a chair and vice-chair, chosen because of their personal expertise and publications. These chairs will act independently in composing their groups. If a work group has several subgroups, the subgroup chairs should be appointed by the main work group (Figure 1). The membership should preferably include non-nephrologists. Members might also be sought from outside Europe.

Recommendations on off-label therapies/drugs

Compared to other geographical areas such as the USA, the situation for Europe might be difficult since regulations, funding sources and distribution processes can differ markedly from country to country. If there are differences in approach between countries, it is often a sign of lack of evidence. Any such differences should be mentioned in the comments.

Relationship with KDIGO and other bodies

From the very beginning, ERA–EDTA endorsed the KDIGO project to produce global guidelines. KDIGO's philosophy is to globalize the evidence and localize the implementation. Many of the members of the Advisory Board of ERBP also play an active role in KDIGO. The collaboration with KDIGO should continue without neglecting our own European identity. It should be noted that since the KDIGO project came into effect, duplication no longer occurs.

KDIGO's role is concerned more with the coordination and generation of traditional guidelines and less in issuing position statements. Here lies a niche for ERBP.

Guidelines generated by KDIGO and other bodies should be considered by ERBP and endorsed if acceptable. Comments, amendments or caveats that relate to local (European) conditions may if needed be added. *Ad hoc* commissions will be appointed to produce position statements, to be published in the core journal of ERA–EDTA, *Nephrol Dial Transplant*.

Furthermore, the task of implementation is difficult for KDIGO to achieve and opens possibilities for local guidance bodies.

Other examples of the interaction between KDIGO and ERBP currently include mutual links at the respective websites and the liaison task force (see the 'Coverage of new topics' section).

Apart from KDIGO, many other bodies are active in the generation of guidance. Those initiatives may be reviewed by ERBP members, without ERBP formally endorsing them. Other initiatives may be endorsed by ERBP or published under joint responsibility with ERBP. The Advisory Board will decide the direction to be followed taking into account the level of evidence, the impact on the nephrological community and patients and the available resources.

Conceptual changes

EBPG have always been developed based on a great deal of voluntary effort. The number of experts involved has been low, the support structures weak and the work load enormous. The following modifications are introduced.

Literature search

Literature search and evidence rating should be offered by an external professional resource, e.g. the Cochrane group. The literature search should be constructed on specific questions based on the PICODD system [27] (Table 5).

The search should be performed in an organized, objective manner. A specific, predefined procedure should be adhered to, avoiding any bias. A restriction according to the impact factor and/or a limitation to only RCTs might be considered. The algorithm should be traceable.

Meta-analyses

Meta-analyses are a difficult tool for evidence assessment and may themselves be prone to bias [28]. They are only

Table 5. PICODD system for the literature search

Abbreviation	Topic of questions
P	Population
I	Intervention
C	Comparison
O	Outcomes
D	Design of study (e.g. RCTs)
D	Duration of follow-up

RCTs: randomized controlled trials.

considered useful as part of a systematic review including interpretation and quality assessment of the publications under consideration. They should only be used to provide an answer to questions that cannot be solved otherwise, are strongly dependent upon the quality of the studies included and may be only 'the best available' evidence until a definitive large study is done [28].

Peer review

The following groups could be considered to perform peer review (list non-exhaustive):

Public (interested individuals). The pre-final draft can be made available for the peer review to the public, especially for guidance documents of a more extended format than position statements. This will mean that the draft will be sent to all members of ERA–EDTA.

Interested societies. It could also be made available to potentially interested societies or other guidance bodies (e.g. European Dialysis and Transplantation Nurses Association/European Renal Nurses Association—EDTNA/ERNA, KDIGO, K/DOQI, ...).

Experts. These should be selected experts, partly non-European and non-nephrologists.

ERA–EDTA appointed reviewers. Both the members of the ERBP Advisory Board and the members of the ERA–EDTA Council, as far as they were not involved in the development of the document under consideration, may take part in this process.

The members of the ERBP Advisory Board who produce the text should be able to identify the relevant interested societies and many of the relevant experts. A literature search should pick up authors not known to the working group.

The system currently used by <http://mc.manuscriptcentral.com> for the review of submitted papers might be adapted for the purpose of reviewing and commenting on the draft. This would allow reviewers to be tracked and prompted for comments.

There is a tendency for reviewers not to feed back if they are happy with the contents, but it is impossible to perceive whether the lack of response is due to acceptance or failure to read the document. Ideally, ERBP should develop specific tools to define, with minimal effort to the reviewer:

- Which sections were taken into consideration by the reviewer?

- How strongly he/she agreed or disagreed with each recommendation?
- What were his/her reasons for disagreement?
- What was his/her impression of the quality and completeness of the rationale?

Implementation

Any implementation strategy should have an impact at three levels: (1) increasing knowledge, (2) changing attitudes and (3) changing outcomes by improving patient health and quality of care. There are several obstacles that impede proper implementation. Many physicians feel that best practice 'guidelines' represent an erosion of clinical freedom. On the other hand, in specific countries and in specific units within countries, local circumstances related to economic conditions, organization of health care delivery or even legal, political or cultural constraints might render the implementation difficult.

Guidance documents are not always sufficiently disseminated down to the level of local users. Their formulation is often too theoretical and too academic, and especially at the level of primary care there may be doubts of the applicability of research findings. Implementation should be followed up by quality management programmes. Once an implementation process is applied, it should be continuously monitored and evaluated. Clinical audit and local service evaluation are quality enhancement processes that seek to improve patient care and outcomes through the systematic review of care against explicit criteria; the final aim is the implementation of change.

Feedback should be obtained on what works, what is difficult (including the economic effects) and what is counterproductive.

Hence, the question is how to implement implementation. For this to come to pass, several specific tools are available.

Presentation at ERA–EDTA meetings and other conventions

ERA–EDTA has a long-standing experience with the presentation of its guidance documents at its own general meetings. From now on, each upcoming ERA–EDTA meeting will strive to contain at least one session on recent advances with ERBP. In addition to the specific content of guidance documents, the following messages should be conveyed: (1) the important distinction between the strength of evidence levels and their impact on the format of guidance delivery and (2) the present status of guidance development and publication, to avoid the confusion the general nephrologist faces with a profusion of documents on the same topics (KDIGO, ERBP, K/DOQI, CARI, etc.).

Additional initiatives should be considered in the following fields: presentation of ERBP documents at other general meetings [e.g. American Society of Nephrology (ASN); European Society for Organ Transplantation (ESOT)], at specific meetings; at small interactive ERA–EDTA CME programmes, recommended as one of the most effective tools as this results in dissemination at local level. Such

sessions could be organized in conjunction with Nephrology Society meetings, with simultaneous video transmission to up to 20 other locations. Two such meetings might be considered each year. A first initiative will be taken after the publication of the ERBP position statement [11] on the KDIGO hepatitis guidelines [7].

Publications and availability on websites

ERA–EDTA has an established ability for extensive publication of guidance documents (Nephrology Dialysis Transplantation—NDT) and making them accessible on websites (http://www.oxfordjournals.org/our_journals/ndt/era_edta.html). All these aspects should be maintained, and several practical steps should be taken to further improve electronic access:

- To present the ERBP position statements.
- To add a link to the KDIGO website in the section 'other guidelines'. The KDIGO website (<http://kdigo.org/>) contains a comprehensive overview of all major guidelines/recommendations and compares guidance statements worldwide about major nephrology issues.
- To add a search engine that would operate on the documents posted on the website.

Accessing guidance documents via internet will likely become the norm. On-line access has many advantages including the following:

- easy searching,
- links to references (PubMed abstract or full text publications),
- links to glossary of terms (e.g. strong, weak. . .) and
- option to use colour and pop-ups.

CD-ROMs, email blasts

Once the first three ERBP position statements have been published (one on the name change [6]; one on hepatitis C [11] and one on anaemia [10]), CD-ROMs and/or e-mail blasts can be sent out containing these texts separately or together.

Quiz

Similar to the initiatives previously taken after the publication of EBPG 'guidelines', quizzes allotting CME points will be published in NDT-Educational. The KDIGO hepatitis C guidelines and the ERBP hepatitis C statement will be the first incentives to generate such a quiz.

Audit

The next implementation step is to audit the application of the recommendations, either at national or at supranational level (EDTA registry and others).

This auditing step might include a feedback system, either neutral (simple statement), rewarding (bonus) or punitive.

The QUEST initiative offers a useful tool to perform active and prospective studies about implementation and feasibility [29–32].

One should consider the organizations to be contacted to achieve these aims. Several possibilities are available: professional bodies; specialty representative groups; scientific/clinical associations; peer review committees; funding bodies; CME groups; public stakeholders; bodies representative for education of patients and allied health professionals. A choice and an order of preference should be made. A structured approach for acting with the help of national societies and offering them several options should be considered. Education of the allied health professions has always been a weak point of ERA–EDTA.

In addition to tackling the scepticism of practicing nephrologists, one should consider asking national societies to formally endorse ERBP documents.

Translation into other languages than English

ERA–EDTA will endorse only its own guidance documents in the original English version. However, translations are considered essential tools of external dissemination. Translation is not a simple task. Misunderstandings are an ever-present danger.

Translations by national societies will be allowed without requiring a fee. The national societies must obtain permission to make the translation from the ERA–EDTA and the Oxford University Press. The responsibility for the translations will be entirely that of the national societies concerned. No objections will be raised if adaptations or amendments are introduced, depending on the local conditions and needs. There will be no linguistic double check of contents. All published ERBP texts (also position statements) should contain the disclaimer: ‘This is the only official version endorsed by ERA–EDTA. Any translation or other adaptation is the responsibility of the body issuing the new text.’

If the translation is requested by industry, approval should be given by the ERA–EDTA Council and the publisher, with reference to the financial aspect as well. A linguistic double check is compulsory in those cases.

Abbreviated versions

Abbreviated versions typically contain only the recommendations and might be published separately (e.g. as a publication in *Nephrol Dial Transplant*), with the full-length version in a supplement of *Nephrol Dial Transplant Plus*. Abbreviated versions may also be distributed separately, e.g. as booklets. Abbreviated versions will not be generated for existing previous EBPG, but only for future ERBP texts that are yet to be developed.

Financial support

Financial support will be offered by ERA–EDTA in the context of its educational and research activities.

Supportive structures

One should consider creating a structure that offers specific professional support. This might include the following:

- (1) Board of directors (ERBP Advisory Board members) chaired by the Advisory Board coordinator.
- (2) Development staff
 - Nomination of a non-medical manager (main duties: contact person for ERBP Advisory Board; fund raising).
 - Specific secretarial support structure (financial manager; secretary).
- (3) *Communication division*: The involvement of PR professionals is strongly recommended in order to improve dissemination. Communication strategies generating official press releases, involving medical and non-medical media, should be developed.
 - *Communication strategies*: After the development of the ‘guidelines’, the next step is the marketing effort, both internal and external. Marketing efforts need to be ongoing, repetitive and via different media.
 - (a) *Internal marketing*. Internal marketing is mainly focused on hitting the targeted stakeholder groups through the production of flyers, the organization of dedicated sessions at scientific meetings (see the ‘Presentation at ERA–EDTA meetings and other conventions’ section) and regular newsletters. Particular ERA–EDTA newsletters to subscribers (members and non-members) should provide a tutorial link that might guide the users through a series of informative demonstrations and scenarios on how to consult clinical practice guidance and related documents.
 - (b) *External marketing*. The following multimedia tools are considered: newspaper articles, meetings with health forums, press conferences or one-to-one interviews (during annual ERA–EDTA meetings), press releases to be sent to European and non-European journalists, to influential newspapers and news agencies (i.e. Reuters, DPA) and establishing a virtual ‘press room’ (making information available online). Press releases should provide a concise document that summarizes recommendations for clinicians (Quick Reference Guide) including the reasons why the document was developed/needed as well as person-to-person organization allowing contact for additional information.
 - (c) *‘Linkage’—an example of internal and external marketing*: Every document produced by ERBP should be branded with the ERBP logo (Figure 2). The logo immediately gives recognition to ERBP projects and favours the liaison with other international guidance groups.

The ERBP webpage with its specific logo should offer an interactive summary of clinical practice guidance



Fig. 2. ERBP logo.

on nephrology that might potentially help the comparison among current recommendations for all users.

Conclusions

In the present text, an overview is given on how the activities of European Renal Best Practice (ERBP), which replaces the previous European Best Practice Guidelines (EBPG), are planned to be developed in future years. The main focus will be on the distinction, in format, between guidance/recommendations/and position statements that are not well evidenced and guidelines, which are.

Conflict of interest statement. None declared.

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Received for publication: 3.3.09; Accepted in revised form: 3.3.09