Workshop on Standards for Systematic Reviews and Clinical Practice Guidelines

Systematic Review Track: Initial Steps in the Systematic Review Process

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My name is Carol Sakala, and I am Director of Programs at Childbirth Connection, a 93-year-old national not-for-profit organization that has worked continuously to improve maternity care on behalf of women, newborns, and families.

I was an early systematic review adopter. Twenty-five years ago, when I learned about the work of Iain Chalmers and colleagues to synthesize results of better quality RCTs for care during pregnancy and childbirth, I instantly knew that systematic reviews would be essential tools for providing guidance in our field and reducing practice variation and controversy. Effective Care in Pregnancy and Childbirth and its 1989 companion publications were truly path breaking and inspired the establishment of the Cochrane Collaboration to extend this work to all fields of health and medicine. A decade after the initial maternity care products, when there was little sign of uptake in this country, I worked with Childbirth Connection to establish our national program to promote evidence-based maternity care. We publicize results of systematic reviews to diverse stakeholders, commission them to fill gaps in knowledge, occasionally collaborate on preparing and updating them, and are working to create a health care system that reliably delivers maternity care consistent with best current evidence — including high-quality performance measures, guidelines, and decision aids that depend upon high-quality SRs.
I congratulate the IOM, Steering Committees, Congress, and AHRQ for two outstanding and much-needed new reports. I would like to focus my remarks today on several areas where the “Standards for Initiating a Systematic Review” are very appropriately pushing the envelope and challenging sponsors and developers.

First, the reports’ view of conflict of interest encompasses the everyday practice of clinicians, who do have a stake, for example, in whether surgery, medical treatment, or watchful waiting is recommended. The reports present striking study results that show how this type of conflict of interest can bias clinical effectiveness activities. I commend the Committee for taking the bold position that individuals with this clinical conflict of interest should be excluded from systematic review teams. This clear challenge to traditional views of authority is likely to face skepticism and resistance. I agree with the Committee that disclosure, diversified SR teams, and careful selection of the team leader can help protect against such conflicts of interest. A balance of the relevant clinical disciplines and consumer and purchaser participation on review teams or their authentic involvement at all key steps can help. The report suggests that it would be possible to find individuals with the needed clinical expertise whose employment and other conditions are free of this type of conflict of interest. I would caution that the general human tendency to look after our own people is well documented in medicine.

I also commend the Committee for recommending the development and publication of protocols and disclosure of any deviation from them as the review is carried out. The growing movement for protocol publication and registration will reinforce these crucial protections against bias and procedures for increased transparency.

I thank the Committee for its attention to the role of consumers in the development of systematic reviews. Members consulted with a consumer panel, commissioned a research paper on key organizations’ experiences with consumer involvement, and provide clear guidance in the report. Thirteen years ago, I helped
organize the Cochrane Pregnancy and Childbirth Group’s Consumer Panel to provide consumer input at various stages in the review process, and my organization continues to support that work. I also have the personal experience of being a consumer co-author of a highly accessed Cochrane Review. So I can say with confidence that consumer collaboration or consultation can work very well, complement professional contributions, and add crucial value. Typical consumer contributions include strengthening the key questions and outcomes of interest (including appropriate attention to harms, long-term effects, and quality of life), and improving the utility of the background section, research priorities, language in general, and the plain language summary. Thus, I greatly appreciate the Committee’s recommendation that consumer involvement should begin with the formulation of research questions and continue through all phases of the process. We have much to learn about effective methods of consumer involvement, and the AHRQ-funded Community Forum has begun its work to build knowledge and capacity in this area. We have much to gain from joining forces with the many global initiatives that are advancing understanding of consumer involvement in systematic reviews and other clinical effectiveness activities.

These and other Committee recommendations for publicly funded systematic reviews will press sponsors and developers to implement more rigorous processes. I am optimistic about uptake, leading to higher quality reviews, for several reasons. First, a culture of quality is rapidly ramping up in our health care system. Discourse is evolving, resistance to change is diminishing, and there is greater buy-in in comparison with just a short time ago. Furthermore, publicly funded systematic review programs will be able to incorporate mechanisms of accountability and presumably will provide adequate resources for carrying out the recommended steps and procedures. I have much greater concern about the degree to which the new standards will spill over to the great majority of systematic reviews that are produced through other channels with fewer accountability
mechanisms and limited sources of financial support. This workshop is an important start
to publicizing the new standards and bringing them into the broader culture of medicine.