

Are global nephrology guidelines feasible?

Garabed Eknoyan

The need for a common approach to treating diseases has long been expressed. In the introduction of his classic book from the first century, *De Medicina*, Celsus states the following: “They also say that the methods of practice differ according to the nature of localities, and that one method is required in Rome, another in Egypt, another in Gaul; but that if the causes which produce diseases were everywhere the same, the same remedies should be used everywhere.” Over time, although the causes of diseases have been shown to be ‘everywhere the same’, their treatment continues to differ. Such variations were magnified after the Second World War, when the number of remedies increased exponentially, and the flourishing pharmaceutical industry started to influence practice. Further variations in quality and cost occurred over time. Initial attempts to address the differences (e.g. utilization review, medical practice profiling and preauthorization) were all managerial measures and were driven by costs. A turning point occurred in 1989, when the Agency for Health Care Policy and Research (AHCPR; now the Agency for Healthcare Research and Quality) was created by legislation in the US to provide objective science-based information to improve decision-making in health-care delivery. A major contribution of the AHCPR was the establishment of a systematic process for developing evidence-based guidelines. Since then, rigorously developed evidence-based guidelines, when implemented, have improved quality, cost, variability, and outcomes (Institute of Medicine [2001] *Crossing the quality chasm*. Washington, DC: National Academy Press).

Nephrology guidelines began to be developed in 1993. Such guidelines initially focused on dialysis but expanded to cover chronic kidney disease (CKD) and proliferated as increasing numbers of organizations developed their own guidelines. The need for a unified approach became evident for the following reasons: CKD

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prevalence is increasing worldwide; complications and problems encountered by patients with CKD are universal; local resources may vary, but the evidence-based care of patients with CKD is independent of geographical location; there is room for improving international cooperation in the development, dissemination and implementation of guidelines. Kidney Disease: Improving Global Outcomes (KDIGO), a non-profit foundation, was established in 2003 “to improve the care and outcomes of kidney disease patients worldwide through promoting coordination, collaboration, and integration of initiatives to develop and implement clinical practice guidelines” (Eknoyan *G et al.* [2004] *Kidney Int* 66: 1310–1314).

The first KDIGO guidelines—on hepatitis C in CKD—were published in April 2008 ([No authors listed] [2008] *Kidney Int* 73 [Suppl 109]: S1–S99). Two others (one on CKD-related mineral and bone disorders and one on care of the kidney transplant recipient) are nearing completion, and a fourth (on acute kidney injury) has just been started. Completion of any guideline is, however, only a first step. Guideline implementation is required for recommendations to be translated into clinical practice and improve patient outcomes. This next phase—adoption and implementation of global nephrology guidelines—involves regional decision-making. Given the differences in health-care systems and available resources in different regions, the prioritization of guideline recommendations must be undertaken locally, based on the evidence presented in global guidelines. A regional effort is fundamental and provides a rationale for having global guidelines. Essentially, instead of devoting regional energy and scarce resources to the duplicative effort of developing guidelines, such resources can be allocated to the implementation of guidelines. In other words, global guidelines are feasible, and they can globalize the evidence while localizing the decision-making.

G Eknoyan is a Professor of Medicine in the Renal Section, Department of Medicine, Baylor College of Medicine, Houston, TX, USA.

Competing interests

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