Pocket Edition of the Diabetes Guidelines Published

CHRC has responded positively to the requests of care providers and developed the Pocket Edition of the clinical guidelines, Managing Diabetes in Primary Care in the Caribbean. The Pocket Edition is a streamlined and updated version of the latter, which was published by CHRC/PAHO in 2006. It comprises eight (8) folded panels and is designed to be very user-friendly in the clinical settings.

The development of the pocket guidelines was a successful partnership between CHRC and the Trinidad and Tobago Health Sciences Initiative (TTHSI), working in collaboration with Johns Hopkins Medicine. A team including members of the CHRC Guidelines Committee and TTHSI first examined the 2006 Guidelines and determined the critical elements that should be included in the Pocket Edition. The content was then updated using recent research findings as well as recommendations from the latest international protocols such as the American Diabetic Association (ADA), European Association for the Study of Diabetes (EASD), and International Diabetes Federation (IDF).

The topics covered in the Pocket Edition include Criteria for Diagnosis; Metabolic, Blood Pressure and Nutritional Targets; Treatment Algorithm; Profile of Oral Glucose-lowering Agents; Types and Mixing of Insulin; Gestational Diabetes; and a Checklist for Tests/Measurements to be taken by the care provider on patient visits so as to ensure optimal care.

The uptake and use of the CHRC Diabetes guidelines have been the subjects of research in a number of countries and the results indicate inconsistent usage across the Caribbean. In addition, clinical audits revealed poor levels of blood glucose control and deficits in routine care. Indeed, examinations of visual acuity, foot pulses, waist circumference as well as advice on smoking, alcohol intake and exercise were either infrequent or absent. The findings of qualitative research studies conducted to identify ways to address this problem were instructive.

Care providers requested the production of a pocket version of the guidelines indicating that although the complete guidelines were appreciated as an important reference, they needed a format that was more practical and convenient.

The publication of the Pocket Edition is an important step in improving the quality of care that patients receive but it is clear that it has to be supported by targeted action at the national level. It is critical that systems be implemented to ensure that all health professionals receive a copy of the guidelines and that the dissemination is linked to or accompanied by training. In addition, the facilities required for their effective use (including drugs, lab facilities, staffing) must be in place. It has also been suggested that policies may be needed to promote their use. In some jurisdictions, payment to physicians is linked to their patients’ meeting targets related to disease control and quality of care. Such a policy may not be appropriate in the Caribbean, given the nature of our health care systems, but innovative incentive programs are needed to encourage care providers to routinely follow the best practices as described in the clinical guidelines.

Patient education and empowerment are highlighted in all CHRC Clinical Guidelines for good reason. The informed patient has a critical role in assisting practitioners to provide the
recommended standards of care. For example, when patients are aware of the best practices, they would encourage care providers to conduct the necessary tests/measurements.

The collaboration between CHRC and TTHSI also includes the development of a video that presents an overview of the 2011 Pocket Edition and highlights the changes in the guidelines since the 2006 edition. The video will be launched at the CHRC Research Conference in Guyana, April 2011.

One of the highlights of the upcoming 56th Annual CHRC Research Conference is the hosting of a mini-symposium to celebrate the life of Prof. John C. Waterlow who died on October 19, 2010 at the age of 94.

Prof. Waterlow was the first Secretary of the Standing Advisory Committee (SAC) for Medical Research in the British Caribbean. The SAC evolved into the Commonwealth Caribbean Medical Research Council (CCMRC), now known as the Caribbean Health Research Council (CHRC). He served for 43 consecutive years from 1956 as Scientific Secretary then as Honourary and Elected Member to Council until his retirement in 1998 – a clear indication of his commitment to the development and strengthening of health research in Caribbean.

He was one of the world’s leading nutritional scientists and included among his many seminal pieces of work are the research on protein turnover, the fatty liver of children with kwashiorkor and the clinical classification of childhood malnutrition (the Waterlow Classification). Among the many honours that he received during his illustrious career was at the inaugural CHRC Awards Banquet in 1995 for his outstanding contributions to Caribbean research.

Prof. Waterlow joined the then University College of the West Indies in 1950 to teach physiology and carry out research on childhood malnutrition. Significantly, he established the Tropical Metabolism Research Unit (TMRU) in 1954 and was its first Director. With the foundation that he built, the TMRU has since been the standard bearer for Caribbean health research. Of particular significance is its research on infant malnutrition, which involved studies on appropriate dietary management, growth and development, mental and psychosocial development, inter alia. Critically, treatment protocols developed at the TMRU have saved and continue to save the lives of hundreds of thousands of malnourished children and adults all over the world. It is therefore not coincidental that the majority of the leading Caribbean health researchers were either trained or worked at the TMRU.

As one of the sub-recipients of the Caribbean’s most recent Global Fund grant, CHRC has received funding to facilitate evaluations of the health sector response to the HIV epidemic in a number of Caribbean countries. Funding has also been secured to continue work in the areas of monitoring and evaluation (M&E) system strengthening and capacity development. The first phase of the 5-year grant began in January 2011 and ends in December 2012.

The conduct of these activities is particularly important given the dearth of evaluation data on the effectiveness of the various HIV programs throughout the Caribbean. Over the last decade, there has been ample funding of national and regional efforts to arrest the spread of HIV and improve the lives of persons affected, however while it is generally felt that there have been significant benefits, there is a need for hard evidence. CHRC will be working with various professionals at the national level in the conduct of evaluations. It has a critical role to
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Global Fund Grant... (cont’d)

build the capacity to evaluate programs – a recognized limitation throughout the region and an area identified as being of highest priority in the recently developed Caribbean Health Research Agenda.

CHRC is also specifically tasked with providing technical support and facilitating training on results oriented project management and performance measurement thus building the M&ES skills of professionals at government Ministries and other agencies engaged in the fight against HIV. An expected outcome of this activity is an increase in the number of evidence-based national reports that measure the progress towards the achievement of their Strategic Plan goals.

This is the second regional grant that the Pan Caribbean Partnership against HIV/AIDS (PANCAP) has received from the Global Fund. The goal of this project, costing $30M, is to reduce the number of new HIV infections in sixteen Caribbean countries and reduce mortality due to HIV and AIDS in the OECS countries. The CARICOM Secretariat has the responsibility for coordinating the implementation of the grant and more emphasis will be placed on the participation of vulnerable groups. Program activities are being implemented by seven (7) regional agencies (sub-recipients), including CHRC.

The Caribbean Medical Journal (CMJ) has had a make-over and was recently re-launched. Its energetic, multi-disciplinary editorial team is working diligently towards taking the Journal to the next level.

The CMJ is peer-reviewed and aims to present the best of Caribbean medical academia to the rest of the world. Apart from Original Scientific articles and Case Reports, the CMJ also contains Commentaries, Reviews, Opinions and Letters to the Editor. In fact the most recent issue contained a very thought-provoking article about the “Cuban Medical Brigade”. Reports on recent and notices of upcoming professional meetings are also featured. Reports of medical books are included and there is a look at the lighter side of Medicine in “Taking it Easy”.

The CMJ is the official publication of the Trinidad & Tobago Medical Association and has been published continuously since 1938 making it the oldest Medical Journal in the English speaking Caribbean. Under the guiding hand of its first editor, Dr. James Waterman, the CMJ grew into a truly regional journal which continues to thrive 70 years after the publication of the first Issue.

Submissions are welcome and these can be sent to the Editor of CMJ by email at medassoc@tntmedical.com.
In this Issue, we take a different approach in the section on Dissemination of Research Findings. The focus is on the uptake of research evidence to produce clinical guidelines. Dr. Lexley Pinto Pereira, Professor of Pharmacology at the UWI in Trinidad and Tobago and a key member of CHRC Guidelines Committees shares her thoughts on guidelines and their use.

Random Thoughts on Guidelines
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It has probably been a quarter century since clinical guidelines were first published. They became necessary because physicians were treating patients based on their own experiences, anecdotal data, results of small, short-term treatment studies, and the opinions of experts. While these approaches were useful at times, they could be very misleading.

The protocol for guideline development was set when a group of experts collectively reviewed data on the diagnosis, evaluation, and treatment of hypertension in the First Joint National Committee (JNC) Report on Detection, Evaluation, and Treatment of High Blood Pressure. Subsequent JNC reports and other guidelines incorporated evidence based on the clinical outcomes of randomized, controlled, long-term studies. Current guidelines are therefore expert consensus reports that identify, review and assess the highest quality evidence to provide health professionals with up-to-date information in a practical, systematic fashion.

Contemporary use of the term guidelines has strayed from the original ‘systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances’ of the Institute of Medicine. Guidelines development seems to have become a business; organizations modify major national recommendations, countries or regions bring out their own versions and stakeholder groups are intimately involved. For example, there are now at least three different organizational guidelines for specific hypertension population groups. One must question whether there are too many guidelines. Which set of recommendations should the practitioner follow? Is the plethora of guidelines confusing?

What is clear is that guidelines are not followed as was intended. Despite the JNC (1 through 7) specifically stating that diuretics were initial drugs of choice based on evidence, the use of these agents declined as newer medications were introduced with heavily promoted messages. In Trinidad & Tobago, salbutamol inhalation was prescribed for 98% of asthmatics studied two years after the Caribbean asthma guidelines were published and elderly patients and children received the lowest percentage of inhaled steroid prescriptions. When glycemic control was evaluated in Barbados after the first edition of the CHRC diabetes guidelines, assessment of body mass index (BMI), and non-pharmacological approaches to disease management did not meet recommendations. An audit of the second edition of these guidelines in Trinidad & Tobago, showed waist circumference and BMI were never measured, and glycosylated haemoglobin was evaluated in less than 10% of patients.

GPs believe guidelines rely on personal professional discretion, which may explain the discordance between their recognition that evidence-based guidelines are important and their lack of adherence to them. Perhaps guidelines are lost in the journey from point of preparation to point of care; perhaps they are too evidence and science driven and less customer driven. Guidelines are made for generalists by specialists but each group has different approaches to clinical practice. Rather than be seen as a cookbook of clinical practice, guidelines must be easy to assimilate, visually acceptable and user-friendly so that they can be readily applied to clinical practice. In this regard, the recent 2011 pocket edition of the CHRC/PAHO guidelines for the Management of Diabetes is a welcome new strategy for the Caribbean. Hopefully complacency will give way to inviting feedback, re-enforcing their dissemination and implementation and embedding them in systems of care.

References