The Standing Guideline Commission

Authors

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Preface

This AWMF Guidance Manual is designed to provide a tool for the scientific medical societies to create and publish up-to-date and high-quality guidelines in the AWMF Guideline Register. It is therefore divided into two parts:

Guideline Development Manual
Guideline Register Rules

The first part – with its workflow charts, aids and tools – supports the guideline developers. The objective of this part is to create guidelines for medical societies according to a reproducible procedure with the highest possible scientific standards, whilst making the development process transparent. Ways to achieve this objective include assigning responsibility for guideline development, constituting the guideline development group, the use of robust methods for evidence synthesis and structured consensus development. Additionally, declarations of interests should be obtained, and conflicts of interest identified and managed. This part equally aims to make it easier to fulfil the quality criteria mapped out in the international instrument for methodological guideline appraisal (“Appraisal of Guidelines for Research and Evaluation” – AGREE II). This part thus serves to illustrate and assure the quality of the individual guidelines in the AWMF Guideline Register.

The second part describes the procedures and rules used by the AWMF within the scope of internal quality management to keep the AWMF Guideline Register up-to-date and to maintain its high level of quality. Among others, these include the review of registered guideline projects in conjunction with already-published guidelines, their classification into "S" classes, the identification and management of conflicts of interest and checking how current each individual guideline is. Thus, the aim of the second part is to assure the quality of the AWMF Guideline Register. Overall, this Guidance Manual forms the basis for the further and continuing education of guideline consultants, coordinators and developers.

The AWMF Guidance Manual will be updated as required. Changes will be disclosed via the newsletter and the AWMF's guideline RSS feed (subscribe at https://www.awmf.org. The editors are responsible for updating. The currently valid version of the AWMF Guidance Manual is available online at https://www.awmf.org/regelwerk/downloads. The text underlined in colour is actively linked in the document. Clicking on the link will take you to the referenced site in this Guidance Manual. Pressing “Alt” + left arrow key takes you back to the original link.
Introduction: What are guidelines?

Guidelines are systematically developed statements reflecting the current state of knowledge that are designed to support doctors, members of other health care professions, patients, public, etc. in delivering appropriate care for specific health problems. They should be based on systematic searches and appraisal of the evidence and weighing of the benefits and harms of alternative methods (1, 2).

Guidelines are important instruments for quality development in health care (3, 4). Their overriding goal is to improve medical care by disseminating current knowledge that should have preferably been subjected to systematic searches and critically appraisal (5-7).

Practice guidelines differ from other sources of "processed" knowledge (systematic reviews, health technology assessments (HTA) with or without meta-analyses) in that they formulate clearly worded recommendations for action that incorporate a clinical appraisal of the objectives relevant to patients, public, etc. along with the strength and applicability of study results (8-11).

Guidelines can be understood as "treatment and decision corridors" which can or should be deviated from in justified cases. The applicability of a practice guideline or of isolated guideline recommendations should be verified for the individual situation according to the principle of diagnosis, consultation, determination of preferences and shared decision-making (3, 12-16).
Introduction

References

Objectives and structure of the AWMF Guidance Manual and Rules for Guideline Development

This AWMF Guidance Manual is designed to provide a tool for the scientific medical societies to create up-to-date and high-quality guidelines and publish them in the AWMF Guideline Register. The Manual’s objective is to assure and describe the quality of both the individual guidelines and that of the AWMF Guideline Register.

The AWMF Guidance Manual is primarily aimed at the medical societies in the AWMF that develop guidelines for the health care system. Furthermore, this Guidance Manual is designed for anyone interested in the methodology, traceability of quality and the development and implementation of guidelines in general.

This AWMF Guidance Manual is based on internationally accepted quality criteria and methodological guideline standards. Intended to provide practical instructions, it is based on quality criteria for practice guidelines defined in AGREE II.

This description follows the “life phases” of a guideline – from planning to updating. Every phase is described, including an introduction, contextual reference to the AWMF’s internal quality management (Guideline Register Rules) and to the AGREE II domains and criteria. Resources and tips, practical examples and references for further reading are also provided. Comments are explicitly encouraged and can be addressed to: imwi@awmf.org.
Planning and organisation

Rationale for guideline topic selection/updating a guideline topic

When selecting the topic for a new or revisable guideline, the first question to ask is: what is/are the perceived health issue(s) that justify the need for the guideline. Ideally, specific areas for potential improvement ought to be identified and scientifically verifiable (1-6). When updating a guideline, an attempt should be made to determine what has changed in that health care sector as a result of the guideline application and what health care problems still continue to exist (see “Planning updates”) (7, 8).

For a guideline to be accepted into practice, it is helpful to provide plausible explanations as to why the subject was selected. Information on the prevalence of the aspect of care in question, current developments and specific areas where care can be potentially improved all serve this purpose. The Goal orientation of the guideline is deduced from this information as well.

AWMF Guideline Register Rule:
None

Contextual reference to the AGREE II instrument:
Domain 1: Scope and purpose
Criterion 1: The overall objective(s) of the guideline is(are) specifically described.

Resources and tips:
Think about why you selected this guideline topic.
Possible criteria for the selection of a guideline topic may include:

- The potential for optimisation and/or improvement of the quality of care is enhanceable by a guideline
- Frequency of the aspect of care in question (e.g. prevalence, incidence)
- Variations in practice (e.g. regional differences in health care provision)
- Individual or population-related burden of disease
- Need for information relating to new health care technologies (e.g. software programs, medicinal products, devices, surgical techniques)
- Need for coordination (interdisciplinary, interprofessional, intersectoral)
- Economic importance (from a macroeconomic perspective)
- Ethical and social aspects (e.g. health equity, access)

It is advisable to document the reasons for the selection.
References


Goal orientation of the guideline

Guidelines are not meant to replace textbooks. Their use can impact the health status of particular patient groups or large parts of the population. Therefore, the objectives of a guideline should be clearly defined in consideration of who is to be reached and what is to be achieved by the dissemination and implementation of the guidelines. (1).

The starting point is a description of the Rationale for guideline topic selection/updating a guideline topic. An orientation towards clearly formulated goals that are relevant for patients, public, etc. makes it easier when narrowing down topics and formulating clinically relevant key questions that are to be covered by the guideline. It should also assist the evaluation of the guideline’s impact on health care and support its use as a tool for quality management. Therefore, it makes sense to formulate very specific objectives that can be verified when achieved (see Preparing for implementation).

AWMF Guideline Register Rule:
None

Contextual reference to the AGREE II instrument:
Domain 1: Scope and purpose
Criterion 1: The overall objective(s) of the guideline is (are) specifically described.

Resources and tips:
Example of how to word a general objective:
To disseminate evidence-based recommendations that help put health care decision-making on a more rationale-based footing. The intention is to improve the structure, process and outcome quality of care whilst empowering patients in general.

Example of how to word a specific objective:
To lower the rate of secondary vascular complications in patients after acute ischemic attacks.

References
Classification into "S" classes using systematic methods

When planning a project to create new guidelines or update existing ones, a decision ought to be made as early as possible about the envisaged development level into "S" classes ("S classification") as defined in the AWMF Guidance Manual (1-3). The “S classification" grid of the AWMF is used to differentiate between development levels, i.e. S1 expert recommendations and guidelines of class S2e, S2k or S3. The “S” stands for the extent to which a systematic methodology was applied during the guideline development process (see Introduction: What are practice guidelines? ). Every class stands for a specific methodological concept that ought to be described clearly for the users (see Formats and dissemination of guidelines, Submission for publication with the AWMF). The class is selected depending on how much effort is suitable and implementable. Thought should also be given to the need for legitimacy of the guideline implementation (convincing the target audience). When selecting a higher “S” classification as part of a guideline update, it should also be considered that the corresponding methodology needs to be adapted as well (see Updating).

AWMF Guideline Register Rule – Grid for classification into "S" classes:
https://www.awmf.org/regelwerk/stufenklassifikation-nach-systematik

Contextual reference to the AGREE II instrument:
None

Resources and tips:

<table>
<thead>
<tr>
<th>Class</th>
<th>Type of Guideline</th>
<th>Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>S3</td>
<td>Evidence- and consensus-based guideline</td>
<td>Representative committee, systematic searching, selection, appraisal of the literature, structured consensus development</td>
</tr>
<tr>
<td>S2e</td>
<td>Evidence-based guideline</td>
<td>Systematic searching, selection, appraisal of the literature</td>
</tr>
<tr>
<td>S2k</td>
<td>Consensus-based guideline</td>
<td>Representative committee, structured consensus development</td>
</tr>
<tr>
<td>S1</td>
<td>Recommendations by expert groups</td>
<td>Consensus development within an informal procedure</td>
</tr>
</tbody>
</table>

Figure 1: Classification into “S” classes using systematic methods
References

Constitution of the guideline development group: Stakeholder involvement

The substantive, topic-related appropriateness of a guideline is framed by the guideline development group, which logically represents experienced users (e.g. physicians, nursing staff, physiotherapists, psychologists, members of other professional groups) and patients, public, etc. Balancing the composition of the guideline development group lays the proper groundwork for identifying potential practical problems comprehensively and for critically appraising all relevant evidence (1-3). This helps prevent the process from being affected by potential biases arising from special interests (4-6). There is no set minimum number of participating medical societies or organisations. Their number depends on the topic, the Goal orientation of the guideline and the target group of the respective guideline. Members of the guideline development group should represent the professional and scientific expertise in the guideline’s subject area as well as patient experience (7). Whenever possible, the views and preferences of the affected population should be incorporated by its direct involvement (8).

It is additionally recommended to include at an early stage persons experienced in guideline development methodology and evidence-based medicine. These persons may be qualified members of the guideline development group or externally commissioned methodologists. The AWMF offers continuing education programmes for the qualification of guideline developers.

The more complete the guideline development group, the greater is the probability that the guideline will be accepted and applied.

AWMF Guideline Register Rule: Classification of S2 and S3 guidelines (excerpt):
If an S2k or S3 guideline (https://www.awmf.org/regelwerk/stufenklassifikationen) is involved, the guideline development group shall be representative of the target audience; proxies from the participating medical society(ies) and/or organisation(s), including the patients, public, etc., ought to participate in the guideline development at an early stage (cf. AGREE II, Domain 2, Criterion 4+5).
If an S2e guideline (https://www.awmf.org/regelwerk/stufenklassifikationen) is involved, the views and preferences of the patients, public, etc. will be sought (see AGREE II, Domain 2, Criterion 5).

Contextual reference to the AGREE II instrument:
Domain 1: Scope and purpose
Criterion 3: The target users (e.g. patients, public, etc.) of the guideline are clearly defined.
Domain 2: Stakeholder involvement
Criterion 4: The guideline development group includes individuals from all relevant professional groups.

Criterion 5: The views and preferences of the target population (patients, public, etc.) have been sought.

Criterion 6: The target users of the guideline are clearly described.

Resources and tips:
In general, the initiator/coordinator/guideline secretariat responsible for the guideline project in alignment with the target audience informs the relevant medical societies and organisations about the planned project and invites them to collaborate (see Appendix 1). To ensure efficient project management, it is best if the number of lead medical societies/organisations does not exceed three. Each medical society ought to have its own standard procedure in place for nominating representatives.

Appendix 1: Letter template “Nominating representatives”

The representatives, with their specialised areas of expertise, represent the medical society/organisation. Experience in writing and implementing guidelines is desirable. The representatives collaborate on guideline development and, during the ongoing guideline process, report the results confidentially to the medical society/organisation they are tasked to represent. It is important to clarify and define the roles and tasks of the representatives in terms of their active collaboration, reporting to their boards during the development process (including special features such as short deadlines for “Living Guidelines” see Planning updates) and as part of the global adoption by the mandating medical society/organisation. This should take place at an early stage, ideally during the constitutive meetings of the guideline development group. As appropriate, it may be helpful for the coordinators to correspondingly inform the boards of the participating medical societies/organisations since the short deadlines also affect the adoption process.
When starting to map the preferences and views of the affected patients, public, etc., consideration should be given to getting self-help organisations involved that are committed to the guideline topic. If such organisations cannot be found, consider contacting self-help umbrella organizations like the German Federal Working Group Self-Help (BAG), the German Working Group of Self-help Groups (DAG-SHG) or the National Clearinghouse for the Encouragement and Support of Self-help Groups (NAKOS). If these attempts fail, additional evidence can be gathered by targeted literature searches for studies on the perspectives of the affected patients, public, etc. or by surveying the affected patients, public etc. or conducting focus groups (9).

Guideline projects registered with the AWMF Register are publicly accessible and can be accessed via an RSS feed. This way, previously uninvolved medical societies/organisations can sign up to collaborate with the coordinators. Coordinators are advised to find out about options for getting other target groups involved or about the reasons for their non-involvement through a dialog with the inquiring parties and then to document the outcome in the guideline report.

When constituting the guideline development group, the following questions need to be answered:

- Who do the recommendations affect and who do I have get involved accordingly?
- Who could contribute to the success of the project (clinically, personally, with methodological expertise, perspectives and experiences)?
- How can the perspectives of the affected patients, public, etc. be accounted for: directly through involvement of the appropriate organisations/persons or indirectly by gathering evidence from a literature search, conducting a survey or administering surveys to focus groups?
References


Developing a project plan

A project plan that defines timelines, activities, and responsibilities will facilitate project management and financial planning. It also helps ensure that the tasks necessary for achieving a certain S class (see Classification into "S" classes) are completed and the publication is submitted by the planned date. The project plan draft should be specifically adapted to the options available to the guideline development group, reviewed regularly and updated as needed (see Assistance “Project schedule”). It is important to clarify the responsibilities and functions within the guideline development group at an early stage, ideally at the constitutive meetings. These deliberations should consider conflicts of interest (division of work for coordinators, steering committee members and representatives, methodologists, guideline secretariats and any topic-specific working groups to be set up, see Table 1).

Table 1: Guideline development tasks considering the classification into "S" classes

<table>
<thead>
<tr>
<th>Implementation according to S-class</th>
<th>Tasks</th>
</tr>
</thead>
</table>
| Planning and organisation S1 S2 S3 | • Selecting/updating a guideline topic (rationale)  
• Rationale and description of the goal-orientation of the guideline  
• Establishing the intended class (S1, S2e, S2k, S3)  
• Constitution of the guideline development group  
  o Involvement of the guideline users (target audience) and patients, public, etc. (target population)  
  o Forming a guideline steering committee, as appropriate  
  o Clarification about which methodological expertise must be included: AWMF-compliant qualification within the guideline development group or is it necessary/possible to involve external methodologists?  
• Inviting medical societies/organisations and requesting them to nominate both representatives and proxies  
• Developing a project plan  
• Establishing a funding strategy  
• Drafting clinically relevant key questions that the guideline aims to address (in collaboration with the guideline steering committee, when extant)  
• Obtaining declarations of interests  
• Registering the guideline project with the AWMF |
| Constitutive meetings S1 S2 S3 | • Discussion and conclusion of the planning phase  
• Determining if the guideline development group is well-balanced; post-nominate as appropriate  
• Presenting and finalising the methodological concept (AGREE II, project plan)  
• Revision and adoption of the key questions, prioritising endpoints and establishing a processing strategy  
• Forming topic-related working groups, as appropriate  
• Discussion on how to assess interests and manage conflicts of interest |
| Systematic review of | • Systematic searches, selection, appraisal and review of the available evidence |
## Planning and organisation

<table>
<thead>
<tr>
<th>Implementation according to S-class</th>
<th>Tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td>the evidence</td>
<td>(aggregate evidence, practice guidelines, primary studies as appropriate)</td>
</tr>
<tr>
<td></td>
<td>o Establishing the search strategy</td>
</tr>
<tr>
<td></td>
<td>o Establishing the inclusion and exclusion criteria</td>
</tr>
<tr>
<td></td>
<td>o Critical appraisal of the methodological quality</td>
</tr>
<tr>
<td></td>
<td>o Creating a guideline synopsis (if applicable)</td>
</tr>
<tr>
<td></td>
<td>o Synthesising the evidence in tabular format or by using formal instruments or strategies</td>
</tr>
<tr>
<td></td>
<td>o Determination of confidence in the quality of the evidence (“level of evidence”)</td>
</tr>
<tr>
<td>Writing draft versions</td>
<td>• Content-related work (in small groups as appropriate)</td>
</tr>
<tr>
<td></td>
<td>• Preparation of recommendations and draft texts based on the evidence included and assessed</td>
</tr>
<tr>
<td>Structured consensus development</td>
<td>• Preparation</td>
</tr>
<tr>
<td></td>
<td>• Selecting the formal procedure</td>
</tr>
<tr>
<td></td>
<td>• Discussion, clinical appraisal, adoption of recommendations</td>
</tr>
<tr>
<td>External review and overall adoption</td>
<td>• External review, e.g. as part of a consultation version</td>
</tr>
<tr>
<td></td>
<td>• Final voting in the guideline development group by email written resolution procedure</td>
</tr>
<tr>
<td></td>
<td>• Formal adoption by the boards of the participating medical societies/organisations</td>
</tr>
<tr>
<td>Guideline documents</td>
<td>• Formats for professional users</td>
</tr>
<tr>
<td></td>
<td>o Long version (only this version is binding)</td>
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<tr>
<td></td>
<td>o Short version/pocket version</td>
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<tr>
<td></td>
<td>o Slide set</td>
</tr>
<tr>
<td></td>
<td>o App version</td>
</tr>
<tr>
<td></td>
<td>o Algorithms and practical aids</td>
</tr>
<tr>
<td></td>
<td>o Indication of student learning objectives</td>
</tr>
<tr>
<td></td>
<td>• Formats comprehensible for laypersons</td>
</tr>
<tr>
<td></td>
<td>o Patient version/decision-making aids</td>
</tr>
<tr>
<td></td>
<td>o “Deciding Wisely Together” recommendations</td>
</tr>
<tr>
<td></td>
<td>• Declaration of interests of all members of the guideline development group and managing conflicts of interest (mandatory)</td>
</tr>
<tr>
<td></td>
<td>• Guideline report</td>
</tr>
<tr>
<td></td>
<td>• If not integrated in the guideline or report, any additional documents (evidence reports, evidence tables)</td>
</tr>
<tr>
<td>Implementation and evaluation</td>
<td>• Identifying potential organisational, structural, financial or staff-related barriers</td>
</tr>
<tr>
<td></td>
<td>• Description of solution strategies and envisioned activities for promoting guideline implementation</td>
</tr>
<tr>
<td></td>
<td>• Defining quality indicators, if applicable</td>
</tr>
</tbody>
</table>
## Planning and organisation

<table>
<thead>
<tr>
<th>Implementation according to S-class</th>
<th>Tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning updates</td>
<td></td>
</tr>
<tr>
<td>S1 S2 S3</td>
<td></td>
</tr>
<tr>
<td>• Notation of date (validity) and responsibilities</td>
<td></td>
</tr>
<tr>
<td>• Establishing a procedure for the status and needs analysis to identify topic areas that are to be revised</td>
<td></td>
</tr>
<tr>
<td>• For updated practice guidelines: In the updated guideline, the most important innovations should be set out at the beginning (“what's new?”), the recommendations should be marked with “verified”, “modified” and “new” and dated (year).</td>
<td></td>
</tr>
<tr>
<td>S1 S2 S3</td>
<td></td>
</tr>
<tr>
<td>• Submitting the guideline documents to the AWMF</td>
<td></td>
</tr>
</tbody>
</table>
Funding strategy

A funding strategy serves in planning and estimating the costs the guideline will incur (1). Medical societies and members of the guideline development groups make the greatest financial contribution to the practice guideline development. Most members of the guideline development group do their work on an honorary basis. The costs for a guideline may vary, depending on the topic to be addressed and the grading class intended. For this reason, it is worth preparing a rough financial framework in advance.

The AWMF supports the guideline development groups by offering basic advice free-of-charge and providing informational materials along with all the aids and tools described in the AWMF Guidance Manual. Moreover, guideline development groups receive additional methodological advice, consensus conferences moderation services as well as support in conflict resolution procedures in the form of mediation. (see Information leaflet for the methodological support provided by the IMWi).

AWMF Guideline Register Rule: Declaration of interests and managing conflicts of interest (excerpt):
The funding strategy for the development of the practice guideline is to be disclosed to the AWMF. Guidelines funded by third parties that have a direct influence on content will be rejected for publication in the AWMF Register; this is in accordance with internationally recommended and practiced policy (see Declaration of interests and managing conflicts of interest).

Contextual reference to the AGREE II instrument (2):

Domain 6: Editorial independence

Criterion 22: The views of the funding body have not influenced the content of the guideline.

Criterion 23: Competing interests of guideline development group members have been recorded and addressed.

Resources and tips:

To be accounted for in the funding scheme:

- Planning and organisation
- Guideline development
- Editing and dissemination
- Implementation
- Evaluating and planning updates
Variables necessary for estimating the time and costs required for planning each specific project

- Number of key questions (see Formulating clinically relevant key questions)
- Searches and appraisals of the evidence
  - Databases (sometimes pay-for-use)
  - Purchasing literature (sometimes pay-for-use)
  - Inclusion and exclusion criteria (sensitivity/specificity), scope of the need to search for the evidence (abstracts/full texts)
  - Volume of text/guideline structure
- Costs for personnel (secretarial offices, guideline infrastructure, methodological advice beyond the free-of-charge basic advice, moderators – see Information leaflet for the methodological support by the IMWi, commissioning external methodologists etc.)
- Costs for materials (office, communication technologies, supplies)
- Travel expenses for consensus conferences and working sessions
- Facility and TED costs at conferences
- Costs for digital tools (e.g. digital conference platforms, literature management programmes)
- Review/consultation procedures
- Adoption by the boards and/or representatives of the medical societies
- Publication, layout, translation
- Preparing for implementation (patient practice guidelines, quality indicators etc.)
- Planned commitment and time resources of the coordinators, experts and patients, public, etc.

Examples of funding grants to guideline projects

- "Proprietary contributions" by active guideline development group members
- Scientific medical societies
- Independent funding institutions (foundations)
- Guideline programmes (Programme for National Disease Management Guidelines of the German Medical Association, National Association of Statutory Health Insurance Physicians and AWMF, i.e. the German DM-CPG Programme, Guideline Programme in Oncology of the AWMF, German Cancer Society and German Cancer Aid, i.e. German Guideline Program in Oncology (GGPO)
Planning and organisation

- Funding options available under the German Digital Healthcare Act (DVG), Fifth Book of the German Social Code (SGB V) §92a+b (funding of complete practice guidelines through the German Innovation Fund) and §139 Funding for evidence searches on specific key questions by the Institute for Quality and Efficiency in Health Care (IQWiG)

- Others
  - Patient and patient advocate organisations (leagues, self-help associations)
  - Topic-related working groups/task forces – associations
  - Funding associations of charitable foundations
  - Self-governing bodies
  - Third-party payers

References
Formulating clinically relevant key questions, prioritising endpoints

When planning searches, it is essential to formulate clinically relevant key questions at an early stage. This will also make the guideline more attractive by keeping its substantive content within sensible and manageable limits. In the context of both Goal orientation of the guideline and updating, decisions should be made as to which questions or recommendations should be the centre of focus. When formulating relevant key questions, endpoints relevant to the affected patients, public, etc. should be set and prioritised. The benefits and harms of interventions should be covered here as well (1). In general, a differentiation should be made between individual patient-related endpoints and population-based endpoints. Ideally, surrogate endpoints should be validated – i.e. the direct connection between the surrogate and the directly relevant endpoint has been demonstrated – or at least has been well justified (2). At an early stage, a consensus should be reached regarding potential endpoints, ideally at the first meeting of the guideline development group. A survey can be administered to the members of the guideline development group and to the affected target population to determine the relevance of endpoints.

Furthermore, a methodological strategy for answering the key questions should be established. Possible strategies include:

- Systematic review of the evidence of the relevant recommendations (see Classification into “S” classes - Criteria S2e and S3 - and Systematic review of the evidence)
- Structured consensus development (see Classification into “S” classes - Criteria S2k and S3 - and Structured consensus development). S3 practice guidelines should list the rationale for the decision to develop consensus-based recommendations.

When planning your own systematic search, it is useful to define the clinically relevant key questions precisely according to the PICO (Patient-Intervention-Comparison-Outcome) scheme (see Figure 3). This will help identify the relevant literature by enabling a useful selection and linking of search terms (particularly in relation to the population and intervention) (3, 4). This precise definition also helps in the preparations for systematic selection and critical appraisal of the evidence as a basis for formulating the recommendations (5).

AWMF Guideline Register Rule:
None
Contextual reference to the AGREE II instrument:

**Domain 1: Scope and purpose**

**Criterion 2:** The health question(s) covered by the guideline is (are) specifically described.

**Resources and tips:**

It makes sense for the entire guideline development group to discuss and agree on the clinically relevant key questions at its first consensus meeting to define the working scope of the guideline development group. Determining the endpoints is of pivotal importance when defining the key questions. The endpoints can be collected and prioritised using a Likert scale (7-9 critically, 4-6 important, 1-3 less important for decision-making). (See Figure 2 and Constitutive meeting).

Examples of individual patient-related endpoints are disease-specific mortality, morbidity and quality-of-life. Examples of population-based endpoints include the occurrence of antibiotic resistances as well as climate compatibility (i.e. carbon footprint) and/or sustainability (i.e. avoidance of waste) of the interventions.

![Figure 2: Identifying the relevance of endpoints (outcomes)](image)

Not every key question has to be based or even can be based on systematic searches; an answer based on expert consensus is acceptable in justified cases if strong evidence is lacking and a relevant care problem is at stake (6). During this first meeting, reasons for prioritising the development strategy ought to be discussed and documented. When
formulating the key questions according to the PICO scheme, it can be helpful to define the respective setting as well. Only individual elements of the PICO scheme may be applicable to some non-interventional questions (e.g. prognostic).

Example of a clinically relevant key question:
What are the merits of pharmacotherapy for secondary prevention after acute stroke?

Example for the precise formulation of a searchable key question according to the PICO scheme:

In

\( P = \) Patients after acute stroke (ischemic attacks), can

\( I = \) the drug Clopidogrel

\( C = \) compared to ASA (acetylsalicylic acid)

\( O = \) be more effective to prevent strokes in the future?

(If applicable, additionally

\( S = \) in outpatient care.)
References

Declaration of interests and managing conflicts of interest

Definition: “A conflict of interest is a set of circumstances that creates a risk that professional judgment or actions regarding a primary interest will be unduly influenced by a secondary interest” (1-4). Conflicts of interest do not have to have a negative connotation per se. They manifest as the juxtaposition of primary interests (e.g. when practice guideline authors formulate evidence- and consensus-based recommendations aimed at improving quality of care) with secondary interests (e.g. direct and indirect financial, academic, clinical, personal), which can vary in magnitude and scope. Conflicts of interest are thus often unavoidable, but not necessarily problematic in terms of influencing guideline contents. The international community agrees that transparency and the fair, reasonable management of conflicts of interest (see position paper of the Guidelines International Network (GIN) (5), AWMF recommendations for managing conflicts of interest associated with the activities of the Scientific Medical Societies, AGREE II Criteria 22 + 23) are the decisive factors critical to the legitimacy and credibility of practice guidelines as perceived by the public and policy makers. The declaration of interests and description of how conflicts of interest are managed aim at building trust and protecting the group from any charges of bias or impartiality which may entail protracted clarification processes. They are a prerequisite for the publication of S1 recommendations for action and guidelines of class S2 and S3. A categorization proposal by the AWMF Standing Guideline Commission focused on direct, financial conflicts of interest can be found in Table 2 (valid since 2022). If applicable, additional definitions for direct, financial and indirect conflicts of interest relating to specific guideline topics may be required by the guideline development group, if applicable in coordination with the AWMF.

AWMF Guideline Register Rule: Declaration of interests and managing conflicts of interest (excerpt):

- The funding strategy for the development of the practice guideline must be disclosed to the AWMF. Guidelines funded by third parties with any direct financial interest will be rejected for publication in the AWMF Register; this is in accordance with internationally recommended and practiced policy.
- All those participating in developing a practice guideline (S2, S3) or a recommendation for action (S1) are obligated to declare their interests – in writing using a pre-printed form (see Appendix 5: Sample form for Declaration of Interests, contents can also be filled in online, see AWMF Portal “Declaration of Interests Online”); the form covers all direct, financial and indirect interests. Where applicable, indirect interests also include the mandating organisation (e.g. medical society) and the scientific focus of the individual concerned.
• The declarations should be issued upon commencement of the guideline project or by the time the invited members confirm to the coordinator that they will participate in the guideline project. For longer-term projects, the declaration must be renewed once a year until the guideline development project is completed, but at least prior to structured consensus development of the recommendations.

• It is the responsibility of the lead medical society(ies) or that/those registering a guideline project to obtain the declaration from the coordinator it has employed. It is the responsibility of the coordinator to obtain and compile the declarations from members of the guideline development group.

• The declarations should be assessed by third parties. The declarations by all members of the guideline development group, including the coordinators, must be assessed. Responsible persons ("conflicts of interest officers") should be selected for this purpose from the guideline development group members or from external circles. Alternatively, the assessment can take place during a discussion among the guideline development group.

• Once a judgment is made as to whether any conflicts of interest exist or whether there is a thematic context for the guideline overall and/or regarding specific key questions, the next step is to rank the relevance of conflicts of interest into low, moderate and high. These deliberations should consider the potential extent of the resulting conflict, the function of the individual(s) concerned within the guideline development group and the protective factors (see Figure 4).

• The declarations of interests must be presented in a standardised summary (e.g. in tabular form, see Appendix 6 and on the AWMF Portal “Declaration of Interests Online“, see https://interestserklaerung-online.awmf.org/) in the long version of the guideline or in the guideline report. In addition, the process in place for documenting and identifying interests and managing conflicts of interest should be described.

• Finalised guidelines will not be accepted into the AWMF Register if their funding leads to conflicts of interest or if the conflicts of interest of individual participants or the management of these conflicts of interest has not been transparently disclosed.
The retention and storage of data is conducted pursuant to the General Data Protection Regulation (GDPR) as currently amended. The complete set of rules on managing conflicts of interest can be found on the AWMF website https://www.awmf.org/regelwerk/erklärung-von-interessen-und-umgang-with-interessenkonflikten

Appendix 5: Sample form for Declaration of Interests
Figure 4: Algorithm for the assessment of interests and management of conflicts of interests
Table 2: Conflict of interest categorization with the respective conflict of interest management as recommended by the AWMF Guidelines Commission

<table>
<thead>
<tr>
<th>Seriousness</th>
<th>Circumstances by category</th>
<th>Consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Low</td>
<td>Individual lectures financed by the industry</td>
<td>Limitation of leadership/management function (coordination, if applicable add a peer without COI) or for the thematic working group (if applicable add a peer without COI)</td>
</tr>
<tr>
<td>Moderate</td>
<td>Activity as expert on industry-financed advisory board</td>
<td>No voting on thematically relevant recommendations or No double voting</td>
</tr>
<tr>
<td></td>
<td>Management responsibility for industry-funded study(ies)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Shareholding in individual companies</td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>Ownership interest</td>
<td>No participation in thematically relevant consultations and no voting rights</td>
</tr>
<tr>
<td></td>
<td>Employment in industry</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Major shareholding by individuals</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Companies (&gt; a certain limit)</td>
<td></td>
</tr>
</tbody>
</table>

Contextual reference to the AGREE II instrument:

**Domain 6: Editorial independence**

**Criterion 22:** The funding organisation has not influenced the guideline contents.

**Criterion 23:** Conflicts of interest on the part of members of the guideline development group were documented and accounted for during the guideline development process.

Resources and tips:

- AWMF Portal “Declaration of Interests Online” (see [https://www.awmf.org/leitlinien/interestserklaerung-online.html](https://www.awmf.org/leitlinien/interestserklaerung-online.html)) for managing the declarations of interests and their assessments – in cooperation with the Clinical Guidelines Services (CGS)-GmbH. Guideline delegates from the AWMF member medical societies apply for a password uniquely specific to their medical society. After being invited by the guideline delegates to do so, the guideline coordinators create their project and enable project-specific access to the guideline development group members. After active application for approval, guideline authors are allowed to reuse previously filled-out declarations from other guideline projects as well.
Appendix 6: Example table: Declaration of Interests and managing conflict of Interests

<table>
<thead>
<tr>
<th>Name</th>
<th>Field</th>
<th>Role</th>
<th>Interests</th>
<th>Managing Conflict of Interests</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Doe</td>
<td>Med</td>
<td>Doc</td>
<td>Yes</td>
<td>None</td>
</tr>
<tr>
<td>Jane Smith</td>
<td>Tech</td>
<td>Eng</td>
<td>No</td>
<td>None</td>
</tr>
<tr>
<td>Mr. Johnson</td>
<td>Law</td>
<td>Adv</td>
<td>Yes</td>
<td>None</td>
</tr>
<tr>
<td>Dr. Brown</td>
<td>Econ</td>
<td>Prof</td>
<td>Yes</td>
<td>None</td>
</tr>
</tbody>
</table>

Appendix 7: Aid for completing the Declaration of Interests form

References

Registering with the AWMF Guideline Register

Guideline projects must be registered with the AWMF before they can be entered in the Guideline Register and later published via the AWMF information system (see Appendices 5 and 6). This pertains to both new guidelines and updates – as a complete or partial update or as a Living Guideline with an update period set at a maximum of one year (see Planning updates). The registration promotes interdisciplinary collaboration in guideline development groups and helps avoid unresolved contradictions or duplications across the various guidelines on related subjects. Practice guidelines on related subjects that are listed when registering a guideline project can provide guideline users with further information.

The early publication of the registration on the website of the AWMF register serves to keep other interested medical societies and organisations informed and allows them to apply to the guideline coordinators if they would like to contribute. Within the scope of Guideline Register management, all registrations are inspected by the AWMF Institute for Medical Knowledge Management (AWMF-IMWi) according to the four-eye principle.

AWMF Guideline Register Rule: Registration procedure for guidelines under planning and development (excerpt):

- The registration should be made upon commencement of the guideline project or by the time the invited members confirm to the coordinators that they will participate in the guideline project.
- The currently valid pre-printed AWMF form “Registration Form” should be used to register guideline projects.
- In particular, special attention is paid to the answers to the question about possible thematic overlaps or duplications in the registration form. Various guidelines on the same health care situation (disease/symptom or intervention) and the same target users (specialisation etc.) are not included in the AWMF Guideline Register. In justified cases, different practice guidelines can temporarily be developed for the same health care setting with various target users. However, these must be free of contradictions where the sectoral borders overlap and in the continuity of care. The aim should be to maintain only one guideline on one topic.
- The predefined update periods for “Living Guidelines” are known and do not exceed 12 months.

The comprehensive AWMF rule governing the registration procedure for guidelines under planning and development: https://www.awmf.org/regelwerk/regeln-fuer-das-ll-register
Appendix 8: Registration form

Contextual reference to the AGREE II instrument:
None

Resources and tips:
The AWMF offers all its member societies an initial consultation on the planning and registration of guideline projects free of charge. Interested parties can contact imwi@awmf.org. Individuals (e.g. initiator/lead author/guideline coordinator) can register the project. The party registering the guideline notifies the guideline delegates and/or the guideline secretariat of the medical society accordingly.

To help users navigate updates submitted as partial, the sections to be updated should be indicated on the registration. The registration as “Living Guideline” is valid for a maximum of 12 months and is renewed annually – see also Planning updates.” If no update is submitted within 12 months, the “Living Guideline” status will expire. The term “Living Guideline” should be mentioned in the title. In the case of guidelines on infectious disease topics, proposals by the ART commission (Anti-infectives, Resistance and Therapy) at the Robert Koch Institute should be observed that will be included in the feedback on the submitted registration from the AWMF-IMWi.
Appendix 9: Instruction guide for completing the registration form “Guideline Project”

Have you thought of everything?

- Have you filled in the Registration Form completely?
- Registering medical society(ies): Is at least one an AWMF member society?
- Are members of the target audience and the medical societies involved in agreement?
- Does the intended S class match the planned methodology?
- Have the links to other guidelines been checked and specified in order to avoid duplication and contradictions due to unclear content?
- Submit the registration to anmeldung@awmf-leitlinien.de
Guideline development

Constitutive meeting

The first joint meeting of all medical societies and organisations involved in the development of the guideline serves as a forum for everyone to get to know each other, to introduce the methodical approach to guideline development according to the AWMF Guidance Manual, to discuss and complete the tasks from the planning phase, whilst as well as for introduction to scientific and content-related guideline development. The first meeting is organized and held at the start of guideline development, or when updating, usually after the guideline has been registered. This meeting is recommended for all guideline classes (1).

Checking the comprehensiveness of the guideline development group

This involves making sure the guideline development group is comprehensive and determining if other medical societies and organisations should get involved (see: Constitution of the guideline development group: Stakeholder involvement).

The comprehensiveness of the guideline development group is not necessarily a prerequisite for S2e guidelines.

Definition of the key questions and endpoints

The pre-formulated clinically relevant key questions are discussed in the guideline development group, supplemented as needed and agreed on by consensus. Firstly, it is essential to set the endpoints relevant to the patients, public, etc. (see Formulating clinically relevant key questions, prioritising endpoints).

Definition of the strategies for answering the key questions

For every clinically relevant key question, it is helpful to determine whether it should be answered on the basis of a systematic search for aggregated evidence, primary studies or, if necessary, by adapting the guidelines. In justified cases, an answer based on expert consensus is also possible (2) (see Formulating clinically relevant key questions, prioritising endpoints). Search strategies should also be planned at the constitutive meeting. Search strategies are then elaborated on with defined responsibilities, including the members of the guideline development group involved in the processing and external methodological experts involved.
Establishing the organizational structure, work plan and time schedule

At the first meeting, the organisational structure and timescale are defined as is an activity plan delineating responsibilities within the guideline development group (see Project plan). Depending on the planned scope of the guideline, it can be useful to establish a guideline steering committee and topic-specific working groups to deal with clinically relevant key questions/problem areas. In addition, it will be decided whether a guideline secretariat should be set up and what tasks, if any, methodologists should be given. At the end of this meeting, all participants have information about what the content of the guideline should look like and who is taking on which tasks (1, 3, 4).

Determining how to manage conflicts of interest

Another objective of the constitutive meeting is to discuss the declaration of interests and the managing of conflicts of interest according to the AWMF Guidance Manual (see Declaration of interests and managing conflicts of interest).

AWMF Guideline Register Rule: Classification of S2 and S3 guidelines (excerpt):

If it is an S2k or S3 guideline:

- The guideline development group is representative of the target users and representatives of the medical society(ies) and/or organisation(s) to be involved accordingly, including the patients, public, etc. are involved in the guideline development at an early stage (see AGREE II criterion 4+5).

If it is an S2e guideline:

- The views and preferences of the patients, public, etc. are sought (see AGREE II Criterion 5).

Contextual reference to the AGREE II instrument:

Domain 1: Scope and purpose
Criterion 3: The target population (e.g. patients, public, etc.) of the guideline is clearly described.

Domain 2: Stakeholder involvement
Criterion 4: The guideline development group includes individuals from all the relevant professional groups.
Criterion 5: The views and preferences of the target population (patients, public, etc.) were sought.
Criterion 6: The target users of the guideline are clearly described.
Guideline development

Resources and tips:
- Ensuring a neutral moderation (e.g. AWMF guideline consultant)
- Set timely meeting dates (date, time, place)
- Consider whether the conference should take place as an attendance meeting or web conference
- For attendance meetings, organize the room, catering, media for the consensus conference (e.g. laptop, projector). For web conferencing, determine the online meeting tool, clarify technical questions for the participants, create options for taking part by phone, if necessary. Provide a system for voting at attendance meetings or web conferences
- The medical societies ought to have nominated their representatives by this time.
- Invitations and documents required for the meeting are sent to all members of the guideline development group in a timely manner and, if relevant, to external moderators and other participants (observers, external experts) as appropriate

References
Systematic review of the evidence: Introduction

Systematic review of the evidence involves the systematic search, selection, appraisal and processing of available evidence on defined clinical key questions relevant to the affected patients, public, etc. (see Formulating clinically relevant key questions) (1). These are drafted in advance by the guideline development group and ought to be addressed by recommendations. As a foundation for this, the key questions should be researched – without or with meta-analyses – or originally created. The results can be published by the guideline development group or by individual members in addition to the guideline itself.

Ratio of evidence-based and consensus-based recommendations for S3 and S2e guidelines

For formal evidence-based guidelines (S3 and S2e), the AWMF Guidelines Commission recommends that evidence-based recommendations make up a proportion of >50%. A recommendation is “evidence-based” when the underlying evidence for the key question to be answered by the pertinent/applicable recommendation was systematically researched, the patients were included in the study based on prospectively established Inclusion and exclusion criteria, a critical appraisal of the power and reliability of the studies was undertaken, and a level of evidence or quality was assigned. This also includes documentation of the steps for research, critical appraisal, assigning a level of evidence or quality. The contents of the study should either be presented in the background text or as supplements in evidence tables. As a result of formal evidence-basing, the quality of the published evidence on a key question becomes transparent (see .Evidence-based guideline recommendations in S3 guidelines: AWMF regulations and recommendations of the AWMF guideline commission", document in German language).

AWMF Guideline Register Rule: Classification of S2 and S3 guidelines (excerpt):

If it is an S2e or S3 guideline:

- A systematic search, selection and critical appraisal of scientific evidence for relevant clinical key questions are required.
- Systematic methods are used to search for the evidence, i.e. the search strategy is described in detail with a list of the search terms and sources used (such as electronic databases, databases of systematic reviews or guidelines, hand-searched specialised journals or conference reports), time frame for the literature search and number of hits (see AGREE II Criterion 7).
- The selection criteria for the evidence are presented explicitly. Inclusion criteria (target population, study design, comparisons, endpoints, language, context) and exclusion criteria are presented (see AGREE II Criterion 8).
• The evidence researched and selected according to criteria established a priori is assessed with respect to its methodological quality and the results are summarized as an evidence overview. This can be in tabular format with comments on quality aspects or by using formal instruments or strategies, e.g. Cochrane Risk-of-Bias Tool, GRADE (Grading of Recommendations Assessment, Development and Evaluation) methodology (see AGREE II Criterion 8+9).

• The result of the assessment determines the confidence in the quality of the evidence (“level of evidence”).

• The recommendations are clearly linked to the description of the underlying evidence in a corresponding section (background text) and/or to an evidence synthesis with a reference list (see AGREE II Criterion 12).

Contextual reference to the AGREE II instrument:

Domain 3: Rigour of guideline development

Criterion 7: A systematic search for evidence was made.

Criterion 8: The criteria for selecting the evidence are clearly described.

Criterion 9: The strengths and weaknesses of the evidence are clearly described.

Criterion 12: The underlying evidence can be clearly assigned to the recommendations.
Systematic searches

Fundamentally, an iterative hierarchical search process is recommended for pragmatic reasons. In the first instance, searching for aggregated evidence, using systematic reviews with and without meta-analyses is recommended as a basis for the development of one's own guideline (2).

Search for systematic reviews and meta-analyses
To limit the effort involved in researching primary studies, a systematic search for systematic reviews, with and without meta-analyses, and HTA reports is useful as well as to check whether the obtained results can answer the key questions, also with regard to how up to date they are required to be. Checking if benefit assessments from IQWiG are available is also expedient, as this evidence is processed specifically for the German health care context.

Search for guidelines
A targeted search in the AWMF Guideline Register for thematically related guidelines is always required when registering a guideline project to avoid duplication and unresolved contradictions in guidelines on related topics as well as, conversely, making it possible to refer to existing guidelines for certain topics (see Registering with the AWMF Guideline Register). To reduce the investigating party's search effort, it might make sense to limit the search to current, thematically relevant and high-quality international guidelines. One or several guidelines are selected as source guideline(s) based on their content-related appropriateness, update status, transferability to the German health care system and their methodological quality, which is systematically verified and documented for the guidelines. In general, the use of existing guidelines should not prevent the guideline development group from carrying out an additional (update) search to ensure that its own guideline is up to date (3, 4).

Search for primary studies
The search should be carried out at primary study level if systematic reviews with and without meta-analyses or existing guideline recommendations have not provided sufficient or sufficiently up-to-date answers to key questions. Here, the work might be reduced for each key question by narrowing it down to first-choice study designs (e.g. randomized controlled trials (RCT) on the efficacy of therapeutic and diagnostic interventions or to cohort studies investigating the accuracy of diagnostic tests). However, these limitations will not always be appropriate.
Search for ongoing or unpublished studies

A substantial number of all studies and trial results are not published or their publication is too much delayed (>50%) (5, 6). A search in study registers can therefore be a valuable addition to the systematic search. This can help guideline developers to find unpublished studies, additional data on published studies and study results as well as obtain information about planned, ongoing and terminated studies.

AWMF Guideline Register Rule: Classification of S2 and S3 guidelines (excerpt):

If it is an S2e or S3 guideline:

- A systematic search, selection and critical appraisal of scientific evidence for relevant clinical key questions are required.
- Systematic methods are used to search for the evidence, i.e. the search strategy is described in detail with a list of search terms and sources used (such as electronic bibliographic databases, databases of systematic reviews or guidelines, hand-searched specialised journals or conference reports), time frame for the literature search and number of hits (see AGREE II Criterion 7).

Contextual reference to the AGREE II instrument:

Domain 3: Rigour of guideline development

Criterion 7: A systematic search for evidence was made.

Resources and tips:

Detailed help on databases as well as the planning and implementation of the search strategy can be found in the manual "Systematische Recherchen für Evidenzsynthesen und Leitlinien [Systematic searches for evidence syntheses and guidelines]" (7).
Databases for searches include, but are not limited to:

- Cochrane Library (with partial databases such as CENTRAL for controlled studies)
- MEDLINE (via PubMed or Ovid)
- Embase (pay-for-use)
- Topic-specific databases, e.g. PsycINFO of the American Psychological Association (APA PsycInfo), Cumulative Index to Nursing and Allied Health Literature (CINAHL), Physiotherapy Evidence Database (PEDro)
- Guideline databases (e.g. AWMF, Guidelines International Network (GIN))
- Other sources
  - IQWiG, possibly other HTA institutes
  - Federal Joint Committee (G-BA)
  - Websites of German/other medical societies/organisations (e.g. The National Institute for Health and Care Excellence, NICE)
  - Study registries, e.g. ClinicalTrials.gov of the U.S. National Library of Medicine or German Clinical Trials Register

After selecting the databases, it is advisable for evidence-based guidelines to define search terms (Medical Subject Headings (MeSH), free text information), search period, study design and possible search limitations (e.g. only children or adults). The next step is to consult with the steering committee or the respective working group(s) or, if applicable, the entire guideline development group (e.g. by circular emails) to ensure that all relevant search terms have been taken into account. It is important to check whether the search terms need to be adapted for different databases. Collaboration with information specialists (e.g. librarians) is recommended.

It may be helpful to use search filters (logical combination of characteristic keywords), relevant to the predetermined inclusion and exclusion criteria (see Selection of evidence). Validated search filters for aggregated evidence, primary studies and guidelines can be found in the manual "Systematic searches for evidence syntheses and guidelines" (7). An example of a very simple, strictly limited search is illustrated in Fig. 5.

**With each search: Don't forget to document the search strategy including the date!**
Figure 5: Documentation of a specific/restricted search strategy in MEDLINE via PubMed

References:


Selection of evidence

Using the predetermined inclusion and exclusion criteria, the search results found/obtained from the respective data source are read through and the papers relevant to the guideline are sifted out. This selection process traditionally has 2 steps and is ideally conducted by 2 independent persons (clinically and methodologically experienced experts):

1. by title and abstract
2. by full text

AWMF Guideline Register Rule: Classification of S2 and S3 guidelines (excerpt):
If it is an S2e or S3 guideline:
- The selection criteria for the evidence are presented explicitly. Inclusion criteria (e.g. target population, comparisons, endpoints, language, context, study design) and exclusion criteria are presented (see AGREE II Criterion 8).

Contextual reference to the AGREE II instrument:
Domain 3: Rigour of guideline development
Criterion 8: The criteria for selecting the evidence are clearly described.

Resources and tips:
Inclusion and exclusion criteria may include, but are not limited to:
- Age, gender, disease status or comorbidities
- Intervention/comparison group
- Follow-up time/setting
- Study or publication type
- Language

The exclusion criteria can also be summarised in the title/abstract. Reasons for the exclusion of verified full texts should be documented for each publication (see Fig. 6). In general, conference presentations (e.g. abstracts) should not be accepted as an evidence base. Whenever guideline development group members contribute additional literature, this should also be stated. The PRISMA flowchart is useful for documenting the selection process (1). Saving the literature in a reference management program that is accessible to the entire guideline development group is recommended, starting with viewing the full-text versions.

Important note: Also list the selection process when documenting the search!
Critical appraisal of the evidence

The relevant evidence included for the guideline should be assessed in a structured way according to specified quality criteria (2). Critical appraisal includes the evaluation of the internal evidence validity (assessment of systematic errors or the risk of bias) as well as other aspects necessary for an evaluation of the trustworthiness or reliability and applicability of the evidence.

Critical appraisal of systematic reviews/meta-analyses

For systematic reviews with or without meta-analyses, it is advisable that the first step be to assess the implementation quality (including the following questions: Was the search for relevant studies comprehensive and well documented? Is the synthesis of study results adequately by meta-analysis adequate?) The use of a checklist is recommended. This should be separated from the assessment of the reliability of the studies included in the systematic reviews (with or without meta-analyses). In addition to formally assessing the risk of bias, aspects such as the study directness with regard to study population characteristics, interventions or endpoints, the consistency and/or heterogeneity as well as the accuracy of results should be assessed. Finally, the quality of the evidence is summarized in a classification grid (level of evidence, and/or quality of the aggregate evidence relating to a key question (3-5), see Assigning levels of evidence).
Critical appraisal of guidelines

For use as an evidence base, guidelines should also be assessed in a structured way with regard to their methodological quality (6). Guidelines, assessed as methodologically sound and thematically appropriate can be used in different ways for your own guidelines:

- for the adoption and/or adaptation of guideline recommendations from one or more source guideline(s)
- as a source of processed evidence (e.g. evidence tables)
- as background information and determination for one's own search requirements

If existing guidelines are used as a source for one’s own guideline recommendations, each individual recommendation should be assessed in addition to the assessment of the overall methodological quality. This includes the assessment of the appropriateness of the evidence classes and grades of recommendation given in the source guideline(s) and the literature on which the recommendations are based, as well as how up-to-date and applicable they are for the German health system (7). If necessary, an appropriate update search should be carried out.

Changes to the recommendations, e.g. due to new evidence or due to a different assessment by the guideline development group with regard to benefit/harm, ought to be justified (see also Formulation and grading recommendations).

Critical appraisal of primary studies

The critical appraisal of primary studies should likewise be criteria-supported in alignment with the underlying study design. In addition to methodological aspects of quality – just as in the case of aggregated evidence – further, clinically relevant aspects ought to be taken into account, such as direct applicability to study population characteristics, interventions or endpoints. Certain criteria should be additionally assessed, if necessary, ideally based on the PICO(S) scheme, e.g. the precision of the effects achieved, the length of the follow-up periods or the appropriateness of the comparative intervention.

Processing the assessed evidence

The assessed studies on a clinically relevant key question/subject area are synthesised in evidence tables. This promotes transparency, improves analysis and ensures traceability, and in turn, accelerates acceptance and implementation of the recommendations as well.

Alternatively to the table format, the results of the critical appraisal can be described in the accompanying text/background text. In this case, the result of the review should be documented by formal instruments or the assessment strategies. Recommendation(s) from
the source guideline(s) should be presented with the specified levels of evidence and/or grades of recommendation, whilst citing the literature on which the source guideline is based.

_Determination of confidence in the quality of the evidence - assignment of levels of evidence_
Levels of evidence are assigned after the critical study appraisal and serve to easily document the confidence in the effect estimates on which a recommendation is based. The assessment should preferably be carried out for one key question per endpoint across all studies as an evaluation of the entire evidence on a key question (8, 9). Alternatively, levels of evidence can be assigned to individual studies (10, 11).

AWMF Guideline Register Rule: Classification of S2 and S3 guidelines (excerpt):
If it is an S2e or S3 guideline:
- The evidence researched and selected according to criteria established a priori is assessed with respect to its methodological quality and the results are summarized as an evidence overview. This can be in table format with comments on quality aspects or by using formal instruments or strategies (e.g. Cochrane risk-of-bias tool, GRADE (Grading of Recommendations Assessment, Development and Evaluation) methodology (see AGREE II Criterion 8+9).
- The result of the assessment determines the confidence in the quality of the evidence (“level of evidence”).
- The recommendations are plausibly linked to the description of the underlying evidence in a corresponding section (background text) and/or an evidence synthesis with a reference list (see AGREE II Criterion 12).

Contextual reference to the AGREE II instrument:
**Domain 3: Rigour of guideline development**
**Criterion 9:** The strengths and weaknesses of the evidence are clearly described.
**Criterion 12:** The underlying evidence can be clearly assigned to the recommendations.
Critical appraisal of the evidence

Ideally, methodologically and clinically experienced/experts carry out the evidence appraisal in close consultation. The critical appraisal can be conducted centrally or by working group members. The manuals of the German Cochrane Center and the AWMF-IMWi provide helpful instructions on how to carry out critical appraisals (3, 12).

The following checklists/instruments are suitable for methodological assessment:

- For systematic reviews with and without meta-analyses:
  The AMSTAR (A MeaSurement Tool to Assess systematic Reviews) - checklist (13). In 2017, revised as AMSTAR 2 checklist with explicit consideration of the inclusion of randomized as well as non-randomized studies (14-16).

- For guidelines:
  The AGREE II Instrument (6). If no resources for a detailed appraisal are available, the appraisal can be narrowed down to domain 3 (rigour of guideline development) and domain 6 (editorial independence). When adopting individual guideline recommendations, users of the guideline should be able to see the reliability of the source guideline by adopting the level of evidence and grade of recommendation including the studies cited therein, as well as the evaluation of any additional literature based on updated searches (7, 17).

- For primary studies (depending on the study design):
  The Cochrane risk-of-bias tool I or II for randomised trials, as well as the tool for evaluating non-randomised intervention studies (3, 12, 18-20). The Scottish Intercollegiate Guidelines Network (SIGN), for example, also provides checklists with aids for filling in the form (21).
Evidence appraisal and grading systems

The GRADE approach views the available evidence from the endpoint or outcome perspective (critical appraisal of the "body of evidence" from all studies for each relevant endpoint), see Figs. 7 and 8. All of the studies included on a particular topic are assessed not only for the risk of bias due to the study design, but also for indirectness, heterogeneity or lack of precision of the results as well as for publication bias. Upgrading is also possible e.g. when studies are shown to be very effective (9, 22-27).

The 2011 Oxford classification is based primarily on the formal appraisal of the study design of individual studies with regard to their internal validity. Downgrading, e.g. in the case of a high risk of bias or indirectness, is also possible.

For an evidence-based guideline a consistent evidence appraisal scheme should be used, if possible. In the event of updates, the decision to use a new evidence appraisal scheme can be made. Parts that have not been revised can remain in the previous scheme. When selecting, it may be necessary to consider whether existing guidelines are used largely as evidence sources and which schemes are used therein. The appraisal criteria and classification(s) should be decided by the guideline development group and documented in the guideline report.

Processing the assessed evidence

In addition to information on the methodological quality of the publications included, the most important clinical characteristics and information on the effect sizes are important for users.
GIN has created an exemplary evidence table with minimum criteria, which the guideline development groups can modify depending on the topic and specific requirements (28) (see Tab. 3 and Appendix 12). Evidence profiles according to GRADE do not depict the body of evidence per study but per endpoint (see Figure 8) (8). Appraisals of guidelines can also be tabulated.

Table 3: Example of an evidence table with critical appraisal per study
Figure 8: Example of an critical appraisal per endpoint across all included studies (GRADE) (29)
References


13. AMSTAR II. Available at: https://amstar.ca/Amstar-2.php (Accessed on 03-MAY-2024)


18. Cochrane - Methodological resources and training Available at: https://methods.cochrane.org/resources-list (Accessed on 13-NOV-2020)


Formulation and grading of recommendations

Formulation of recommendations
Guideline recommendations should be formulated clearly and specifically and guide action (1). This is done by checking whether the formulations follow a conditional logic: Are the conditions for the recommended preventive, diagnostic or therapeutic intervention clearly presented (if ... then)? Are the formulations worded precisely in relation to the addressed patients, public, etc. and the intervention?

Guideline users should be informed about any alternative courses of action (see also decision-making aids in the section "Formats understandable for laypersons"). If these are not included in the recommendations, they ought to be addressed in the accompanying text.

It is also important to check whether specific recommendations are required for specific groups of people (2, 3).

Furthermore, the choice of words for the strength of a recommendation and the specified grade of recommendation should match (e.g. "we recommend" or "should" for a strong recommendation and "we suggest" or "ought to" for a conditional or weak recommendation; see Grading of Recommendations).

Differentiation between statement and recommendation
It is important to differentiate between statements (e.g. XY is effective/ineffective) and course of action recommendations (XY should be used/not be used). The formulation of actionable recommendations which explicitly account for a clinical judgment of the relevance and the applicability of study results, and which weigh the potential benefits against the harms of the target intervention is an essential characteristic of guidelines. A guideline's wording sets it apart from other sources of synthesized knowledge, such as evidence reports, systematic reviews or health technology assessments. Recommendations are meant to give the user the orientation needed, also regarding remaining uncertainties in the light of the identified study evidence. Recommendations represent the perception of the guideline development group (4).

In contrast, statements can be understood as assertions of fact that are potentially justiciable. Therefore, substantiation by citing the source (literature) or a well-documented evidence synthesis are indispensable for statements, to the extent that these are required (see Systematic review of the evidence).
Formulation of recommendations based on existing guidelines

Recommendations based on existing guideline recommendations can either be adopted unchanged or adapted, if necessary, for example, if the guideline development group comes to a different assessment of the evidence reliability or the weighing of benefits and harms. This can relate to the grade of recommendation or content. The change should be explained in the accompanying text (5) ((see "Resources and tips" – "Critical appraisal of the evidence").

Grading of recommendations

The assignment of recommendation grades serves to present the guideline development group's estimation to what extent the desired consequences of a recommendation outweigh the negative consequences (6, 7) or vice versa (8). The grading of the recommendations is based on a benefit-harm assessment and confidence in the identified evidence – especially in the effect sizes. It is also based on the views and preferences of the affected patients, public, etc. (9), incorporating the clinical expertise of the guideline development group and thus explicitly subjectively ranked elements. The more reliable the estimations of benefits and broad applicability, the more likely a strong recommendation will be issued.

In the case of S3 guidelines, the formal consensus development process for adopting recommendations focuses on clinical aspects to judge the methodologically synthesised evidence. The recommendations are then discussed on this basis. Finally, the strength of the recommendations is determined, and a grade of recommendation assigned. When discussing and assigning the grades of recommendation, the following aspects should specifically be considered in conjunction with the underlying evidence (based on (12)):

- How substantial are the expected benefits and harms of the intervention?
- How certain is the underlying evidence and/or how reliable are the effect estimates? Which endpoints or partial key questions lack evidence?
- How important are the endpoints?
- How certain is the estimation of the views and preferences of the affected patients, public, etc. and their variability?
- How much does the weighing of benefits and harms support the individual patient-relevant endpoints or potentially stand in relation to population-based endpoints like climate compatibility (carbon footprint) and sustainability (e.g. with regard to avoidance of waste) for the intervention?
- Does the cost-benefit ratio favour the intervention?
- How applicable is it estimated to be to everyday life/to different health care sectors in terms of acceptance and feasibility?
• Are there social, ethical and/or legal considerations that influence the strength of the recommendation (10)?

The level of evidence and the grade of recommendation can therefore differ. A justification based on the mentioned appraisal criteria should be documented in a comment or in the background text to the recommendation.

By additionally indicating the strength of consensus (percentage of agreement within the guideline development group) for each recommendation, the guideline users are given an impression of the extent to which all participants were in agreement.

For consensus-based guidelines (S2k), the strength of recommendations is identified and adopted during the formal consensus process. Nevertheless, it is not planned to state schematic grades of recommendation or levels of evidence because recommendations are not based on any systematic processing of the evidence. The grade of a recommendation is expressed in words.

For evidence-based guidelines (S2e), the determination of the content and strength of the recommendations can be made during an informal consensus process; the use of a structured consensus procedure is optional. When discussing and assigning the grades of recommendation, in addition to the methodological evaluation of the underlying evidence, clinical evaluation should be used, similar to the procedure for S3 guidelines.

AWMF Guideline Register Rule: Classification of S2 and S3 guidelines (excerpt):
If it is an S2k or S3 guideline:

• The methods for formulating recommendations are clearly described. This requires formal consensus techniques (e.g. consensus conference, nominal group process or Delphi method (see AGREE II Criterion 10).

• Every recommendation is discussed and voted on as part of a structured consensus development with a neutral moderator. The objectives are to find a solution to pending decision-making issues, to establish a final ranking of the recommendations (S2k guideline) and determine the grade of recommendation (S3 guideline), and to measure the strength of consensus.
Contextual reference to the AGREE II instrument:

Domain 3: Rigour of guideline development

Criterion 10: The methodological procedure for formulating the recommendations is clearly described.

Criterion 11: The health benefits, side effects and risks have been considered in formulating the recommendations.

Domain 4: Clarity and presentation

Criterion 15: The recommendations of the guideline are specific and unambiguous.

Criterion 16: The different options for management of the disease or health condition are clearly presented.

Resources and tips:
There are various schemes for grading recommendations. To date, no particular formulation has been shown to be superior (11). In studies of guidelines users and writers, negative recommendations were perceived as more binding than positive ones (12, 13). The use of the listed three-stage (see Table 4) or two-stage scheme (see Table 5 - GRADE scheme) is recommended; different wording is used.

Table 4: Three-stage grid for grading recommendations

<table>
<thead>
<tr>
<th>Icon</th>
<th>Grade of recommendation</th>
<th>Description</th>
<th>Wording</th>
</tr>
</thead>
<tbody>
<tr>
<td>↑↑/↓↓</td>
<td>A</td>
<td>Strong recommendation</td>
<td>Should/should not</td>
</tr>
<tr>
<td>↑/↓</td>
<td>B</td>
<td>Recommendation</td>
<td>Ought to/ought not to</td>
</tr>
<tr>
<td>⇔</td>
<td>0</td>
<td>Recommendation open</td>
<td>May be considered/ may be omitted</td>
</tr>
</tbody>
</table>

Table 5: Two-stage grid for grading recommendations (GRADE)

<table>
<thead>
<tr>
<th>Icon</th>
<th>Description</th>
<th>Wording</th>
</tr>
</thead>
<tbody>
<tr>
<td>↑↑/↓↓</td>
<td>Strong recommendation</td>
<td>We recommend/we do not recommend</td>
</tr>
<tr>
<td>↑/↓</td>
<td>Conditional recommendation</td>
<td>We suggest/we do not suggest</td>
</tr>
</tbody>
</table>
An open recommendation can be assigned even when using the GRADE scheme. This should be explained in the guideline text, as GRADE preferably recommends – in instances where there is an uncertainty of knowledge/evidence – to address these and to refrain from making a recommendation.

Symbols can be additionally used to distinguish clearly between the strength of recommendations; this is also possible for consensus-based recommendations see Table 4 and 5 (14).

In order to make the decision for a particular strength of recommendation transparent for all stakeholders as well as for the guideline users, a well-structured presentation of the decision-making criteria is helpful (15, 16). This is easily possible using digital guideline tools, see Fig. 8 (16, 17).

Figure 9: Example of the structured presentation of decision-making criteria for a recommendation: GRADE Evidence to Decision Framework (EtD) using the GRADEpro software
References


17. McMaster University and Evidence Prime Inc. GRADEpro. 2019. Available at: https://gradepro.org/ (Accessed on 03-MAY-2024)
Structured consensus development

Structured consensus development is aimed at discussing and adopting the recommendations and, thus, at answering the clinically relevant key questions (1, 2). Guideline development ought to be based on scientifically robust formal consensus methods like the Nominal Group Process, the Structured Consensus Conference used according to the type of the US National Institutes of Health (NIH type) and/or the Delphi Technique (see Appendix 14). Reasons for using formal procedures are that decision-making by individuals and groups is susceptible to a wide range of adverse impacts as well as the fact that formal procedures are superior to informal ones in terms of representativeness, efficiency, reproducibility and acceptance of the results (3). Selection of a suitable method ought to consider size and heterogeneity of the group, complexity of the topic and the key questions alongside existing resources (see Appendix 14). Often, a combination of various methods proves most effective. One example is the Delphi technique that uses web-based tools to gather initial trends on group projections; another is the Nominal Group Process for discussing complex topics in a working group alongside the formulation and grading of recommendations. The Structured Consensus Conference is set up for final adoption of recommendations in a large committee.

Outcome quality essentially depends on how the procedure is prepared and implemented. The recommendations to be adopted must be made available to the participants in writing with sufficient background information in a timely manner (see also Appendix 13). The previously accomplished preliminary work, objectives and pending tasks should be implemented into the consensus process itself (see Appendix 14).

It is advisable to engage an external, independent moderator trained in structured consensus development methods to identify and prevent potential sources of systematic bias and undesirable group phenomena during implementation (e.g. an AWMF guideline consultant) (3-5). The procedure and results are to be documented in the guideline report.

AWMF Guideline Register Rule: Classification of S2 and S3 guidelines (excerpt):

If it is an S2k or S3 guideline:

- The methods for formulating recommendations are clearly described. This requires formal structured consensus techniques (e.g. consensus conference, nominal group process or Delphi method (see AGREE II Criterion 10).
- Every recommendation is discussed and voted on as part of a structured consensus development with a neutral moderator. The objectives are to find a solution to pending decision-making issues, to establish a final ranking of the recommendations (S2k guideline) and determine the grade of recommendation (S3 guideline), and to measure the strength of consensus.
Contextual reference to the AGREE II Instrument:

Domain 3: Rigour of guideline development

Criterion 10: The methodological procedure for formulating the recommendations is clearly described.

Resources and tips:

- Set timely meeting dates (date, time, place)
- Organize rooms, catering, media for the consensus conference (e.g. laptop, projector, if appropriate TED system for larger groups) or the web conference (ensure that all participants have the required technical requirements, if necessary, also enable dial-in by telephone)
- In a timely manner, invite the guideline development group (moderators, working groups, representatives and any additional participants such as methodologists or individual experts without voting rights).
- Send out materials and information to the participants in a timely manner so that they can prepare for the conference
  - Draft versions of: Long version and guideline report
  - Voting template for recommendations and statements to be voted on
    (Word processing format, do not use a presentation format)

- Appendix 13: Letter template “Invitation to the consensus conference”
Appendix 14: Formal consensus development techniques

Table 6: Establishing the strength of consensus

<table>
<thead>
<tr>
<th>Strength of Consensus</th>
<th>Agreement From</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strong consensus</td>
<td>&gt;95% of participants</td>
</tr>
<tr>
<td>Consensus</td>
<td>&gt;75 - 95% of participants</td>
</tr>
<tr>
<td>Majority approval</td>
<td>&gt;50 - 75% of participants</td>
</tr>
<tr>
<td>No majority approval</td>
<td>&lt; 50% of participants</td>
</tr>
</tbody>
</table>

A consensus with acceptance of the recommendation is reached with an approval of >75% of the voting representatives. Abstentions due to conflicts of interest are deducted from the voting representatives.

Managing justified dissent:

If only majority approval, i.e. no consensus is achieved for a recommendation or if dissent is found, this is also documented in the relevant guideline section and in the guideline report.

Generally, the following options for presenting dissent are:

1. A medical society petitions to have a special vote or the reasons for justified dissent noted along with the statements that cannot be supported. The medical society itself formulates this special vote as a concrete alternative proposal, together with its justification, this will be included in the guideline.

2. A medical society petitions that the guideline report clarify that it was involved in the development process but does not support the final text of the guideline. The guideline text approved by consensus of the members of the guideline development group and adopted by the other medical societies is not revised.
3. A medical society withdraws its participation and is no longer mentioned as a participant. The guideline text remains unchanged, as is the case under 2.
4. The other medical societies involved decide about continuing the negotiations or publication of the guideline without the involvement of the dissenting medical society.

References
Identifying research needs

The formulation of recommendations will reveal whether strong research findings exist to answer a key question or whether there is a need for (further) research to fill in the gaps in evidence. Given their predominantly interdisciplinary and multiprofessional constitution, guideline development groups are ideal bodies for formulating research questions. It is recommended to concentrate on a few, relevant key questions and to select these in a criteria-based manner. These research needs should be verified with regard to the implementation options and, if necessary, also brought to the attention of those who fund research (1). In addition, questions for student research projects and/or doctoral theses can be suggested.

AWMF Guideline Register Rule:
None

Contextual reference to the AGREE II instrument:
None

Resources and tips:
In order to prioritize research questions, the criteria that are useful for selecting guideline topics can be helpful, such as the burden of disease or practice variation in care (see: Rationale for guideline topic selection). The restriction with regard to a complex of topics or to all guideline topics can be achieved by means of a Likert scale survey of the guideline development group members.

In order to stimulate research tenders if a need for research has been identified, research funding agencies such as the Federal Ministry of Health (BMG), Federal Ministry of Education and Research (BMBF), German Cancer Aid (DKH), German Research Foundation (DFG) or the innovation committee at the G-BA can be alerted to the need for research.

References
**Editing**

**Clarity and presentation**

The way its recommendations are formulated and embedded into the context of the overall guideline plays a pivotal role in a guideline's acceptance and applicability. Recommendations ought to be clearly formulated, attractively presented and easily identifiable for the guideline's users (see Formulating of recommendations).

These are some editorial aspects to consider:

- Clear and specific, emphasized recommendations with well-founded background information
- Stating the sources on which a recommendation is directly based (see Critical appraisal of the evidence)
- For S2e and S3 guidelines, stating the level of evidence and/or the grade of recommendation for evidence-based recommendations and identifying recommendations reached by expert consensus (see AWMF Rules for the Guideline Register)
- Additionally, stating the strength of consensus for S2k and S3 guidelines
- Identifying new sections and/or recommendations when guidelines are updated (see Planning updates)
- Presenting information in a structured way to allow digitalisation or the digital availability of the guideline knowledge (see Formats and dissemination of guidelines)
- Orienting towards the care process, stating treatment alternatives or embedding the recommendations in clinical algorithms (1, 2)

It should moreover be considered that for legal reasons the recommendations should only state the active ingredients and/or general drug classes and that the names of product and/or brands should be refrained from.

**AWMF Guideline Register Rule:**

None
Contextual reference to the AGREE II instrument:

Domain 4: Clarity and presentation

Criterion 15: The recommendations are specific and unambiguous.
Criterion 16: The different options for management of the disease or health condition are clearly presented.
Criterion 17a: The guideline’s key recommendations are easy to find.

Resources and tips:

- Use a template for a structured presentation of the guideline (Templates from AWMF for S2e-, S2k and S3 guidelines; (see Aids and appendices to the English Version of the “Guidance Manual and Rules for Guideline Development” (zip-Datei)) for creating new guidelines and updating existing ones)
- Presentation of recommendations in a structured format (see Figs. 10-12)

<table>
<thead>
<tr>
<th>Grade of Recommendation</th>
<th>Evidence- and consensus-based recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Anal margin cancer &lt; 2 cm in diameter without regional or distant metastases (Stage I) should be locally excised with an adequate minimum safety distance (0.5 cm).</td>
</tr>
<tr>
<td>GRADE</td>
<td>Comparison of local excision vs. radiochemotherapy, indirect evidence from retrospective comparative observational studies, mainly on anal canal cancer: Chai et al. 2018 [106]; Chakrabarti et al. 2019 [163]; Jelinek et al. 2015 [164]; Deshmukh et al. 2018 [107] – Detailed study characteristics and results, see evidence report Chapter 3.2.3</td>
</tr>
<tr>
<td>Very low @◯◯◯</td>
<td>OS: No statistically significant differences, HR 1.07 (95% CI: 0.80–1.44)</td>
</tr>
<tr>
<td>Very low @◯◯◯</td>
<td>PFS: No statistically significant differences, HR 0.94 (95% CI: 0.09–9.44)</td>
</tr>
<tr>
<td>Very low @◯◯◯</td>
<td>Recurrence: No statistically significant differences, RR 1.26 (95% CI: 0.03–45.83)</td>
</tr>
<tr>
<td>“Critical endpoints”, for which no data were available:</td>
<td>QoL, CFS, stool incontinence, CR, CSS/CSM, EFS, LC/LRC, late morbidity, LF</td>
</tr>
<tr>
<td>Further results:</td>
<td>No statistically significant differences with regard to treatment-associated deaths (GRADE: very low).</td>
</tr>
<tr>
<td></td>
<td>In a retrospective, non-comparative cohort study (Kynaston et al. 2018 [108]) R1 resections were more common in local excision of anal canal tumours (86%) observed than with tumours of the anal margin (48%).</td>
</tr>
</tbody>
</table>

Source: Consultation version of the S3 guideline for anal cancer, AWMF Registration No. 081-004OL. (As of: June 2020)

Figure 10: Example presentation of recommendations in an S3 guideline with evidence evaluation as per GRADE
<table>
<thead>
<tr>
<th>Grade of Recommendation</th>
<th>New/modified/verified status (year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>e.g. A ↑↑</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level of Evidence</th>
<th>Literature: State the references here that justify the recommendation.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>[Quote 1, Quote 2, Quote 3]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Strength of consensus: e.g. 95%</th>
</tr>
</thead>
</table>

Figure 11: Example - Template for an S3 guideline recommendation with evidence assessment according to Oxford 2011 from the S3 guideline template

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>New/modified/verified Status (Year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>e.g. ↑↑↑</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Consensus strength: e.g. 95%</th>
</tr>
</thead>
</table>

Figure 12: Example template of an S2k guideline recommendation (here the grade of recommendation grade is only given with an arrow symbol)
Presentation of a guideline based clinical pathway in the form of a clinical algorithm that follows strict conditional logic: “If-then” (if possible, also state the levels of evidence and grades of recommendation) see Fig. 13 as an example.

Figure 13: Example: Orientation on the clinical pathway: Clinical algorithm
Algorithm for differentiating acute lower respiratory tract infections (acute bronchitis, acute exacerbation of chronic bronchitis, influenza infection, community-acquired pneumonia, S3 guidelines AWMF Registration No. 082/-001 (Status: 1 July 2009)

- Using digital tools for the structured development, management and dissemination of guidelines. Examples: MAGICapp (app.magicapp.org) or GRADEpro (https://gradepro.org/). Both are based on the GRADE methodology and are therefore particularly suitable for guideline development groups that use GRADE for guideline development.

References
External review

A review process prior to publication of a guideline allows any uncertainties or missing areas to be identified. This is conducted by persons who were not involved in developing the guideline. These should be experts from the medical field, patient representatives and, if necessary, methodologists.

AWMF Guideline Register Rule:
None

Contextual reference to the AGREE II instrument:
Domain 3: Rigour of guideline development
Criterion 13: The guideline has been externally reviewed by experts prior to its publication.

Resources and tips:
There are a variety of external review options, e.g.

- A public consultation phase: The guideline is made available to the (specialist) public for comment for a limited period of time, e.g. 6 weeks and includes a Structured Comments Sheet. This can be in parallel on the lead medical society site and the AWMF Guideline Register (possibly with a link). It is sent to all participating organisations with a request to pass it on to their members. Where appropriate, an expansion of the distribution list, e.g. for relevant media or higher-level institutions, should be considered.
- A peer consultation phase (e.g. during the adoption phase by chairpersons of the medical societies or by external experts)
- Publication in a peer-reviewed journal

Don't forget: Coordinate any comments and the way to deal with them during the consultation phase with the guideline development group and document them in the guideline report!

Global adoption

After the structured consensus development process is completed, including any external review and final editing by the coordinators, the overall guideline is adopted by all members of the guideline development group, usually in an email resolution procedure. The next step is formal adoption by the boards of the participating medical societies/organisations. This ensures that all parties involved in developing the guideline and the co-editing medical societies/organisations bear mutual responsibility for the contents. Any changes desired by
the medical societies to passages requiring consensus approval must be re-approved by consensus within the guideline development group and re-submitted to the chairpersons of the other participating medical societies.

AWMF Guideline Register Rule: Classification of S1, S2 and S3 guidelines (excerpt):
If it is an S1 recommendation for action or an S2k, S2e or S3 guideline,
- The guideline is finally adopted by the boards of all participating medical societies/organisations.

Contextual reference to the AGREE II instrument:
None

Resources and tips:
The representative of the medical society supports the formal adoption of the guideline before the board of the medical society or organisation they represent.
It should be determined in advance whether there are any and, if so, what rules apply to the authorisation of their representative and the internal adoption procedure of each medical society. Options include, but are not limited to:
- The board of the medical society itself authorizes the content of the finalized guideline, above and beyond the approval of the representative,
- The medical society has set up a guidelines commission which drafts the corresponding resolution for the board.
- The representatives are authorised by their medical society to agree on behalf of the board (the medical society agrees almost automatically with their consent).

It is recommendable to obtain written feedback from the medical society; this can follow an informal procedure (e.g. by email) using the letter template “Request formal adoption by the boards of the medical societies as well as by approval of the right of use agreement”.

Don't forget: The guideline report should document how amendments are managed!
Formats and dissemination of guidelines

The provision of versions in different formats can be helpful when in disseminating the guidelines and supporting their implementation (1). This includes formats for professional users as well as formats that are understandable for laypersons.

Formats for professional users (e.g. long and short version, guideline report)
This includes the long version with background information and, where relevant, evidence syntheses and a guideline report describing the methodology. The report is intended to make the guideline development process transparent and thereby plausibly undergird the trustworthiness of the guideline.

Uniform editorial preparation (use of Templates for creating and updating S2e, S2k and S3 guidelines (see Aids and appendices to the English Version of the “Guidance Manual and Rules for Guideline Development” (zip-Datei), Sample Evidence Table and Guideline Report, linking the literature using literature management programmes) (2), possibly also specific to the medical society and compliance with reporting standards facilitate a quick overview (see: Clarity and presentation).

A short version containing a summary of the recommendations and/or flowcharts concisely depicting the optimal care procedure or embedding recommendations into clinical algorithms are helpful to provide quick information in practical settings.

Modified after the “Choosing Wisely” campaign (3) it is recommended that the most important negative and positive guideline recommendations be highlighted as “Deciding Wisely Together” recommendations. These should ideally be published together with formats understandable for laypersons (4) (see also Formats understandable for laypersons).

Identifying recommendations that are useful for student learning objectives and comparing them with existing catalogues of learning objectives can be helpful for disseminating guidelines for student education.

Other ways of dissemination are publications in specialist journals, practical aids for implementing the recommendations, pocket versions and training materials such as slide sets and CME articles.

Formats understandable for laypersons (e.g. patient guidelines, decision-making aids)
We strongly recommend writing versions for laypersons or patients because these are becoming increasingly important (5, 6). It is important to use language and writing composition throughout that is comprehensible for laypersons, whilst keeping in mind the affected patients, public, etc. (7, 8).
For patient guidelines that are published in the AWMF register, minimum quality requirements are set with regard to information about the authors and with reference to the guideline on which they are based (see AWMF rules for the guideline publication; point 5). Other formats understandable for laypersons include short summaries and/or explanations of the most important recommendation(s) written in plain language, e.g. “Deciding Wisely Together” recommendations, which are criteria-supported and selected in collaboration with members of the affected target group (4). The “decision aid” format can also support those affected.

Digital guideline formats
Digital guideline formats can be developed, for example, as mobile websites or apps, both for professionals and for patients, public, etc. (e.g. decision aids) (9, 10). It is advisable to develop the guideline in a content management system (CMS) which, due to the data structure, allows digital transfer to the "point of care" or to other knowledge systems using programming interfaces. Internationally agreed terminology (SNOMED - Systematized Nomenclature of Medicine Clinical Terms) (11) and specifications (EBMonFHIR (The Fast Healthcare Interoperability Resources (FHIR) Resources for Evidence-Based Medicine (EBM) Knowledge Assets project (EBMonFHIR)) (12) should be used. Contractual agreements to safeguard copyrights are important when adopting guideline contents from the platforms of other providers (see Copyrights and exploitation rights to guidelines).

The aim of digitizing guidelines as a whole is to continually adapt guideline recommendations to a quality improvement cycle with the exchange of structured data on evidence generation, summary, dissemination and implementation (evidence ecosystem see Fig. 14) (13). The concept of the Living Guideline is ideal for this purpose (see Planning updates).
AWMF Guideline Register Rule: Submission for publication with the AWMF (excerpt):
If these are S1 recommendations for action and S2 or S3 guidelines:

- Information on the methodological procedure with regard to the intended classification S1, S2k, S2e, S3 is available (see rules for S1, S2k, S2e, S3 classification). If the description of the methodological procedure in the context of guideline development (guideline report) does not indicate that the criteria for the specified classification have been met, the classification may be corrected.

- Submitted patient guidelines are checked by the AWMF-IMWi according to the 4-eyes principle:
  - Reference to the underlying guideline and adoption of the recommendations
  - Information on the authors including the involvement of patients
  - Information on the development process including conflict of interest management
  - Coordination with the guideline development group
Contextual reference to the AGREE II instrument:

**Domain 4: Clarity of design**

**Criterion 17**: The guideline’s key recommendations are easy to find.

**Resources and tips:**

- **Versions of a guideline on the AWMF website:**
  Guideline versions can be downloaded individually by registration number on the AWMF website (e.g. long version, short version, patient guideline, guideline report) see Fig. 15.

- **For citing guidelines, we recommend the following common format:**
  Lead medical society(ies)
  Title of the guideline
  Version date
  Available at: Link to the guideline page at the AWMF
  Accessed on (date)

- **For publications on guidelines that are listed in databases such as MEDLINE, we recommend naming all members of the guideline development group, e.g. as "collaborators"**
Figure 15: Example of the presentation of guidelines on the AWMF website

- Please note that a link should always be made to the respective guideline detail view and not directly to the PDF of the respective guideline (deep link). Here is an example: [https://register.awmf.org/de/leitlinien/detail/003-001](https://register.awmf.org/de/leitlinien/detail/003-001)
- Templates for S2 and S3 guideline development see Fig. 16, template for the guideline report see [Appendix 15](#)
- Examples for “Deciding Wisely Together” recommendations, see Fig. 17 + 18 and for a decision aid Fig. 20
- An example for identifying student learning objectives in guidelines, see Fig. 19
Appendix 15: Guide for preparing a guideline report for authors of S2k, S2e and S3 guidelines
### “TO DO” recommendations

**Recommendation 5.2.4.A. Culprit-only vessel vs. multivessel PCI**

In patients with coronary multivessel disease and several relevant stenoses (>70%), only the lesion causing the infarction ("culprit lesion") should be treated within the context of acute revascularisation.

*(Thiele et al. 2017; Thiele et al. 2018)*

For rationale, see Chapter 5.2.4.

### “NOT TO DO” recommendations

**Recommendation 6.3.6.A. Dopamine**

Dopamine should NOT be used for the management of cardiogenic shock.

*(De Backer et al. 2010; De Backer et al. 2012)*

For rationale, see Chapter 6.3.6.


---

**Figure 17:** Example of the identification of “Deciding Wisely Together” recommendations for professionals

Source: S3 Guideline: Early detection, diagnosis, therapy and follow-up care of breast cancer, AWMF Registration No. 032-045OL (update status.: 1 December 2017) [https://www.awmf.org/leitlinien/detail/ll/032-045OL.html](https://www.awmf.org/leitlinien/detail/ll/032-045OL.html)

**Figure 18:** Example of a “Deciding Wisely Together” recommendation for laypersons
**RECOMMENDATION II.1.** Characteristic symptoms of gallstones are well-remembered attacks of pain in the epigastric region or right upper abdomen lasting more than 15 minutes. These can also radiate into the back and right shoulder and are often associated with nausea and occasionally with vomiting; apart from this, complications of cholecystitis may already be present with the first symptom (Statement, III, strong consensus, NKLM).

Figure 19: Example of showing a Student Learning Objective in a guideline

Source: IQWiG, [https://www.gesundheitsinformation.de/zum-ausfuellen-eine-entscheidungshilfe_2221_de.html](https://www.gesundheitsinformation.de/zum-ausfuellen-eine-entscheidungshilfe_2221_de.html)

Figure 20: Examples of a personal decision guide for people making health decisions


**Copyrights and exploitation rights to guidelines**

The copyrights to a guideline are shared jointly among the members of the guideline development group (14). Therefore, the dissemination of the guidelines should be decided jointly. Permission from the co-ownership community is required to utilise the guidelines in various forms (e.g. reprints or modern dissemination forms like apps etc.) or to grant sublicenses for the right of use to third parties (e.g. for joint ventures with publishing houses). The guideline development group should regulate the exploitations rights for all formats.
through which the guideline is to be distributed by granting delineated rights of use, rather than arbitrary use. A written agreement should be made in each case.
The respective guideline development groups, represented by the lead medical societies, shall grant AWMF the rights of use for the electronic publication in the Internet-based information system “AWMF online”.

AWMF Guideline Register Rule: Submission for publication with the AWMF (excerpt):

- The copyrights to the guidelines lie exclusively with the authors (author groups) of the medical societies and organisations involved. This includes the right to change, supplement or delete contents. As a general rule therefore:
  The medical societies involved in the guideline project have written agreement governing the exploitation rights to the guideline contents.
  The medical societies/organisations shall grant AWMF the rights of use for the electronic publication on the Internet-based information system “AWMF online” on the World Wide Web (WWW).
- At an early stage, the lead medical society(ies) clarify the exploitation rights to any further utilisation of guideline content by third parties for each guideline project and document this in writing (see Model contract granting rights of use to guidelines and Explanatory notes to the model contract)
References


3. Choosing Wisely. Available at: https://www.choosingwisely.org/ (Accessed on 03-MAY-2024)


11. SNOMED International. Available at: https://www.snomed.org/ (Accessed on 03-MAY-2024)

12. HL7international, EBMonFHIR. Available at: https://wiki.hl7.org/EBMonFHIR (Accessed on 03-MAY-2024)


Implementation and evaluation

Preparing for implementation

The benefit of a guideline is not revealed until it is applied to routine clinical practice. Implementation constitutes the difficult task of translating recommendations for action into specific courses of action. High methodological and technical quality, as well as good applicability and wide dissemination of the guidelines is important for their implementation, but is usually not sufficient to bring about a change in behaviour (1-4). The classic topic of “hand hygiene in hospitals” succinctly illustrates the barriers that can exist to implementation of guideline recommendations, despite any degree of recognition and acceptance (5).

The first step is to identify potential organisational, structural, financial and human resources-related barriers and propose solutions to them (6-8). The second step should address which implementation strategies the guideline development group can actively support (9, 10). The guideline or the guideline report should describe the results of these two steps.

AWMF Guideline Register Rule:
None

Contextual reference to the AGREE II instrument:

Domain 5: Applicability

Criterion 18. Possible helpful and hindering factors for guideline application are described.

Criterion 19. The guideline makes suggestions and/or names instruments that support the application of the guideline recommendations.

Criterion 20. The possible financial impact of the guideline recommendations was taken into account.

Criterion 21. The guideline names parameters for the evaluation of the process and/or result quality of the guideline.

Resources and tips:

Recommendable strategies for dissemination and implementation include, but are not limited to:

- Obtaining feedback from patients, nursing staff, doctors
- Forming local groups to adopt or adapt the guideline
- Interactive educational workshops on the guidelines
- Discussion of the guideline in quality circles
The guideline development group itself can best prepare for implementation by applying “Good Guideline Development Practices”, editorial and dissemination work alongside public relations. It is recommended that members of the guideline development group also get actively involved in conducting the implementation strategies. This can be supported by a preparatory barrier analysis.

Figure 21: Barrier analysis based on the “Force Field Analysis” (K. Lewin)
References


Preparing the evaluation

Guidelines serve to improve knowledge transfer and the quality of care. A guideline does not become relevant or sensible until it is accepted and applied; but also when proven benefits are conferred by it. Therefore, it is recommended to conduct an evaluation that accompanies implementation of the guideline and is geared to its specific goals (see Goal orientation of the guideline), whilst particularly documenting the relevance for the affected patients, public, etc. (1).

This can be anchored in health services research projects, internal institutional quality management projects, voluntary quality initiatives (e.g. peer review procedures, see Preparing for implementation) and/or conducted within the scope of external, comparative quality assurance.

The guideline's implementation and implications on health care can be examined by applying clinical review criteria, and quality indicators derived from the guideline recommendations that address specific objectives (2-6).

In an effort to save data and avoid misguidance, the standards placed on methodology for identifying, selecting and critically appraising clinical variables and quality indicators should be equally as high as for the guidelines themselves. The possible use of existing indicators should be actively explored.

There are manuals for the specific methodological procedure for the guideline programme oncology and the German DM-CPG programme, as well as a reporting standard of the GIN working group (7, 8). A national methodological standard was formulated as part of a research project, with the broad participation of stakeholders, including representatives from patient organizations (9). Advice, e.g. from a guideline consultant at the AWMF with expertise in deriving quality indicators is recommended.

Ideally, the results of the evaluation serve to improve the guideline or, if necessary, lead to new research. Digital data exchange is essential for use (see digital guideline formats).

AWMF Guideline Register Rule:
None

Reference to the AGREE II instrument
Domain 5: Applicability
Criterion 18: Possible helpful and hindering factors for guideline application are described.
Criterion 19: The guideline makes suggestions and/or names instruments that support the application of the guideline recommendations.
Criterion 20: The possible financial impact of the guideline recommendations was taken into account.

Criterion 21: The guideline names variables for the evaluation of the process and/or result quality.

Resources and tips:
Consider which key aspects you can use to evaluate the guideline’s implementation and its implications on health care. Prior to formulating the clinical variables and quality indicators, the following questions need to be answered:

- What is the health care objective?
- How well substantiated is the guideline recommendation that reflects this objective (strength of recommendation, strength of consensus)?
- Is implementation of this recommendation measurable?
- Is there unequivocal evidence that potential for improvement exists?
- Which health care data can be used for the evaluation?

References


Planning updates

The quality of a guideline primarily depends on whether the recommendations are reviewed for their update status at regular intervals and then updated as needed. The guideline document should indicate a specific due date and statements on additional periodic or, if relevant, event driven updating, including the respective responsibilities.

The need for continuous supplementation and updating of a guideline is not only a function of the availability of new and emerging scientific knowledge, but also depends on the results obtained from an analysis of the guideline’s previous application. Both serve to identify potential for improvement in health care.

Accordingly, a status and needs analysis forms the starting point for identifying topic areas in need of revision. The methodological prerequisites are specified in the guideline requirements described in the AWMF Guidance Manual.

Updating can be carried out partially for selected sections only or completely (1). In the case of partial updates, the guideline development group checks the validity of the sections that have not been updated before submission and confirms them for an appropriate period of time (2).

Living Guideline

In order to keep guidelines continuously up to date, the process can be used as a living guideline that is updated at least once a year.

In the updated guideline, the most important innovations should be set out at the beginning ("what's new?"), the recommendations should be marked with “verified”, “modified” and “new” and dated (year) (3, 4). The methodological approach is supplemented in the guideline report (5).

AWMF Guideline Register Rule: Deletion of non-updated guidelines from the AWMF (excerpt) and submission for publication with the AWMF (excerpt):

Guidelines whose validity has expired (according to the validity period specified in the guideline) and for which no update has been registered will be completely removed from the electronic publication via the AWMF information system.

The maximum period of validity is 5 years from the date of approval by the medical society(ies) and organisation(s) involved.
If it is an S2k, S2e or S3 guideline:
Information on the period of validity and for updating the guideline is available (see AGREE II Criterion 14) and a contact person responsible for updating is named. The predefined update periods for “Living Guidelines” are known and do not exceed 12 months.

**Contextual reference to the AGREE II instrument:**

**Domain 3: Rigour of guideline development**  
**Criterion 14:** A procedure for updating the guideline exists.

**Resources and tips:**
Current research results or findings from health care may make it necessary to update the recommendations of a valid guideline at short notice. Furthermore, the public can be notified quickly by means of an addendum/amendment via the AWMF website.

The easiest way to ensure continuous updating is when the original guideline had been systematically developed. Literature searches and strategies for answering clinically relevant key questions can be saved and reused, if necessary. In order to update a guideline, the literature review is checked and, if relevant, adjusted and then only needs to cover the period after the publication of the previous guideline version.

**Living Guideline**
In the case of Living Guidelines, updates are made every year at most. Working out Living Systematic Reviews as a basis for guideline recommendations is ideal. In addition, the updating of guideline recommendations should also be verified whenever new scientific evidence or health care findings emerge over the year.

A systematic review of the need for revision with the result that no changes are required is also considered to be an update. A criteria-based check and ranking of the content to be updated is helpful, e.g. using the “UpPriority” tool of the GIN working group (6).
Table 7: Updating options according to the AWMF Guidance Manual

<table>
<thead>
<tr>
<th>Update option</th>
<th>Partial, Complete</th>
<th>Living Guideline</th>
<th>Amendment/Addendum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registration</td>
<td>Required</td>
<td>Annual registration required</td>
<td>Not required</td>
</tr>
<tr>
<td>Extent of update</td>
<td>Selected (partial) or all key questions (complete)</td>
<td>As required, examine all key questions respectively</td>
<td>Few key questions (up to approx. 5% of the recommendations)</td>
</tr>
<tr>
<td>Update periods</td>
<td>≤ 5 years</td>
<td>Specified ≤ 12 months</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Identification of changes</td>
<td>On the title page</td>
<td>On the title page</td>
<td>Easily visible as an introduction in the document</td>
</tr>
</tbody>
</table>

The extent of revision (partial, Living Guideline or limited to individual key questions) depends on whether there has been any recent updating, on the results of any updated guidelines searches, on the results of current, relevant research findings from systematic literature searches and on the judgment of the experts in the guideline development group (see also Tab. 7). For Living Guidelines, the validity of all recommendations should be verified or confirmed, even if there only a few recommendations that need to be modified. In addition, obtaining targeted feedback from the field on the successes/problems associated with implementing the guideline, status and needs analyses as well as prioritising are indispensable. In this context, the following key questions need to be answered:

- Who shall be responsible for monitoring and initiating the update of our guideline?
- What impact has our guideline had?
- Which new key questions have emerged?
- Has new scientific knowledge emerged that makes it necessary to change our recommendations?
- Are there key questions requiring systematic search of the literature and synthesising of the evidence?
- Which resources are available to the guideline development group?

These questions ought to always be reappraised whenever a guideline is updated.
Figure 22: Quality management for the continued revision and updating of guidelines.


References

Publication with the AWMF

Submission for publication with the AWMF

As per the Guidelines Conference of 4 October 1995, the AWMF shall publish the guidelines developed and adopted by the AWMF member societies (see Global adoption) in the “AWMF online” information system. Submission of guidelines to the AWMF grants the AWMF the right to present the texts on the internet-based AWMF Guideline Register.

Versioning and archiving the guidelines in the AWMF Guideline Register

The AWMF always issues a register-compliant version number. Expired guidelines will be archived by the AWMF and provided to the lead medical societies on request (see AWMF rules for guideline publication, point 8).

AWMF Guideline Register Rule: Submission for publication with the AWMF (excerpt):

- The guideline project was registered at an early stage with the AWMF; this registration triggered the generation of an AWMF registration number (see Rule Registration procedure for guidelines under planning and development). The medical societies shall make the AWMF registration number and the class (S1, S2e, S2k or S3) clearly visible on the title page of the guideline.

- Information on guideline funding, the declaration of interests and the managing of conflicts of interest is provided (see Rule Declaring interests and managing conflicts of interest). The AWMF will not accept finalised guidelines for publication if they have funding issues that might lead to conflicts of interest or the conflicts of interest of the individual participants are not transparently disclosed.

- Information on the methodological procedure with regard to the intended classification S1, S2k, S2e, S3 is available (see rules for S1, S2k, S2e, S3 classification). If the description of the methodological strategy as part of guideline development (guideline report) does not demonstrate that the criteria for the stated classification have been fulfilled, the classification will be corrected, where applicable.

- Information on the period of validity and updating the guideline is available (see AGREE II Criterion 14) and a contact person responsible for updating is named.

- Documents submitted by lead medical society(ies) will be adopted in unamended form. The AWMF only reserves the right to correct obvious spelling errors and issues a register-compliant version number.
The AWMF archives old (i.e. not further pursued guidelines or precursor versions of recent guidelines) and provides these to the lead medical societies upon request (e.g. for inquiries within the scope of review processes).

Contextual reference to the AGREE II instrument:
None

Resources and tips:
Prior to submission of the guideline for publication with the AWMF, the guideline documents should have received final approval and the guidelines delegate and/or the guideline secretariat of the lead medical society(ies) should be informed thereof.

It is advisable to use a checklist to check the completeness of the documents (see Appendix 21).

**Appendix 21: Checklist for publication with the AWMF**

![Checklist image]
The AWMF Guideline Seal of Approval

Since August 2004, the "AWMF-certified" seal of approval can be issued for guidelines of S3 classification, provided they are of the appropriate quality. The guideline coordinators can submit an informal application for certification by email to the AWMF Institute for Medical Knowledge Management (AWMF-IMWi): imwi@awmf.org

Entry requirements for the certification procedure are fulfilment of the quality criteria set forth in the AWMF Guidance Manual:

- Submission of the publication to the AWMF
- Classification S3 guideline

The certification procedure shall be initiated once the entry requirements have been fulfilled. This encompasses:

- Critical appraisal of the methodological quality of the guideline based on AGREE II (methodological appraisal)
- Estimation by an external reviewer of the anticipated impact of the guideline on health care in its area of application (clinical expert review)
- Approval by the AWMF (resolution)

Selection criteria for the reviewers include the disclosure of any conflicts of interest (AWMF standard form), no involvement in the development of the guidelines, but experience in the application of AGREE II (reviewer with methodological expertise) or scientific and clinical experience in one of the fields relevant to the expert appraisal (expert reviewer). If the certification is successful, the guideline shall be published on the AWMF website as an "AWMF Guideline" with its seal of approval; the printed version of the guideline may also bear this seal of approval until any content changes are made thereto.

AWMF Guideline Register Rule:
None

Contextual reference to the AGREE II instrument:
Requirements for S3 guidelines in accordance with AGREE II
Appendices

1. Letter template for “Nominating representatives”
2. Project schedule
3. Information sheet for methodological support by the IMWi
4. Digital Tools Proposal List
5. Sample form for Declaration of interests
6. Example table: Declaration of interests and managing conflicts of interest
7. Instruction guide for completing the Declaration of interests form
8. Registration form
9. Instruction guide for completing the Registration form Guideline project
10. Constitutive meetings / inaugural meeting – Preparatory steps and time planning
11. Consensus conference - preparatory steps and scheduling
12. Sample evidence table
13. Letter template “Invitation to the consensus conference”
14. Formal consensus development techniques
15. Guide for preparing a guideline report for authors of S2k, S2e and S3 guidelines
16. Letter template: “Formal adoption by the boards of the medical societies including approval of the Right of Use agreement
17. Explanatory notes on the agreement on the granting of rights of use
18. Consultation comment sheet
19. Consultation documentation
20. Sample letter "Request for formal adoption by the boards of the professional associations and approval of the license agreement"
21. Checklist for publication of a guideline with the AWMF
22. AWMF Guideline Register Rules
Appendix 1: Letter template “Nominating representatives”

Letter template – Invitation to participate in a guideline project

INSTRUCTIONS
Please select from the alternative wording proposals highlighted in green or separated by "/". Fill in grey-highlighted fields separately.
This is a rough template. Please process specifically and add text as appropriate!

Sender
[Guideline coordinator, title of the lead medical society/organisation sending out the invitation]

Address
[Personal contact person, title of the medical society/organisation to be invited, administrative office]

Re: Invitation to participate in a guideline project and request to nominate a representative

Dear [Title, name of personal contact person],

If the guideline has already been registered
I am pleased to inform you that the [S2k/S3] guideline [title of the guideline, AWMF Reg. No.] has been entered in the registry of the Association of the Scientific Medical Societies in Germany (AWMF).

If the guideline has not yet been registered
I am pleased to inform you about the planning of a [S2k/S3] guideline [title of the guideline].

I have been commissioned by [title of the lead medical society] to coordinate the guideline project and take the first steps by approaching the medical societies and organisations concerned with this topic, with the objective of putting together a representative panel of experts for the target users of the guideline.

The guideline is being developed based on the methodological requirements of the AGREE II Appraisal of Guidelines for Research & Evaluation instrument and should be supervised by a representative of the AWMF.

If the medical society/organisation to be invited has already developed a related guideline
Because the medical society/organisation you represent is involved with the thematically related [S2k/S3] guideline [title of the guideline, AWMF Reg. No.] / has published the thematically related [S2k/S3] guideline [title of the guideline, AWMF Reg. No.], I would like to invite you to participate in our guideline project and contribute your expertise.

In case the medical society/organisation to be invited has not yet developed a related guideline
The experience and perspectives your medical society/organisation has to offer are crucial to the success of this interdisciplinary project. I would therefore like to invite you to participate in our guideline project and contribute your expertise.

I would like to ask you to appoint a representative as a contact person whom I can get in touch with concerning guideline matters and whom I can invite to working group meetings and guideline conferences.
In addition to contributing their scientific and personal experience to the project, this representative should represent the interests of your medical society/organisation in our guideline development group. Their involvement is meant to ensure that the content of the guideline can also be officially supported by your medical society/organisation after conclusion of the development process.

By virtue of their scientific reputation/experience in the field of our guideline topic, I would like to propose Mr. / Ms. [title, name] for this office. Of course, I am also open to an alternative nomination on your part.

Could you therefore kindly fill in and return the enclosed fax reply form by [date].

If your medical society/organisation is unable to participate in our project or does not see any necessity in doing so, I would be very grateful for a short reply specifying your reasons.

For any further questions, please do not hesitate to contact me by phone. I look forward to working with you.

Best regards,

Signed
Appendix

Reply to:
[Guideline coordinator, title of the lead medical society/organisation sending out the invitation]

[FAX number]

Guideline Project
[Title, AWMF Reg. No.]

Medical society / organisation: ...........................................................................................................
[Title of the invited medical society/organisation]

We would gladly like to participate in your guideline project and nominate the following

Representative(s):
Title, first name, surname: ..............................................................................................................
Institute/Hospital: ............................................................................................................................
Street + house number: ....................................................................................................................
Postal code + city: ...........................................................................................................................
Email address: .................................................................................................................................
Phone: ...........................................................................................................................................
Fax: ...................................................................................................................................................

Proxy of the representative:
Title, first name, surname: ..............................................................................................................
Institute/Hospital: ............................................................................................................................
Street + house number: ....................................................................................................................
Postal code + city: ...........................................................................................................................
Email address: .................................................................................................................................
Phone: ............................................................................................................................................
Fax: ..................................................................................................................................................
Date, signature, stamp: .....................................................................................................................
Appendix 2: Assistance Project schedule

Assistance „Project schedule“

A project schedule with defined time frames, activities and responsibilities facilitates project management, planning of funding, ensuring the completion of the tasks necessary to achieve a certain S-class (see S-classification) and adherence to a target publication date. It should be created individually and adapted to the possibilities of the guideline group.

<table>
<thead>
<tr>
<th>Implementation according to S-class</th>
<th>Responsible</th>
<th>Tasks</th>
<th>Time frame</th>
</tr>
</thead>
</table>
| Planning and organisation           | Function within the guideline group; for example, coordinator, steering group, guideline-group, Topic-specific working group, methodologists, guideline-secretary’s office | • Selecting/updating a guideline topic (rationale)  
• Rationale and description of the goal-orientation of the guideline  
• Establishing the intended class (S1, S2e, S2k, S3)  
• Constitution of the guideline development group  
  o Involvement of the guideline users (target audience) and patients, public, etc. (target population)  
  o Forming a guideline steering committee, as appropriate  
  o Clarification about which methodological expertise must be included: AWMF-compliant qualification within the guideline development group or is it necessary/possible to involve external methodologists?  
• Inviting medical societies/organisations and requesting them to nominate both representatives and proxies  
• Developing a project plan  
• Establishing a funding strategy  
• Drafting clinically relevant key questions that the guideline aims to address (in collaboration with the guideline steering committee, when extant)  
• Obtaining declarations of interests  | |
| Constitutive meetings               |             | • Registering the guideline project with the AWMF | |

<table>
<thead>
<tr>
<th>Implementation according to S-class</th>
<th>Responsible</th>
<th>Tasks</th>
<th>Time frame</th>
</tr>
</thead>
</table>
| Constitutive meetings               |             | • Discussion and conclusion of the planning phase  
• Determining if the guideline development group is well-balanced; post-nominate as appropriate  
• Presenting and finalising the methodological concept (AGREE II, project plan)  
• Revision and adoption of the key questions, prioritising endpoints and establishing a processing strategy  
• Forming topic-related working groups, as appropriate  
• Discussion on how to assess interests and manage conflicts of interest | | | |
<table>
<thead>
<tr>
<th>Implementation according to S-class</th>
<th>Responsible Function within the guideline group; for example, coordinator, steering group, guideline-group, Topic-specific working group, methodologists, guideline-secretary’s office</th>
<th>Tasks</th>
<th>Time frame</th>
</tr>
</thead>
</table>
| Systematic review of the evidence | • Systematic searches, selection, appraisal and review of the available evidence (aggregate evidence, practice guidelines, primary studies as appropriate)  
  o Establishing the search strategy  
  o Establishing the inclusion and exclusion criteria  
  o Critical appraisal of the methodological quality  
  o Creating a guideline synopsis (if applicable)  
  o Synthesising the evidence in tabular format or by using formal instruments or strategies  
  o Determination of confidence in the quality of the evidence (“level of evidence”) | | |
| Writing draft versions | • Content-related work (in small groups as appropriate)  
  • Preparation of recommendations and draft texts based on the evidence included and assessed | | |
| Structured consensus development | • Preparation  
  • Selecting the formal procedure  
  • Discussion, clinical appraisal, adoption of recommendations | | |
| External review and overall adoption | • External review, e.g. as part of a consultation version  
  • Final voting in the guideline development group by email written resolution procedure  
  • Formal adoption by the boards of the participating medical societies/organisations  
  • Rules regarding exploitation rights | | |
| Guideline documents | • Formats for professional users  
  o Long version (only this version is binding)  
  o Short version/pocket version  
  o Slide set  
  o App version  
  o Algorithms and practical aids  
  o Indication of student learning objectives  
  • Formats comprehensible for laypersons  
  o Patient version/decision-making aids  
  o “Deciding Wisely Together” recommendations | | |
<p>| Guideline report | • Declaration of interests of all members of the guideline development group and managing conflicts of interest (mandatory) | | |
| | • If not integrated in the guideline or report, any additional documents (evidence reports, evidence tables) | | |</p>
<table>
<thead>
<tr>
<th>Implementation according to S-class</th>
<th>Responsible</th>
<th>Tasks</th>
<th>Time frame</th>
</tr>
</thead>
</table>
|                                     | Function within the guideline group; for example, coordinator, steering group, guideline-group, Topic-specific working group, methodologists, guideline-secretary’s office | • Identifying potential organisational, structural, financial or staff-related barriers  
• Description of solution strategies and envisioned activities for promoting guideline implementation  
• Defining quality indicators, if applicable |           |
| S2e S3                              |             |       |            |
| Implementation and evaluation       |             |       |            |
| S1 S2 S3                            |             |       |            |
| Planning updates                    |             |       |            |
| S1 S2 S3                            |             |       |            |
| • Notation of date (validity) and responsibilities  
• Establishing a procedure for the status and needs analysis to identify topic areas that are to be revised  
• For updated practice guidelines: In the updated guideline, the most important innovations should be set out at the beginning (“what’s new?”), the recommendations should be marked with “verified”, “modified” and “new” and dated (year). |       |            |
| S1 S2 S3                            |             |       |            |
| • Submitting the guideline documents to the AWMF |       |            |
Information leaflet for the methodological support provided by the IMWi*

Free-of-charge IMWi services:
1. A total of four hours’ initial consultation to support the guideline development per guideline project (registration procedure, project planning, guideline methodology, including requirements of the AWMF Guideline Registry)
2. Two hours of initial mediation within the scope of guideline development per guideline project
3. General consultation on guidelines at a cross-project level/medical knowledge management

Fee-based services provided by the IMWi (hourly rate of €100 plus 7% VAT)*:
1. Follow-up consultations on guideline projects exceeding the four hours of free-of-charge initial consultation, e.g. steering committees meeting by telephone, video conferencing or in-presence
2. Moderation of consensus conferences by video conferencing or in-presence meeting
3. Follow-up mediation exceeding a two-hour free-of-charge mediation
4. Time for preparation and follow-up of consensus conferences (usually 2 hours), work meetings or mediation sessions
5. Travel expenses to in-presence meetings

*subject to any other regulations in special guideline programmes (National Disease Management Guidelines or Practice Guideline Programme Oncology)

The IMWi will require the following information for invoicing:
1. Name and exact address of the invoice recipient (as appropriate indicating the function, e.g. treasurer of the medical society XY, if required: Cost centres and processing number, special invoice forms for faculties supported by the innovation fund guidelines, as appropriate additional invoice numbers)
2. As appropriate desired accounting periods (quarterly statement, yearly, after every consensus conference, etc.)
3. Other necessary contractual agreements (e.g. prior quotes submitted, split invoicing to multiple parties of lead medical societies etc.)
Appendix 4: Digital Tools Proposal List

Digital Tools Proposal List
Examples of offers tendered are listed here. These are both free-of-charge as well as fee-based offers, this usually depends on the scope of services.

For overall guideline development:
GRADEpro
https://www.gradepro.org/
MAGICapp
https://app.magicapp.org/

Delphi pre-votes for online surveys:
SurveyMonkey
https://www.surveymonkey.de
LimeSurvey
https://www.limesurvey.org/de/
FreeOnlineSurvey
https://freeonlinesurveys.com/
OnlineSurveys
https://www.onlinesurveys.ac.uk/
Survey Planet
https://surveyplanet.com
SuperSurvey
https://www.supersurvey.com
SmartSurvey
https://www.smartsurvey.co.uk/free-online-surveys
LamaPoll
www.lamapoll.de
Office 365
https://www.office.com
Google Forms
https://docs.google.com/forms
Jotform
https://www.jotform.com/de

In-presence or online voting:
TED-System (e.g. available from the German Cancer Society [Practice Guideline Programme Oncology])
VoxVote
https://www.voxvote.com
Vechox
https://www.vevox.com
Zoom
https://explore.zoom.us/de/products/meetings

For literature search, literature management:
EndNote
https://endnote.com/
Citavi
https://www.citavi.com/de
Zotero
https://www.zotero.org/

For literature screening and appraisal:
Rayyan
https://www.rayyan.ai/
Covidence
https://www.covidence.org/
Appendix 5: Sample form for declaration of interests

Declaration of interests

(Title, AWMF Reg. No.)

Attn.: (Guideline coordinator)

Preliminary remarks

All members of the guideline development group are obligated to fill out the Declaration of Interests form below. Declaration is issued vis-à-vis the guideline coordinator. This should be issued upon commencement of the guideline project or by the time the members confirm to the coordinator that they will participate in the guideline project. For longer-term projects, the declaration must be renewed once a year until the guideline development project is completed, or at least prior to consensus development.

All interests must be listed in the declaration irrespective of whether the declaring party themselves sees a topical relationship to the guideline or a conflict of interest or not. Third parties should be the ones to assess whether conflicts of interest exist and whether there are any doubts about the necessary level of neutrality for involvement in the guideline development process or in special areas/key questions of the guideline in which the professional judgment of an expert might be unduly influenced by secondary interests and then discussed in the guideline development group. The declaration covers interests within the current year and the 3 preceding years.

The originals of the declarations shall remain confidentially with the guideline coordinator. The contents of the declarations should be disclosed in the long version of the guideline or in a standardised summary in the guideline report. Additionally, the collection method, the appraisal of the declarations and the results of the discussion on managing conflicts of interest should be presented.

Information to be provided where personal data are collected from the data subject pursuant to Article 13 GDPR

The guideline coordinator gathers your data for the purpose of the above-mentioned guideline project as well as to comply with the requirements of the AWMF Guidance Manual. In order to carry out the guideline project, it is necessary that data are gathered and processed according to Article 6(1)(b) GDPR. The data is not made available to third parties unless it is for the purpose of complying with the AWMF Guidance Manual. The data are deleted as soon as they are no longer required for the purpose of processing. Within the scope of guideline projects, you are entitled to request information about the data stored on you and have the right to rectify inaccurate data or demand erasure of data in case of any unauthorised data storage.
**Declaration**

1. General information

<table>
<thead>
<tr>
<th>Surname, first name, title</th>
<th>Presently</th>
<th>Earlier within the current year or the 3 preceding calendar years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer / Institution</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Position / Function at the institution</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Email address</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For any questions, reachable by telephone at</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Function within the guideline development group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time period framing the declaration</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2. Direct, financial interests

Financial relationships with companies, institutions or interest groups in the health care system are recorded here. Have you or the institution for which you work received financial benefits/funding within the current year or the 3 preceding calendar years from companies in the health industry (e.g. pharmaceutical industry, medical device industry), industrial interest groups, commercially oriented contract institutes, insurers/health insurance providers, or from public donors (e.g. ministries), corporate entities/self-government bodies, foundations or other donors? In the following table, please enter concrete details on all relevant aspects.

<table>
<thead>
<tr>
<th>Nature of relationship/type of activity</th>
<th>Names of the joint-venture partners</th>
<th>Time period of the relationship/ type of activity¹</th>
<th>Topic, context to the guideline²</th>
<th>Type of financial benefits/funding ³</th>
<th>Amount of financial benefits/funding ⁴</th>
<th>Recipient(s)⁵</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role as consult/expert</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seat on a scientific advisory board</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Role as lecturer and/or educator</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Authorship or co-authorship</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Research projects/conduct of clinical trials</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proprietary interests (patent, copyright law, share ownership⁶)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

¹ Within the documentation period, i.e. covers the current year and the 3 preceding years, dates: from (month/year) to (month/year)

² State the topic, also the active principle and/or trade name of drugs and/or devices (free text), additionally give a self-rating of the context to the guideline: “No” or “Yes”

³ Honoraria, third-party funds, non-cash perks (e.g. personnel or materials; travel expenses, sponsorship of attendance at meetings and hospitality at events), sales license

⁴ The amounts can be rounded off (e.g. for amounts > € 1000 round up to the nearest 1000): The disclosures refer to the total sum of financial benefits/funding received for a given activity during the documentation period, dates: from (month/year) to (month/year).

⁵ These details will be treated confidentially.

⁶ Please specify: a) if you personally receive the financial benefits/funding or b) the institution for which you work and you have a direct decision-making role in the allocation of financial benefits/funding within your institution. No disclosures are required if you do not have a direct decision-making role.

⁶ Only applies to proprietary interests within the health care system; details on mixed funds are not required here either.
3. **Indirect interests**

Personal relationships with interest groups within the health care system, “intellectual”, academic and scientific interests or points of view as well as focus of clinical activities/revenue streams (time period covering the current year or the 3 preceding calendar years). This also includes ones that might be indirectly related to personal financial interests.

- Have you been or are you currently active in any scientific or medical societies, professional association, self-government bodies/institutions, patient self-help groups, consumer advocate organisations or other associations? If so, in which function (e.g. proxy or representative for these or other practice guidelines, board chairperson)?
- Can you detail the focus of your scientific and/or clinical activities? Do you feel you belong to a particular “school of thought”?
- Have you played a leading role in shaping the substantive content of continuing education programmes?
- Do you have personal relationships (as partner or first-degree relative) to a representative of a company in the health care industry?

In the following table, please enter concrete details on all relevant aspects.

<table>
<thead>
<tr>
<th>Nature of relationship/type of activity</th>
<th>Names/areas of special focus (please specify in concrete terms)</th>
<th>Time period of the relationship/type of activity 7</th>
<th>Topically relevant to guideline 8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Membership/function in interest groups</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Focus of scientific activities, publications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Focus of clinical activities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leading role in continuing education programmes/educational institutions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal relationships (as partner or first-degree relative) to a representative of a company in the health care industry</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

7 Within the documentation time period, i.e. covers the current year and the 3 preceding years, dates: from (month/year) to (month/year)

8 Give a self-rating "No" or "Yes"
4. Other interests

Are there any other aspects or circumstances that you feel might be perceived by third parties as limiting your objectivity or independence?

I hereby declare to the best of my knowledge and belief that I have listed all circumstances currently known to me that might potentially lead to a personal conflict of interest affecting my participation in the development of the guideline on this topic. I moreover declare that I shall treat the discussion of the declarations of the other members of the guideline development group as absolutely confidential. I have been informed that the details will be published with the guideline in a standardised summary in an accompanying practice guideline report, and that the present form will be archived and protected against viewing by unauthorised third parties. I hereby agree.

Date, __________________________ Signature __________________________

Supplementary notes

- Please complete the following form in full.
- Please state the reasons for any information you cannot or do not wish to provide on certain questions.
- If no digital record is made: Please save the completed form and send it to the guideline secretary: xxx@yyy.zz
# Appendix 6: Example table: Declaration of interests and managing conflicts of interest

The following presents a tabular summary of the declarations of interests along with the results of the conflicts of interest assessment and the measures adopted after discussion of the facts by the guideline development group and implemented during the consensus conference.

<table>
<thead>
<tr>
<th>Work as consult/expert</th>
<th>Work in a Scientific Advisory Board</th>
<th>Paid role as lecturer and/or educator</th>
<th>Paid authorship or co-authorship</th>
<th>Research projects/conducting clinical trials</th>
<th>Proprietary interests (patent, copyright law, share ownership)</th>
<th>Indirect interests</th>
<th>Guideline topics affected by conflicts of interest(^1), classification by relevance, consequence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prof. [Example]</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Company Name 1. Company Name 2. Health Insurer Name</td>
<td>No</td>
<td>Member: Medical Society Name 1, Medical Society Name 2, Family member in managerial position at Company 1.</td>
<td>Systemic therapy (moderate), abstention</td>
</tr>
<tr>
<td>Dr. [Example]</td>
<td>Company Name 3., Company Name 4.(^2)</td>
<td>Company Name 3.(^2)</td>
<td>No</td>
<td>No</td>
<td>Patent on XXX test</td>
<td>No</td>
<td>Pharmacotherapy (moderate) abstention Early detection (high), abstention from the discussion</td>
</tr>
<tr>
<td>Example MPH</td>
<td>No</td>
<td>No</td>
<td>Company 5</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Member Medical Society Name 3. Diagnostics (minor), no consequences</td>
</tr>
<tr>
<td>Prof. [Example]</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Representative Medical Society Name 4. Member Representative Name 5. None</td>
</tr>
<tr>
<td>MSc</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Example MPH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Example MPH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(^1\) Here, the summary table only includes the details determined to be thematically related to the guideline after the guideline development group discussed and evaluated the facts fully disclosed to the AWMF in the corresponding form. The completed declarations will be filed with the guideline secretariat.

\(^2\) Alternatively, a "Yes" may also be entered and the name of the company omitted.
Appendix 7: Instruction guide for completing the declarations of interests form

Instruction guide for completing the Declaration of Interests form – Answers to frequently asked questions

Please also observe the explanatory footnotes on the Declaration of Interests form!

1) **What is the time period for the information I have to provide?**
The declarations apply to the current year and the previous three years (example: Disclosure for March 2021 – then disclosures from 1 January 2018 to March 2021)

2) **Do I have to declare all interests, even if they are thematically unrelated to the current guideline topic?**
Yes, please specify all direct, financial and indirect interests that might be questioned, irrespective of the thematic context you might personally see yourself. This enables the assessor to determine any thematic reference. One advantage for you is that you can use this declaration of interests for other purposes as well.

3) **What counts as an "institution" within the health care system?**
Among others, these include commercially orientated contract institutes, health insurers/health insurance providers, or public donors (e.g. ministries, DFG), corporate entities/self-government bodies, foundations and possibly employers as well.

4) **I have held several lectures for an institution/organisation (example: Medical Association): do I have to specify all of them?**
Yes. However, it's sufficient if you simply summarise the information: 2018-2020 "Lectures for the medical association" and name the topics.

5) **I have written several book chapters for publishing houses – do I have to disclose all of them?**
It is sufficient if you state "book chapters" and specify the topics.

6) **Do I have to list all my publications?**
No, you do not need to include your entire publication list/PubMed list. You can limit yourself to information on areas of topical focus and/or to listing the publications that describe the focus of your scientific activities.

7) **Many trials are conducted at our hospital. Do I have to list them all?**
You only need to list those trials for which you are responsible (organisational responsibility).

8) **How accurately must I specify the amount of my remuneration?**
You can disclose the money you received as a rounded-off total per category and time period e.g. personal honoraria approx. € 10,000 from 01/2018 - 03/2021
Appendix 8: Registration form

Guideline Project Registration Form
Version of 4 April 2023

<table>
<thead>
<tr>
<th>Title of the guideline:</th>
<th>New guideline ✔️</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of registration:</td>
<td>Upgrade ✔️ Update ✔️ AWMF-Registry No.: 123456</td>
</tr>
<tr>
<td></td>
<td>Partial ✔️ Complete ✔️ Living Guideline</td>
</tr>
<tr>
<td>Intended class:</td>
<td>S1 ✔️ S2 ✔️ S2k ✔️ S3</td>
</tr>
<tr>
<td>Registration date:</td>
<td></td>
</tr>
<tr>
<td>Planned completion date</td>
<td>(month/year)</td>
</tr>
<tr>
<td>Reasons for the topic</td>
<td></td>
</tr>
<tr>
<td>selection</td>
<td></td>
</tr>
<tr>
<td>Goal orientation of the</td>
<td></td>
</tr>
<tr>
<td>guideline</td>
<td></td>
</tr>
<tr>
<td>Relation to existing</td>
<td>Erter AWMF Registry No:</td>
</tr>
<tr>
<td>guidelines</td>
<td></td>
</tr>
<tr>
<td>Registering person:</td>
<td></td>
</tr>
<tr>
<td>Registering medical</td>
<td></td>
</tr>
<tr>
<td>society/ies:</td>
<td></td>
</tr>
<tr>
<td>Involvement of third</td>
<td></td>
</tr>
<tr>
<td>parties AWMF medical</td>
<td></td>
</tr>
<tr>
<td>societies</td>
<td></td>
</tr>
<tr>
<td>Involvement of other</td>
<td></td>
</tr>
<tr>
<td>medical societies or</td>
<td></td>
</tr>
<tr>
<td>organizations:</td>
<td></td>
</tr>
<tr>
<td>Contact person (Guidelines office):</td>
<td></td>
</tr>
<tr>
<td>Guidelines coordination</td>
<td></td>
</tr>
<tr>
<td>(name):</td>
<td></td>
</tr>
<tr>
<td>Area of care:</td>
<td>Outpatient ✔️ Inpatient ✔️ Semi-inpatient ✔️</td>
</tr>
<tr>
<td></td>
<td>Prevention ✔️ Early detection ✔️</td>
</tr>
<tr>
<td></td>
<td>Diagnostics ✔️ Therapy ✔️ Rehabilitation ✔️</td>
</tr>
<tr>
<td></td>
<td>Primary care ✔️ Care by a specialist physician ✔️</td>
</tr>
<tr>
<td>Patient target population:</td>
<td>Adults ✔️ Children/adolescents, supplement as needed:</td>
</tr>
<tr>
<td>Guideline target group</td>
<td></td>
</tr>
<tr>
<td>(target users):</td>
<td></td>
</tr>
<tr>
<td>Planned methodology</td>
<td></td>
</tr>
<tr>
<td>(Type of evidence-based,</td>
<td></td>
</tr>
<tr>
<td>type of consensus</td>
<td>development):</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Supplemental information</td>
<td></td>
</tr>
<tr>
<td>on the project (available yes/no, if yes, where?):</td>
<td></td>
</tr>
</tbody>
</table>

Please complete and email to: anmeldung@awmf-leitlinien.de

Note on data protection: The AWMF gathers your data for the purpose of registering a guideline project. In order to carry out the guideline project, it is necessary that data are gathered and processed according to Art. 6 (1)(b) GDPR. The data is not made available to third parties unless it is for the purpose of complying with the AWMF Guidance Manual. The data are deleted as soon as they are no longer required for the purpose of processing. You are entitled to request information about the data stored on you and have the right to rectify inaccurate data or demand erasure of data in case of any unauthorized data storage.
### Instruction Guide for completing the Registration Form “Guideline Project”

**Version of 4 April 2023**

<table>
<thead>
<tr>
<th><strong>Title of the guideline:</strong></th>
<th>Please propose a declarative, but concise title for your guideline. In case of a “Living Guideline”, please include that in the title.</th>
</tr>
</thead>
</table>
| **Type of registration:**   | □ New guideline  
□ Upgrade or □ Update of AWMF Register No: .......................  
Please select under the register number the lead medical society that will be managing the guideline, if two medical societies are registering the new project.  
□ Partially  
□ Entirely  
□ Living Guideline  
Please observe the update periods: Maximum 5 years for practice guidelines; for “Living Guideline” the update periods are annually. |
| **Intended S class:**       | S1, S2e, S2k, S3, please specify. For help in deciding which class you should select, please visit https://www.awmf-leitlinien.de  
Heading AWMF Guidance Manual ➔ Guideline Registry, Classification of the developmental stages |
| **Registration date:**      | DD-MMM-YY |
| **Planned completion date (month/year):** | Please indicate by when the guideline is expected to be completed and note that the AWMF Guidance Manual requires that the application be online at least **6 weeks** prior to completion. This serves to inform the public whilst allowing other medical societies and organisations to actively express their interest in collaborating on the guideline.  
After the completion date, the administrative offices of the AWMF will ask you for information on the project’s status. If such information is not given, your application will be deleted from the registry.  
Please note in the case of “Living Guidelines”: Indicate the update periods, these are a maximum of 12 months. |
Reasons for the topic selection:
Please state why you selected this guideline subject. The justification should contain data on the prevalence of the aspect of care and the potential for improvement. In case guidelines are being updating: Please indicate what implementation of the guideline has already achieved in relation to health care. If necessary, delineate which specific chapters/recommendations are to be revised and which still remain valid.

Goal orientation of the guideline:
Please specifically indicate the objectives to be addressed in the guideline and achieved by its dissemination and implementation.

Relationship to already-existing guidelines in the AWMF registry:
First, please indicate whether content overlap with existing guidelines or guideline projects registered in the AWMF registry is possible, e.g. which guidelines have already dealt with specific subject areas in your guideline or (to some extent) have already made recommendations on these and, secondly, where you find that meaningful additions can be made to existing guidelines. The search function on the AWMF homepage can be used for this purpose. Please specify the AWMF registry numbers of these guidelines.

Registering individual (person)
Please specify who is registering the guideline; this need not be the coordinator

Lead AWMF medical society(ies):
Please specify the medical society(ies) registering the guideline (usually one to three).

Other lead medical societies or organisations
Please indicate if a medical society or organisation should be listed as co-lead.

Involvement of other AWMF medical societies or organisations:
Please indicate which AWMF medical societies have been asked to cooperate in your guideline and which have already committed. Please note: In their own interest, the representatives of all of the below-mentioned target audience of the guideline should be involved in its development.

Involvement of other medical societies or organisations:
Please indicate which organizations have been asked to cooperate in your guideline (e.g., patient organizations, professional associations; please also include medical societies outside the AWMF). To avoid errors, please state the full names of other parties and organisations instead of abbreviations. Please note: In their own interest, the representatives of all of the
### Contact person (guidelines secretary):

Please enter the address at which interested parties can contact the individuals responsible for registration / the guideline project (this need not be identical to the coordinator's address)

For technical reasons, we can only accept one e-mail address for guidelines secretary. Please decide which person(s) should be named. If necessary, we recommend setting up a specific e-mail

### Guideline coordination (Name):

Please indicate which person(s) is/are responsible for coordinating the guideline writing process

### Area of care:

Please state the health care sector/s, segments and

- outpatient/inpatient/ partial inpatient
- Prevention, early detection, diagnostics, therapy, rehabilitation
- primary care/specialized care

### Patient target group:

- Adults
- Children/Adolescents

Please tick at least whether the guideline is being developed for adults and/or for children/adolescents. Please state the target group of persons for whom the guideline is being developed (e.g. infants / small children / children / adolescents / adults / pregnant women /)

### Guideline target audience (target users):

Please state who should use this guideline and to whom the guideline information is directed. For example, these may be physicians in specific fields, patients or other professional groups. You can add the details relating to the target audience that is not directly involved:

### Planned methodology (Type of evidence basing, type of consensus finding techniques):

If the objective of your guideline is one of the classes S2e, S2k or S3, please indicate,

1. how the literature was searched, selected and appraised (S2e, S3)
2. which of the formal consensus techniques (nominal group process, consensus conference, Delphi method) will be applied during voting on the recommendations (S2k, S3) and how the neutrality of the moderation is ensured.

### Supplemental information on the project (available yes/no, if yes: where?):

If additional information is available on your Guideline Project:

Please state where this to be found (e.g. via the guidelines office) and/or list it here (e.g. on the existence of international guidelines, the promotion of Guideline Projects), where applicable as links.
Dear Guideline Coordinators,

To ensure that the planned inaugural meeting can be held successfully, we would like to summarise for you the preparatory steps that need to be undertaken and the time periods to be planned for them:

<table>
<thead>
<tr>
<th>Preparatory step</th>
<th>Time schedule</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Invitation to the inaugural meeting</strong></td>
<td>At the latest 6 weeks before the inaugural meeting</td>
<td>Timely invitations to online conferences are also required given that guideline honorary work may additionally be involved</td>
</tr>
<tr>
<td><strong>Creating the outline and key questions</strong></td>
<td>At the latest 2 weeks before the scheduled inaugural meeting</td>
<td>Knowledge of the planned structure and key questions facilitates the preparatory work and the discussion and specification of the tasks of the guideline group members</td>
</tr>
<tr>
<td><strong>Optional: Division into working groups</strong></td>
<td>At the latest 2 weeks before the scheduled inaugural meeting</td>
<td>Facilitates the definition of the tasks of guideline group members</td>
</tr>
<tr>
<td><strong>Declaration of interests and management of conflicts of interest</strong></td>
<td>The portal at <a href="https://www.awmf.org/leitlinien/Interessenerklaerung-online.html">https://www.awmf.org/leitlinien/Interessenerklaerung-online.html</a> facilitates the conflicts of interest management for coordinators and authors by making available the individual declarations of interest on further projects. We recommend that the conflicts of interest categories and conflicts of interest management be presented in the inaugural meeting and issues that arise be clarified.</td>
<td></td>
</tr>
</tbody>
</table>

1. **Invitation to the inaugural meeting**
   - Invitation of the nominated representatives to the inaugural meeting, if needed, re-scheduling by asking about alternative dates (e.g. via Doodle)
   - Timely invitations to online conferences are also required given that guideline honorary work may additionally be involved.

2. **Creating the outline and key questions**
   - Preparation of **proposed guideline outline** and **planned key questions** (ideally in PICO format)
   - Knowledge of the planned structure and key questions facilitates the preparatory work and the discussion and specification of the tasks of the guideline group members.

3. **Optional: Division into working groups**
   - Processing the **proposals for working groups**
   - Facilitates the definition of the tasks of guideline group members.

4. **Declaration of interests and management of conflicts of interest**
   - Project placement on the AWMF Portal **Declarations of interest Online** via the guideline delegates of the lead medical society (or dissemination of the AWMF pre-printed form).
   - Optimal processing of proposals relating to the **conflicts of interest categories** (low, moderate, high), if necessary with the AWMF guideline consultant.
   - The portal at https://www.awmf.org/leitlinien/Interessenerklaerung-online.html facilitates the conflicts of interest management for coordinators and authors by making available the individual declarations of interest on further projects. We recommend that the conflicts of interest categories and conflicts of interest management be presented in the inaugural meeting and issues that arise be clarified.
## Dissemination of the agenda + outline, key questions + working group proposals

<table>
<thead>
<tr>
<th>Contents of agenda:</th>
<th>At the latest 2 weeks before the scheduled inaugural meeting</th>
<th>1st joint meeting of all medical societies and organisations important for:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Introduction by the coordinators</td>
<td></td>
<td>• Getting to know each other</td>
</tr>
<tr>
<td>• Introduction of the participants</td>
<td></td>
<td>• Introducing the methodological approach to guideline development</td>
</tr>
<tr>
<td>• Methodological introduction ideally by the AWMF guideline consultant, regardless of S class:</td>
<td></td>
<td>according to the AWMF Guidance Manual instruction guide</td>
</tr>
<tr>
<td>o Verification of the completeness and representativeness of the guideline group</td>
<td></td>
<td>• Discussion/completion of the tasks from the planning phase</td>
</tr>
<tr>
<td>o Evidence-basing</td>
<td></td>
<td>(guideline structure, management of conflicts of interest, working group</td>
</tr>
<tr>
<td>o Formal consensus development</td>
<td></td>
<td>formation)</td>
</tr>
<tr>
<td>o Establishing the policy on the management of conflicts of interest: Present defined categories for the</td>
<td></td>
<td>• Introduction of the scientific and substantive guideline development</td>
</tr>
<tr>
<td>assessment including management policy</td>
<td></td>
<td>(definition of questions, prioritisation of endpoints, definition of</td>
</tr>
<tr>
<td>• Establishing voting rights: per medical society/ organisation one vote?</td>
<td></td>
<td>processing strategies, or search procedures).</td>
</tr>
<tr>
<td>• Outline of the guideline, definition of the key questions (clinical questions, PICO) and endpoints</td>
<td></td>
<td>• If the guideline group has not yet been completely constituted, subsequent appointments can be made as necessary.</td>
</tr>
<tr>
<td>(relevant outcomes), definition of the strategies for answering the key questions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Presentation and classification of the working groups</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• If the decision has been made for online pre-voting: the guideline coordinators write a brief</td>
<td></td>
<td></td>
</tr>
<tr>
<td>description of the project, presentation of the digital tool (e.g. SurveyMonkey, LimeSurvey) and the</td>
<td></td>
<td></td>
</tr>
<tr>
<td>time frame</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Establishing the organizational structure, work flow and time schedule</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

As soon as it is foreseeable that the schedule (in whatever step) cannot be met, please contact the guideline consultant or the AWMF-IMWi. Options should then be examined as to whether and how the planned date is feasible (e.g. as a work meeting) or whether a new date should be set.
Appendix 11: Consensus conference – Preparatory steps and time planning

Consensus conference – Preparatory steps and time planning

Dear Guideline Coordinators,

To ensure that the planned consensus conference can be held successfully, we would like to summarise for you the preparatory steps that need to be undertaken and the time periods to be planned for them:

<table>
<thead>
<tr>
<th>Preparatory step</th>
<th>Time schedule</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Invitation to a consensus conference</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Invitation of the participants, if applicable</td>
<td>At the latest 6 weeks before the scheduled inauguration meeting</td>
<td>Timely invitation promotes acceptance and participation (honorary basis)</td>
</tr>
<tr>
<td>Appointment scheduling (e.g. via Doodle)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Optional: Online pre-voting

Establish whether online pre-voting will take place (choose digital tool, e.g. SurveyMonkey, LimeSurvey)

<table>
<thead>
<tr>
<th>Preparatory step</th>
<th>Time schedule</th>
<th>Advantages:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish whether online pre-voting will take place</td>
<td>At the latest 4 weeks before the scheduled inaugural meeting</td>
<td></td>
</tr>
<tr>
<td>In the case of online pre-voting: Dissemination of the online pre-voting plus guideline - and/or draft chapters</td>
<td>At the latest 3 weeks before the scheduled consensus conference</td>
<td>All guideline development group members as well as all participating experts/ methodologists must have the opportunity to prepare on all topics.</td>
</tr>
</tbody>
</table>

- Better substantive preparation for the guideline development group
- Recommendations with more than 95% approval without substantive comments can be deemed to have been reached by consensus
- Identification of discussion-relevant topics
- Option for formulating amendment proposals for both the guideline development group and the guideline coordinators
- Focus on the “essentials”

Disadvantages:

- Time expenditure for data transfer to the tool, organisation
- Any costs incurred by the digital tool
Experience has shown that reminder emails can significantly increase participation in the online survey.

<table>
<thead>
<tr>
<th>- and/or all previously drafted background texts including evidence tables</th>
<th>Experience has shown that reminder emails can significantly increase participation in the online survey.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>In the case of <strong>online pre-voting:</strong> Dissemination of the results to the fully constituted guideline development group, as applicable with the new wording resulting from the redrafting</th>
<th><strong>At the latest 2 weeks before the scheduled consensus conference</strong> Possibility to evaluate and process the survey results: Approval rates, comments</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Consensus conference without online pre-voting</strong> Dissemination of the recommendations, with background text including evidence tables to the guideline development group</th>
<th><strong>At the latest 2 weeks before the scheduled consensus conference</strong> Adequate time for preparation; allowing the possibility to submit comments to the guideline coordinators in advance</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Assessment of conflicts of interest and management of conflicts of interest</strong> Ensure that the declarations of interest are complete; Establishment of the conflict of interest categories (low, moderate, high) by the assessors and assessment of the declared interests, if applicable with the support of the AWMF guideline consultant; Notification to the members of the guideline development group whom conflict management mandates that they must abstain from voting on certain recommendations or prepare a double vote.</th>
<th><strong>At the latest until the scheduled inaugural meeting</strong> The declared interests in defined conflict of interest categories must be assessed before the consensus conference is held so that conflict of interest management according to the policy stipulated in the AWMF Guidance Manual can be conducted in the consensus conference. Failure to submit a declaration of interests prevents participation in the consensus development.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Dissemination of the agenda</strong> <strong>Contents:</strong> • Introduction of the participants • (If not yet conducted in the inaugural meeting) completeness and representativeness of the guideline development group</th>
<th><strong>At the latest 1 week before the scheduled consensus conference</strong></th>
</tr>
</thead>
</table>
- (If not yet conducted in the inaugural meeting) establishing voting rights: one vote per medical society / organisation?
- Methodological introduction ideally by the AWMF guideline consultant, regardless of S class:
  - Evidence-basing
  - Formal consensus development
  - Conflicts of interest: Defined categories for the assessment including management
- Consensus-finding on recommendations, statements, or any graphics, flow charts under neutral moderation with AWMF guideline consultant
- Time planning, next steps

<table>
<thead>
<tr>
<th>Appendix</th>
</tr>
</thead>
</table>

As soon as it is foreseeable that the schedule (in whatever step) cannot be met, please contact the guideline consultant or the AWMF-IMWi. Options should then be examined as to whether and how the planned date is feasible (e.g. as a work meeting) or whether a new date should be set.
Appendix 12: Sample evidence table

Objective of the evidence table:
Assessment of the current evidence as an information basis for the formulation and grading of recommendations

Example of an evidence table:
We ask you to understand that this is merely an example of an evidence table and should be modified according to the particular topic of the guideline.

<table>
<thead>
<tr>
<th>Reference Type of study</th>
<th>Participants (number and characteristics)</th>
<th>Drop-out rate</th>
<th>Intervention</th>
<th>Control</th>
<th>Target variable(s)</th>
<th>Primary result</th>
<th>Note/Level of Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of patients in the study (inclusion and exclusion criteria, differences between groups (e.g. included and evaluated group), number of recruited and / or of evaluated patients (per group or ITT))</td>
<td>Overall data and / or per group (absolute numbers and / or in percent)</td>
<td>Details on the intervention for each group (dosage, time period, etc.)</td>
<td>Details on the control group (dosage, time period, etc.)</td>
<td>Specification of the primary target variable (usually based on the sample size calculation) and secondary target variable(s) (specified by the author)</td>
<td>Results of the primary and secondary target variables: Effect strength and precision (absolute numbers, mean value or percentage data, p-value, confidence intervals)</td>
<td>Specification of conspicuous positive and / or negative aspects related to study design, implementation and evaluation (e.g. unreasonable hypothesis, lack of blinding in RCTs, inadequate statistical methods)</td>
</tr>
<tr>
<td></td>
<td>Number of patients in the intervention group</td>
<td>Number of patients in the control group</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Appendix 13: Letter template “Invitation to the consensus conference”**

**INSTRUCTIONS**

Fill in each field highlighted in grey with your specific information.

This is a rough template. Please complete the form and add text as appropriate!

**Sender:**
[Guideline coordinator, title of the lead medical society/organisation sending out the invitation]

**Address**
[Personal contact person, title of the medical society/organisation to be invited]

**Re.: Invitation to a consensus conference**

Dear [Title, name of representative],

We are pleased to inform you that great progress has been made in the creation of the [S2k/S3] guideline [title of the guideline, AWMF Reg. No.].

The draft recommendations must receive formal approval by consensus for them to be accepted into the development stage [S2k or S3].

Because the medical society/organisation [title of the medical society/organisation] you represent is a stakeholder in the guideline [title of the guideline], we wish to give you the opportunity to participate in the process for adopting the recommendations of this interdisciplinary guideline.

We would therefore like to cordially invite you

on [Date]

from [time]:

to [location and conference venue].

The formal adoption procedure [nominal group process, structured consensus conference] will be moderated by Mr./Ms. [name] from the AWMF. You will be introduced to the procedure and the techniques at the venue.

In the attachment, you will find documents that will help prepare your content, including:

- The draft guidelines (full text including the guideline report)
- A summary of the recommendations to be approved by consensus

Would you please complete and return the enclosed reply form to us by (date).

[Email address]

[Your medical society's address]

We look forward to working with you.
Yours sincerely,
<table>
<thead>
<tr>
<th>Medical society/organisation:</th>
<th>..........................................................................................................................</th>
</tr>
</thead>
<tbody>
<tr>
<td>Representative:</td>
<td>..........................................................................................................................</td>
</tr>
<tr>
<td>Title, first name, last name:</td>
<td>..........................................................................................................................</td>
</tr>
<tr>
<td>Institute/Hospital:</td>
<td>..........................................................................................................................</td>
</tr>
<tr>
<td>Address:</td>
<td>..........................................................................................................................</td>
</tr>
<tr>
<td>Postal code, city:</td>
<td>..........................................................................................................................</td>
</tr>
<tr>
<td>I will attend:</td>
<td>(  ) Yes</td>
</tr>
<tr>
<td></td>
<td>(  ) No, but will be represented by</td>
</tr>
<tr>
<td>Title, first name, last name:</td>
<td>..........................................................................................................................</td>
</tr>
<tr>
<td>Date, signature, stamp:</td>
<td>..........................................................................................................................</td>
</tr>
</tbody>
</table>
Appendix 14: Formal consensus development techniques

Formal consensus-building techniques
The objective is to achieve manipulation-free and reproducible results through structured interaction within which individual contributions of the participants are systematically collected, made transparent and synthesised.

Involvement in the consensus process:
- Experts, users and patients, public, etc.
- Interdisciplinary and multi-professional composition, as appropriate, any guideline development group
- Independence or plurality of dependencies/perspectives

Consensus development methods:
- Nominal group process (approx. 15 – 20 participants)
- Structured NIH-type consensus conference (>20 – 60 participants)
- Delphi technique (up to approx. 200 participants)

Preparatory work:
Define objectives, methodology, voting procedure and, if applicable, any venue
Invite all participants in the adoption process
Send out materials in a timely manner

Nominal group process
Independent moderator
Handouts/transmitted documents: Guideline manuscript, recommendations, any applicable evidence tables

Procedure:
- Presentation of the statements / recommendations to be approved (working group head, moderator)
- Silent generation of ideas: Which recommendation/grade of recommendation do you not agree to? Substantive inquiries, supplementation, alternative?
- Round robin: moderator records the positions in the written resolution procedure and summarises comments
- Pre-vote by discussing the individual comments – if required, creation of a ranking list
- Debate / discuss items at issue
- Final voting on every recommendation and all alternatives
- Steps are repeated for each recommendation
Table 8: Advantages, disadvantages and risks for bias associated with the nominal group process

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
<th>Potential risk of bias</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group dynamics for exchanging ideas</td>
<td>Less anonymous contributions</td>
<td>Selection of participants</td>
</tr>
<tr>
<td>Strong group interaction</td>
<td>Longer duration (e.g., several days)/meeting required</td>
<td>Majority and minority influences</td>
</tr>
<tr>
<td>Feeling of ownership</td>
<td>Usually only one opportunity to give feedback on a recommendation</td>
<td>Social loafing</td>
</tr>
<tr>
<td>Clarification options</td>
<td>Only feasible up to a maximum of 15 participants</td>
<td>Group think</td>
</tr>
<tr>
<td>Relatively little organisational effort</td>
<td></td>
<td>Brainstorming, Presentation of the information</td>
</tr>
</tbody>
</table>

Structured NIH-type consensus conference

Independent moderators support small groups and plenary meeting.

Procedure:
In the first part of the conference
- Participants meet in small, topic-related groups
- Elaboration of common positions/proposed recommendations
Alternatively, this step can take place in advance within interdisciplinary/professional working groups

In the second part of the conference,
- the group leaders present to the plenum the results obtained in the small group discussions
- Substantive inquiries
- Justified amendment proposals are put to vote
- The results have to be recorded at the end of the conference.

Table 9: Advantages, disadvantages and risks for bias associated with the NIH-type structured consensus conference

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
<th>Potential risk of bias</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suitable for up to approx. 60 participants, or more if appropriate</td>
<td>In the plenum: Little opportunity to interact</td>
<td>Selection of participants</td>
</tr>
<tr>
<td>Anonymous electronic voting systems possible</td>
<td>In the plenum: Little opportunity to structure the group discussion</td>
<td>Presentation of the information</td>
</tr>
<tr>
<td>Plenum is suitable for advanced external auditing, promotes acceptance</td>
<td></td>
<td>Majority and minority influences Group think Social loafing Brainstorming</td>
</tr>
</tbody>
</table>
Delphi Technique

This is a multi-stage survey method that is carried out in writing/online among experts from various disciplines. It attempts to give group members the opportunity to review and/or compare their statements by means of a feedback process whereby participants are informed about the group's (summarised) response.

Procedure

- Solicit anonymous written contributions using structured questionnaires. Alternatively, a vote can be held using an online tool with the following options per recommendation: “I agree”, “I'm opposed, but have the following amendment proposals”. The abstentions required based on conflicts of interest are also considered.
- Summarize contributions and give feedback to the group
- Continue the questioning rounds until a group response is reached (consensus or justified dissent)

Table 10: Advantages, disadvantages and risks for bias associated with the Delphi technique

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
<th>Potential risk of bias</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suitable for larger groups as well</td>
<td>No direct exchange of ideas</td>
<td>Selection of participants</td>
</tr>
<tr>
<td>Anonymisation protects individual contributions and helps contributors focus on content</td>
<td>Large amount of organisational effort</td>
<td>Presentation of the information</td>
</tr>
<tr>
<td>Feedback / positions recorded on a pre-printed form</td>
<td>Pressure to conform during feedback phase</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 15: Guide to writing a guideline report for authors of S2k, S2e and S3 practice guidelines

This guide is designed to help you document your methodical approach to developing your guideline. Please consider the issues listed already during the planning stage of your guideline project and try to report in as much detail as possible. This will ensure transparency, quality and acceptance of your guideline. This guide primarily contains a description of the criteria defined in the Appraisal of Guidelines for Research and Evaluation (AGREE) II Instrument (https://www.agreetrust.org).

For this reason, the full version of AGREE II is also recommended as a basis for information. Please take special note of the criteria reviewed for all guidelines submitted for publication with the AWMF and used to justify the classification of each guideline as S2e, S2k or S3 (see highlighting). The description must demonstrate clearly that the requirements formulated in the rules have been met (www.awmf.org/leitlinien/).

Please include 3-5 keywords that will make your guideline easier for users to find via the search function on our website

Keywords (German):
Keywords (English):

1. Scope and purpose
   - Rationale for guideline topic selection
     (see AGREE II Criterion 1)
   - Goal orientation of the guideline
     (see AGREE II Criterion 1)
   - Target population (e.g. patients, public, etc.)
     (see AGREE II Criterion 3)
   - Area of health care
     (see AGREE II Criterion 3)
   - Target users/target audience
     (see AGREE II Criterion 6)

2. Constitution of the guideline development group: Stakeholder involvement
   - Representativeness of the guideline development group: Participating professional groups
     (see AGREE II Criterion 4) S2k S3
   - Representativeness of the guideline development group: Accounting for the views and preferences of the target population (e.g. patients, public, etc.)
     (see AGREE II Criterion 5) S2k S2e S3

3. Rigour of guideline development: Search, selection and critical appraisal of scientific facts (evidence-basing)
   - Formulating clinically relevant key questions, prioritising endpoints
     (see AGREE II Criterion 2)
   - Systematic searches
     (see AGREE II Criterion 7) S2e S3
   - Selection of evidence
     (see AGREE II Criterion 8) S2e S3
   - Critical appraisal of the evidence and synthesising the evidence S2e S3
Appendix

(see AGREE II Criterion 9)

**Linking evidence and recommendations** [S2e S3]

(see AGREE II Criterion 12)

**Formulation of recommendations and structured consensus development techniques**

- Structured consensus development: Procedure and implementation [S2k S3] (AGREE II Criterion 10)
- Consideration of health benefits, side effects and risks (see AGREE II Criterion 11)
- Formulation of recommendations and assignment of levels of evidence and/or grades of recommendation [S2e S3] (see AGREE II Criterion 12)

4. **External review and adoption**

- External review (see AGREE II Criterion 13)
- Adoption by the boards of the publishing medical societies/organisations [S2h S2e S3]

5. **Editorial independence**

- Guideline funding [S2k S2e S3] (see AGREE II Criterion 22)
- Declaring interests and managing conflicts of interest [S2k S2e S3] (see AGREE II Criterion 23)
  See also [https://www.awmf.org](https://www.awmf.org) “Declaration of interests and managing conflicts of interest”.

6. **Dissemination and implementation**

- Concept for dissemination and implementation (see AGREE II Criterion 18)
- Supporting materials for guideline application (see AGREE II Criterion 19)
- Discussion of potentially helpful and hindering factors for guideline application
- Criteria for monitoring and/or auditing the process and/or outcome quality of the guideline: Quality objectives, quality indicators (see AGREE II Criterion 21)

7. **Period of validity and update processes**

- Date of the last content revision and status (valid until...date)
- Procedure for updating the guideline (see AGREE II Criterion 14)
Appendix 16: Letter template “Formal adoption by the boards of the medical societies including approval of the Right of Use agreement”

Contract on granting of rights of use to the S...Guideline “...”

by and between

the Arbeitsgemeinschaft der Wissenschaftlichen Medizinischen Fachgesellschaften e.V. [Association of the Scientific Medical Societies in Germany], represented by Prof. Dr. Treede, hereinafter referred to as AWMF,

the German Society for ..., hereinafter referred to as [abbreviation of the medical society]

The medical society 1,

The medical society 2,

The medical society 3,

etc.

hereinafter referred to as entitled parties,

represented by the President of the Medical Society xxx

on the one hand

and

Professor X,
Professor Y,
Dr. (Ms.) Z.,
Dr. n.n.,

hereinafter referred to as authors, represented by Prof. X, coordinator,

on the other hand,
the following contract on granting of rights of use to the AWMF guideline ... to be jointly
prepared by the authors shall be concluded as follows:

**Preamble**

The medical societies regularly decide to develop medical scientific guidelines in accordance with
the Guidance Manual and Rules for Guideline Development of the Association of the Scientific
Medical Societies in Germany (AWMF Guidance Manual). Experts with proven expertise are
appointed to the respective guideline group for the development or revision of medical scientific
guidelines for this purpose, on behalf of and in the name of the boards of directors of the
participating medical societies. These experts act on behalf of and in the name of the medical
society which deputes them, taking into account the AWMF Guidance Manual. The guidelines
developed by these experts and adopted by consensus are to be regarded as a joint work under
copyright law. In accordance with the objectives and requirements of the guideline development of
the medical societies and the AWMF, the guidelines thus developed and adopted are to be
disseminated to medical societies in specialist circles and to patients via the AWMF and the boards
of directors of the medical societies. To achieve this goal, the guidelines are distributed free of
charge by the entitled parties. To achieve this objective, the rights of use described below are to be
granted to the entitled parties free of charge in order to promote their not-for-profit objectives. The
authors, as copyright holders see this as their voluntary contribution to the realisation of the
statutory objectives of the entitled parties. In addition, however, due to the possibility of gaining
new medical knowledge at any time, it is also necessary for the entitled parties to retain control over
the dissemination of the guideline at all times in order to ensure that corrections or even recalls of
the guideline or individual components thereof can be made at short notice. Under no
circumstances should outdated guidelines be disseminated under the name of the entitled parties.
For this reason, pursuant to Section 34 (5) sentence 2 of the German Copyright Act (UrhG), the
parties agree to derogate from the dispositive provisions of Section 34 [Transfer of rights of use]
UrhG. To this end, corresponding recall rights for the parties are agreed in Article 3 (4) and (5)
hereto.

In acknowledgement and recognition of these principles and the provisions of the AWMF Guidance
Manual, the signatories agree as follows:
Article 1 Subject of the Contract

(1) The subject of this contract shall be the S... guideline ... to be developed in the long version, together if applicable with any short version, coat pocket version, patient guideline etc. and the associated guideline report (hereinafter referred to as “Subject of the Contract”).

(2) The authors assure that they are authorised to grant the contractual rights of use to the Subject of the Contract.

Article 2 Granting of rights of use

(1) The authors are co-authors of the individual works (full-length version, short version, coat pocket version, patient guideline, guideline report, etc.) within the meaning of Section 8 UrhG, which make up the Subject of the Contract within the meaning of Article 1 (1) hereto and are entitled to represent the other co-authors. The subject of the guideline versions are in particular the topics

| |
| |
| |

(2) In accordance with the following provisions, the authors grant the entitled parties separate, spatially unrestricted, one-time transferable and non-exclusive rights of use to the Subject of the Contract for the duration of the statutory protection periods. The rights of use shall be granted free of charge.

(3) In each case of onward transfer of the right of use granted in accordance with Article 3 hereto, the entitled parties shall be granted a further right of use directly by the authors. For each new grant of rights, notification of the transfer of the right of use to a third party in accordance with Article 3 hereto made vis-à-vis the coordinator of the guideline group, Professor ..., as representative of the authors, is necessary and also sufficient.
Article 3 Substance of the rights of use

(1) The rights of use include the right to one's own non-excerpted reproduction, dissemination, and storage, making publicly accessible also by means of interactive products or services, the right of presentation, as well as the right of reproduction via image and sound media, in printed and electronic form, as well as the provision as application software for mobile operating systems (apps).

The entitled party is authorised in particular to

- replicate and disseminate in printed form
- replicate and disseminate in electronic media formats (e.g., magnetic tape, CD-ROM, CDI, DVD, Electronic Paper, hardware memory, hard drive, USB storage) and public accessibility (e.g., internet, intranet, or other wired or wireless data networks), including playback on stationary or mobile receiving devices, monitors, PDAs, mobile phones, smartphones, tablet PCs, or other receiving devices via download (e.g. PDF, app) or retrieval in any other form, etc. for translation, transmission and adaptation into other languages or versions (e.g. podcast, audio book or other image or sound media), transmit by means of television, cable or satellite, radio or other audiovisual media, place in archives, including electronic archives, as well as use in other types of usage known in the future and - as far as possible - for all other rights administered by collecting societies. Furthermore, the authors assign to the entitled party the statutory remuneration claims pursuant to Sections 44a et seq. UrhG, insofar as the entitled party has these administered by a collecting society that jointly administers the rights of publishers and authors; the entitled party accepts the assignment.

(2) The entitled party is prohibited from using the Subject of the Contract for other purposes or in any other way.

(3) The right of use shall also include the right to edit the work in order to correct obvious spelling and grammatical errors. Changes to the content are permitted insofar as they are obvious inaccuracies that do not require the author's specialist knowledge to correct. In cases of doubt, there is no right of amendment. The right of use also includes the right to reprint the work regularly and to mark it accordingly.

(4) The entitled parties have the right to discontinue the distribution/public availability of the
Subject of the Contract or its parts within the meaning of para. 1 at any time (non-exercise of the rights of use) if and to the extent that there are concrete indications that the Subject of the Contract or one of its parts contains errors or does not (or no longer) correctly reflect the current medical standard. In this case, the medical societies shall request the authors to revise the guideline. Specific indications within the meaning of this rule are, in particular, high-quality phase 3 studies that cast doubt on the recommendations of the Subject of the Contract.

(5) The authors, on their part, have the right to demand the cessation of the dissemination/making available to the public of the Subject of the Contract or its parts within the meaning of para. 1 at any time, provided that the requirements of para. 4 are met and the entitled parties do not desist from further distribution/making available to the public of the Subject of the Contract or its parts within the meaning of para. 1 on their own initiative. The entitled parties shall comply with this request.

(6) The rights of use are granted free of charge.

(7) For new editions and edited versions of the work, the right of use is granted in the same way in accordance with the provisions of paragraphs 1 – 4.

Article 4 Transfer of the granted right of use to third parties

(1) The authors also grant the entitled parties the right to transfer the right of use as a simple, non-transferable right of use in the manner and scope described below to suitable publication organs and specialist publishers and other media (third parties). The transfer of this subordinate right of use must also be free of charge. The content of the transferable right of use shall be determined in accordance with Article 3 (1) and (2).

(2) The entitled parties shall contractually stipulate vis-à-vis the third parties that, in the event of the subject of the agreement or one of its parts not being further disseminated in accordance with Article 3 (4) and (5), the third party shall also not further disseminate/publicly disclose the subject matter of the agreement or the affected part within the meaning of Article 3 (1).
Article 5 Recognition of authorship

The authors shall be named as authors in an appropriate manner in the Subject of the Contract and its parts. Mentioning them only in the guideline report is not sufficient.

Article 6 Establishment of copyright

(1) The authors assure that they, together with the other co-authors, are entitled to dispose of the copyright to the work in the manner described above, that they have not made any dispositions that conflict with the granting of the rights of use to the authorised persons, and that the content or parts of the work are not taken from unlawfully protected works of other copyright holders.

(2) Requests for rights of use will be forwarded by the authors to the AWMF or one of the other entitled parties for processing, insofar as this is expedient for exercising the rights of use granted.

Article 7 Termination of the contract

(1) The contract shall end at the end of the contract term without the need for termination.

(2) The authors can also only declare termination to individual entitled parties. Individual entitled parties may also terminate this agreement vis-à-vis the authors. In this case, the contract between the remaining parties shall continue to remain in force unchanged.

(3) The parties are at liberty to terminate the contract for good cause.

(4) The authors (also) consider any of the following events to constitute good cause:
   a) The entitled party dissolves, changes its purpose to an extent that is not in line with the objectives pursued with the Subject of the Contract, becomes insolvent and/or is placed under sequestration, insolvency proceedings are initiated against the assets of the entitled party or the initiation of insolvency proceedings is rejected for lack of assets or the entitled party is subject to comparable far-reaching changes in its financial position,
its ability to act or its statutory structure.

b) The entitled party breaches a material obligation under this agreement and does not remedy this breach within a period of one month set in writing, stating the material reasons; in particular, compliance with the rights of use and compliance with the restrictions of Article 3 hereto, including by third parties, shall be deemed to be material contractual obligations.

c) The entitled party uses the Subject of the Contract in a form that is not covered by this contract or to which the authors have not consented, unless this use is discontinued immediately, at the latest within one month of receipt of a written request to cease and desist.

(5) Occurrence of any of the following events shall constitute good cause for the entitled parties:

The authors breach a material obligation under this agreement and do not remedy this breach within a period of one month set in writing and stating the material reasons; in particular, the possibility of granting the contractual rights of use shall be deemed a material contractual obligation.

(6) Any notice of termination must be in writing.

(7) The authors' rights of recall under Sections 41, 42 UrhG shall remain unaffected.

Article 8 Settlement at the end of the contract

Upon termination of this agreement, the entitled parties shall immediately refrain from using the subject of the agreement, verifiably delete or destroy any copies made (including digital copies, e.g. on data carriers) or return them to the authors upon request. In case of content used online, the authors shall inform the entitled party after termination as to which content is to be removed.
Article 9 Final provisions

(1) Should individual provisions of this contract be wholly or partially invalid or lose their legal validity at a later date, this shall not affect the validity of the rest of the contract. The invalid provisions shall be replaced by the statutory provisions. The same shall apply if the contract contains an unforeseen loophole.

(2) There are no ancillary agreements to this contract.

(3) The ‘Explanatory notes to the “Contract on Granting of Rights of Use”’ contained in Annex 1 form an integral part of this contract. However, only the above provisions are binding.

Place, date

AWMF, Prof. Dr. Rolf-Detlef Treede

Place, date

Place, date

President of the medical society

Coordinator
Appendix 17: Explanatory notes on the agreement on the granting of rights of use

Explanatory notes to the “Contract on Granting of Rights of Use”

I. General / purpose of the contract

The purpose of the agreement is to constitutively define the copyright situation relating to the creation of so-called AWMF guidelines in order to avoid disputes and misunderstandings. Without a contractual agreement of this type, the statutory regulations would apply, which do not always adequately take into account the special situation in the creation of scientific-medical guidelines. Copyright law was created primarily keeping in mind works which are to be commercially marketed.

The primary purpose of drawing up written contracts is to avoid disputes. The parties to the contract should be able to clearly determine which rights and obligations exist at all times. In order to achieve this clarity, the contract makes use of copyright law terminology. The purpose of the following explanations is to clarify the wording used in order to make it easier for the parties to understand.

II. Clarifications concerning the contract

All parts of the contract are binding. This also applies explicitly to the Preamble, which must be used to interpret the provisions of the contract. The motivating factors as to why the parties entered into the agreement and their objectives are set out in the Preamble.

1. Article 1 Subject of the contract

The Subject of the Contract is the guideline yet to be developed in all its versions. This includes the long version, the short version and any pocket versions or patient guidelines to be created. This also includes the corresponding guideline report yet to be created.

2. Article 2 Granting of rights of use

As a work in progress is involved, it is absolutely essential that Article 2 (1) hereto specify the topic of the guideline project in order to define the Subject of the Contract.

The systemic structure of the contract is based on a two-stage concept:
In the first stage, the copyright holders, i.e. the members of the AWMF guideline group (authors) and the participating medical societies, grant so-called simple and transferable rights of use. In case of a simple right of use, the entitled party is placed in a position to use the work in the manner described in more detail, without excluding use by others. Alternatively, the law also envisages the granting of so-called exclusive rights of use. In case of an exclusive right of use, it is not possible to allow other parties to use the guideline. However, in case of AWMF guidelines, since several institutions are entitled to use the guidelines, and disseminate them, only simple rights of use come into question.

In the second stage, the entitled parties (AWMF and medical societies) are in turn entitled to transfer their acquired rights of use to a third party. This requires separate contracts. Who this third party may be is governed by Section 4 of the contract. The special feature of this second transfer is that in this case no comprehensive right of use is granted, but rather a limited and non-transferable right of use is transferred. This means that the chain of transfer of rights of use ends at the level of the third party. These third parties (publishers, etc.) are therefore entitled to publish the guideline in a specialist journal, for example, to publish it as a book or to make it available to end users in the form of a computer program (app) (so-called public access). However, they, on their part are not entitled to grant rights of use to other entities (subordinate rights of use).

It should be emphasized that no financial consideration was or may be agreed upon at either level.

3. Article 3 Substance of the rights of use

The various types of use to which the AWMF and the medical societies are entitled are defined in more detail in Article 3. This is an exhaustive catalogue. Corrections to the guideline by the entitled parties are permitted only to a very limited extent within the scope of Section 3 (3) in order to minimize the obvious risk of Improvements for the worse. It should be noted that only the AWMF and the medical societies have this limited right to make corrections. The publishers authorised at the second stage no longer have this right to make corrections.
Furthermore, both the authors and the entitled parties have the option of discontinuing the dissemination of the guideline in the event that new scientific and medical findings emerge. In order to do justice to the considerable effort involved in developing a guideline, the unilateral right to recall the guideline is limited to cases in which scientific and medical evidence casts doubt on the medical robustness of the guideline content. It is of course possible at any time to stop the further dissemination of the guideline by mutual agreement.

**Article 4 Transfer of the granted right of use to third parties**

This paragraph specifies the extent to which and the persons to whom the entitlement the rights of use may be transferred.

**Article 5 Recognition of authorship**

This provision serves to ensure that the authors receive the appropriate recognition in the pending publications.

**Article 6 Establishment of copyright**

Article 6 (1) serves to ensure that the authors actually have the option to grant the rights of use governed by the contract and have not already done so, e.g. by granting an exclusive right of use.

Paragraph 2 of this provision is intended to relieve the authors of administrative tasks. The AWMF and the medical societies are more likely to be in a position to make decisions due to their permanently staffed offices.

**Article 7 Termination of the contract**

In principle, the rights of use are granted for the entire duration of the statutory term of protection. In case of doubt, this is 70 years post mortem auctoris. As it may also be necessary to terminate the agreement before the expiry of this period, provisions on termination must be included. The provisions contained in Article 7 are standard cases of termination under copyright law, adapted to the special features of commercial use applicable to not-for-profit associations.
The recall rights mentioned in Article 7 (7) refer to a right of revocation for non-exercise (Section 41 of the German Copyright Act (UrhG)) and the right of revocation for changed conviction of the author (Section 42 UrhG).

**Article 8 Settlement at the end of the contract and Article 9 Final provisions**

In the event of a dispute, these provisions serve to help the parties identify a course of action and thus reduce the potential for conflict.
Appendix 18: Comments sheet for the consultation version

Comments sheet for the consultation version

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Please return via e-mail by DD/MM/20xx at the latest to:
## Appendix 19: Documentation for consultation

**Documentation for consultation**

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Appendix 20: Letter template: “Formal adoption by the boards of the medical societies including approval of the Right of Use agreement”

Address / letterhead of the inquiring medical society

Address of the medical society/organisation in question

Re.: Guideline project (title, AWMF Reg. No.)
Request formal adoption by the boards of the medical societies including approval of the Right of Use agreement

To Whom It May Concern:

We are pleased to inform you that the S2e/S2k/S3 guideline (title of the guideline registered with the AWMF under AWMF Reg. No.) has now been completed with the involvement of your representatives (Names) and approved with finality within the guideline development group.

Therefore, we would request formal adoption be issued by (Name of the medical society/organisation in question).

Moreover, we advise you to approve the written agreement governing the exploitation rights within the scope of disseminating guideline (called the Right of Use agreement). The purpose of the agreement is to constitutively delineate the legal context governing the creation of guidelines to thereby avoid misunderstandings. Please also refer to the explanatory notes on the contract for granting exploitation rights. This contract should be signed by the lead medical society (representing all participating medical societies) as well as by guideline coordinators (representing the authors as the proprietary community).

Please grant your approval hereto.

If you have any questions, please do not hesitate to contact us at any time – in exchange with your representative(s).

Looking forward to your approval.

Best regards,

(Signatory guideline coordinators, on behalf of the lead medical society)
Appendix 21: Checklist for publication of a guideline with the AWMF

Publication of a guideline with the AWMF online:

Checklist

To avoid follow-up inquiries from the AWMF and thus unnecessary delays in the publication of your guideline, please check all of the following items before submitting the guideline to the AWMF (email: imwi@awmf.org):

Title of the guideline: ____________________________________________________________
AWMF Register No. ___ / ___

The guideline text has been corrected fully .................................................................
The guideline text has been divided into chapters, which are numbered consistently .......
The corresponding ICD-10 codes are contained in the guideline wherever possible .......
The title pages of the guideline (also print publications!) and all related documents clearly and visibly contain the
- AWMF Register No. of the guideline ........................................................................
- Methodological classification of the guideline (S1, S2e, S2k or S3) ..............................
The title page of the guideline clearly and visibly contains the lead and participating medical society(ies) ...................................................................................................................

For all guidelines (S2e, S2k, S3): The guideline report is attached ...................................

For all guidelines (S2e, S2k, S3) and recommendations for action (S1): The declarations of interests of all participants and the procedure for documenting, identifying and managing conflicts of interest are described .........................................................................................

For S3 guidelines: List the number of evidence-based recommendations ....................
List the number of consensus-based recommendations ...............................................

If the guideline is also being published in a journal: The publishing house has been informed that the rights to electronic publication have been granted to the AWMF ..................
The details given as rationale for topic selection, goal orientation of the guideline, links to related guidelines, participating medical societies and organisations, area of care, patient target population, target audience can be found in the
Guideline text/guideline report .......................................................................................

or should be transferred unchanged by the AWMF from the guideline registration to the
guideline data sheet ........................................................................................................

Key words for indexing the guideline to concretise the search function on the AWMF
website and make the guideline easier to find:
.........................................................................................................................................................

For publication in the library of the Guidelines International Network (G-I-N Library):

English title of the guideline: ...........................................................................................

English key words from the title (ideally MeSH): ............................................................
.........................................................................................................................................................

Version 2.1, 7 December 2022.
Appendix 22: AWMF Guideline Register Rules

I. Classification into "S" classes using systematic methods

Classification as S1 guideline
Within an informal consensus meeting, a group of experts constituted from the medical society(ies) to be representative shall draft a recommendation that is finally adopted by the board of the medical society(ies) and any other participating organisations.

Classification as S2 guideline
Subdivision into the classes S2k (consensus-based) and S2e (evidence-based) with the valid definitions:

If it is an S2k guideline,
- The guideline development group is representative of the target audience, and representatives of the relevant medical society(ies) and/or organisation(s) to be involved as appropriate, including patients, public, etc., are involved in guideline development at an early stage (see AGREE II criterion 4 + 5)
- The methods for formulating recommendations are clearly described. This requires formal structured consensus techniques, e.g. consensus conference, nominal group process or Delphi method (see AGREE II Criterion 10)
- Each recommendation is discussed and voted on within the structured consensus process with a neutral moderator whose objectives are to resolve still open decision-making issues, to conclusively grade the recommendations and to measure the strength of the consensus
- A description of the methodological approach (guideline report) is provided with the guideline. Note: Recommendations from S2k guidelines do not contain any schematic details on the grades of evidence and recommendations because the evidence has not been systematically synthesised
- Information on the period of validity and for updating the guideline is available (see AGREE II Criterion 14) and a contact person responsible for updating is nominated. The predefined update periods for “Living Guidelines” are known and do not exceed 12 months
- The guideline is finally adopted by the boards of all participating medical societies and organisations
If it is an S2e guideline,

- The views and preferences of the patients, public, etc. are sought (see AGREE II Criterion 5)

- A systematic search, selection and critical appraisal of the scientific evidence for the relevant clinical key questions are required

- Systematic methods are used to search for the evidence, i.e. the search strategy is described in detail with a list of the search terms and sources used (such as electronic databases, databases of systematic reviews or guidelines, hand-searched specialised journals or conference reports), time frame for the literature search and number of hits (see AGREE II Criterion 7)

- The selection criteria for the evidence are presented explicitly. Inclusion criteria (e.g. target population, comparisons, endpoints, language, context, study design) and exclusion criteria are presented (see AGREE II Criterion 8)

- The evidence researched and selected according to criteria established a priori is assessed with respect to its methodological quality and the results are synthesised in an evidence overview. This can be in table format with comments on quality aspects or by using formal instruments or strategies (e.g. Cochrane risk-of-bias tool, GRADE (Grading of Recommendations Assessment, Development and Evaluation) methodology (see AGREE II Criterion 8 + 9)

- The result of the assessment determines the confidence in the quality of the evidence (level of evidence)

- The recommendations are clearly linked to the description of the underlying evidence in a corresponding section (background text) and/or to an evidence synthesis with a reference list (see AGREE II Criterion 12)

- A description of the methodological approach (guideline report) is provided with the guideline

- Information on the period of validity and for updating the guideline is available (see AGREE II Criterion 14) and a contact person responsible for updating is named. The predefined update periods for “Living Guidelines” are known and do not exceed 12 months

- The guideline is finally adopted by the boards of all participating medical societies and organisations
Classification as S3 guideline

Guideline with all elements of systematic development

If it is an S3 guideline,

- the guideline development group is representative of the target audience and representatives of the medical society(ies) and/or organisation(s) to be involved accordingly, including the patients, public, etc. are involved in guideline development at an early stage (see AGREE II Criterion 4 + 5)

- A systematic search, selection and critical appraisal of the scientific evidence for the relevant clinical key questions is required

- Systematic methods are used to search for the evidence, i.e. the search strategy is described in detail with a list of the search terms and sources used (such as electronic databases, databases for systematic reviews or guidelines, hand-searched specialised journals or conference reports), time frame for the literature search and number of hits (see AGREE II Criterion 7)

- The selection criteria for the evidence are presented explicitly. Inclusion criteria (target population, study design, comparisons, endpoints, language, context) and exclusion criteria are presented (see AGREE II Criterion 8)

- The evidence researched and selected according to criteria established a priori is assessed with respect to its methodological quality and the results are summarized as an evidence overview. This can be presented in a tabular format with comments on quality aspects or by using formal instruments or strategies (e.g. Cochrane risk-of-bias tool, GRADE (Grading of Recommendations Assessment, Development and Evaluation) methodology (see AGREE II Criterion 8 + 9)

- The result of the assessment establishes confidence in the quality of the evidence (level of evidence)

- The recommendations are clearly linked to the description of the underlying evidence in a corresponding section (background text) and/or to an evidence synthesis with a reference list (see AGREE II Criterion 12)

- The methods for formulating recommendations are clearly described. This requires formal structured consensus techniques, e.g. consensus conference, nominal group process or Delphi method (see AGREE II Criterion 10)
• Every recommendation is discussed and voted on as part of a structured consensus development with a neutral moderator. The objectives are to find a solution to pending decision-making issues, to establish a final grading of the recommendations (S2k guideline) and/or to establish the grade of recommendation (S3 guideline) and to measure of the strength of consensus the finished guideline states the levels of evidence and/or grades of recommendation for each recommendation

• A description of the methodological approach (guideline report) is provided with the guideline

• Information on the period of validity and for updating the guideline is available (see AGREE II Criterion 14) and a contact person responsible for updating is named. The predefined update periods for “Living Guidelines” are known and do not exceed 12 months

• The guideline is finally adopted by the boards of all participating medical societies and organisations

II. Registration procedure for guidelines in planning and development

Registration of the guideline project (new development or update) with the AWMF is a prerequisite for inclusion in the guideline register and subsequent publication of the guideline via the AWMF information system. The registration promotes interdisciplinary collaboration in guideline development groups and helps avoid unresolved contradictions across the various guidelines on related topics.

The publication of the registration online can keep other interested medical societies and organisations informed and allows them to apply to the guideline coordinators if they want to offer their collaboration.

The registration should be made upon commencement of the guideline project or by the time the invited members confirm to the coordinator that they will participate in the guideline project.

The currently valid preprinted AWMF “Registration Form” should be used to register guideline projects (links to the registration form). As part of the maintenance of the guideline register, all registrations are inspected by the AWMF at the AWMF Institute for Medical Knowledge Management (IMWi).

Workflow of the application procedure

The registration of guideline projects with the AWMF is processed according to the following workflow:

1. The applicant medical society(ies) submit the application to register the planned guideline project on the completed Registration Form to the AWMF-IMWi. (Please only submit to the email address anmeldung@awmf-leitlinien.de).
2. Every 14 days, the AWMF-IMWi applies the 4-eyes principle to review and check the registrations to ensure completeness of the Registration Form and conformity with the AWMF Guidance Manual. In particular, special attention is paid to the answers to the question about possible thematic overlaps or duplications in the registration form. Different guidelines on the same health care setting (disease/symptom or intervention) and the same target audience (specialisation etc.) are not entered in the AWMF Registry. In justified cases, different practice guidelines can temporarily be developed for the same health care setting with various target users. However, these need to be consistent in the continuity of care and at the overlapping interfaces. The objective should be to maintain only one guideline on one topic.

3. The applicant medical society(ies) shall receive a letter (via email) from the AWMF-IMWi, in which they are informed of the outcome of the deliberations.

4. If the resolution is positive, the AWMF-IMWi shall
   - assign a registration number to the guideline project
   - notify the applicant that the guideline project has been entered in the registry of applications together with the request to submit any changes to the applications promptly (e.g. with regard to the cooperating medical societies or the completion date) so that these too can be entered in the registry.
   In the event of uncertainties or a perceived need for supplementation/correction, the AWMF-IMWi shall return the application with a request for clarification and to proceed accordingly from point 1.

5. On the day after the completion date specified in the registration, the applicant medical society(ies) will receive an automatically generated reminder email with a request to communicate the status of the project and its newly anticipated and final completion date. If no reply is received, the registering medical society(ies) will receive a personalized letter (by e-mail) after approx. four weeks asking once again for a response. If there is still no response within the next two weeks, the guideline project will be removed from the registry.

6. If extensions of the completion date are applied for in a timely manner and justified, they will be processed according to the procedure in item 5. The predefined update periods for “Living Guidelines” are specified and do not exceed 12 months.

7. The maximum term of registration is five years.
   Registrations older than five years are automatically deleted from the AWMF Registry. The registered medical society(ies) shall receive a personalised letter (by email) from the AWMF-IMWi which informs them about
   - the fact of deletion
   - the option to resubmit the application.
III. Declaration of interests and management of conflicts of interest in guidelines projects

Conflicts of interest are defined as circumstances that create a risk that professional judgments or actions regarding a primary interest will be unduly influenced by a secondary interest. Conflicts of interest do not have to have a negative connotation per se. They manifest as the juxtaposition of primary interests (e.g. when practice guideline authors formulate evidence- and consensus-based recommendations aimed at improving quality of care) with secondary interests (e.g. direct and indirect financial, academic, clinical, personal), which can vary in magnitude and scope. Conflicts of interest are thus often unavoidable, but not necessarily problematic in terms of influencing the contents of the guidelines. It is international consensus that transparency and the fair, reasonable management of conflicts of interest (see Position paper of Guidelines International Network, and recommendations for managing conflicts of interest associated with the activities of the Scientific Medical Societies, are the decisive factors critical to the legitimacy and credibility of practice guidelines as perceived by the public and policy makers see AGREE II Criterion 22 + 23).

The declaration of interests and the description of the policy for managing conflicts of interest aim at building trust and protecting the group from any speculations about bias or partiality which may, under certain circumstances, entail protracted clarification processes. They are a prerequisite for the publication of S1 recommendations for action and S2 and S3 guidelines via the AWMF Guideline Registry.

The following rules apply:

1. The funding strategy for the development of the practice guideline must be disclosed to the AWMF. Guidelines funded by third parties with any direct substantive influence will be rejected for publication in the AWMF Registry; this is in accordance with internationally recommended and practiced policy.

2. All those participating in developing a practice guideline (S2, S3) or a recommendation for action (S1) are obligated to declare their interests in writing using a preprinted form (see Sample form for Declaration of interests; the contents can also be filled in online, see AWMF Online Portal “Declarations of interests”); the form covers all direct, financial and indirect interests. Where applicable, indirect interests include the affected party's mandating organisation (e.g. medical society) and their area of scientific focus.

3. The declarations should be issued by the commencement of the guideline project or by the time the invited members confirm to the coordinator that they will participate in the guideline project. For longer-term projects, the declaration must be renewed once a year until the guideline development project is completed, or at least prior to consensus development.
4. It is the responsibility of the lead medical society(ies) and/or that medical society registering a guideline project to obtain the declaration from the coordinator it has appointed. It is the responsibility of the coordinator to obtain and compile the declarations from members of the guideline development group.

5. The declarations should be assessed by third parties. The declarations by all members of the guideline development group, including the coordinators, must be assessed. For this purpose, the responsible parties should be selected (“conflicts of interest officer”) who can be appointed from the community of guideline development group members or from external circles. Alternatively, the assessment can take place during a discussion among the guideline development group.

6. The evaluation of the declarations of interests includes
   a) An assessment as to whether any conflicts of interest exist
   b) An estimation of the thematic reference to the guideline overall and/or regarding specific key questions addressed in the guideline
   c) The assessment of the relevance of any conflicts of interest should be classified on a scale of 1 to 3 (low, moderate or high). These deliberations should consider the criteria for determining the magnitude of any potential conflict resulting therefrom
      - the function of the concerned individual within the guideline development group and their decision-making and discretionary powers associated with them and
      - the protective factors applied to the guideline (evidence-basing with systematic searches, selection and appraisal of the literature, evidence tables, structured consensus development using formal techniques such as the nominal group process, DELPHI, consensus conference, independent methodologists for evidence-basing and consensus development, external appraisals like peer review and consultation procedures)

7. The policy for management of conflicts of interest should be based on the following principles:
   - Coordinators of guideline projects should not have any thematically relevant conflicts of interest. In cases where this is unavoidable (e.g. because the expertise and commitment of the person concerned is indispensable), a co-coordinator without any thematically relevant conflicts of interest should be appointed (e.g. a methodologist or an expert in the field as a peer) or the guideline group be asked for deliberations and a decision.
   - Participants with minor conflicts of interest should not hold any lead functions within the guideline development group (Members of steering committees/steering groups, working group leaders, persons mainly responsible for evidence processing, moderators). In cases
where this is unavoidable, members without thematically relevant conflicts of interest should constitute the majority in steering committees, whilst it should be ensured that one member without thematically relevant conflicts of interest is appointed as a peer for individual functions.

- Participants with moderate conflicts of interest should not participate in appraisal of evidence and consensus development. To the extent that their knowledge is indispensable, these participants shall have the status of advisory experts without voting rights.
### List of abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AGREE</td>
<td>Appraisal of Guidelines for Research &amp; Evaluation = Instrument for methodological evaluation of practice guidelines</td>
</tr>
<tr>
<td>AMSTAR</td>
<td>A MeaSurement Tool to Assess systematic Reviews = Checklist for the methodological assessment of systematic reviews and meta-analyses, since 2017 as AMSTAR II</td>
</tr>
<tr>
<td>ASA</td>
<td>Acetylsalicylic acid</td>
</tr>
<tr>
<td>AWMF</td>
<td>Association of the Scientific Medical Societies in Germany</td>
</tr>
<tr>
<td>AWMF-IMWi</td>
<td>AWMF – Institute for Medical Knowledge Management</td>
</tr>
<tr>
<td>BAG</td>
<td>German Federal Working Group Self-help</td>
</tr>
<tr>
<td>BMF</td>
<td>German Federal Ministry of Education and Research</td>
</tr>
<tr>
<td>BMG</td>
<td>German Federal Ministry of Health</td>
</tr>
<tr>
<td>CC</td>
<td>Consensus conferences</td>
</tr>
<tr>
<td>CINAHL</td>
<td>Cumulative Index to Nursing and Allied Health Literature</td>
</tr>
<tr>
<td>CGS-GmbH</td>
<td>Clinical Guideline Services-GmbH (a limited liability company)</td>
</tr>
<tr>
<td>DFG</td>
<td>German Research Foundation</td>
</tr>
<tr>
<td>DKG</td>
<td>German Cancer Aid</td>
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<tr>
<td>DRKS</td>
<td>German Clinical Studies Registry</td>
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<tr>
<td>DVG</td>
<td>German Digital Healthcare Act</td>
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<tr>
<td>EID</td>
<td>Evidence to Decision Framework</td>
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<tr>
<td>GGPO</td>
<td>German Guideline Program in Oncology</td>
</tr>
<tr>
<td>GIN</td>
<td>Guidelines International Network</td>
</tr>
<tr>
<td>GoR</td>
<td>Grade of Recommendation</td>
</tr>
<tr>
<td>GRADE Working Group</td>
<td>Working Group for Grading of Recommendations Assessment, Development and Evaluation</td>
</tr>
<tr>
<td>GDPR</td>
<td>General Data Protection Regulation</td>
</tr>
<tr>
<td>HL7</td>
<td>Health Level 7</td>
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<tr>
<td>HTA</td>
<td>Health Technology Assessment</td>
</tr>
<tr>
<td>IQWiG</td>
<td>Institute for Quality and Efficiency in Health Care</td>
</tr>
<tr>
<td>LoE</td>
<td>Level of Evidence</td>
</tr>
<tr>
<td>MAGIC App</td>
<td>Making GRADE the Irresistible Choice App</td>
</tr>
<tr>
<td>MeSH</td>
<td>Medical Subject Heading</td>
</tr>
<tr>
<td>NAKOS</td>
<td>National Clearinghouse for the Encouragement and Support of Self-help Groups</td>
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<tr>
<td>NGP</td>
<td>Nominal group process</td>
</tr>
<tr>
<td>NIH</td>
<td>National Institutes of Health</td>
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<tr>
<td>NICE</td>
<td>The National Institute for Health and Care Excellence</td>
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<tr>
<td>NVL</td>
<td>(German) National Programme for Disease Management Guidelines</td>
</tr>
<tr>
<td>NKLM</td>
<td>National Competence-Based Catalogue of Learning Objectives for Undergraduate Medical Education</td>
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<tr>
<td>OL</td>
<td>German Guideline Program in Oncology (GGPO)</td>
</tr>
<tr>
<td>PEDro</td>
<td>Physiotherapy Evidence Database</td>
</tr>
<tr>
<td>PICO(S)</td>
<td>Patient-Intervention-Comparison-Outcome-(Setting)</td>
</tr>
<tr>
<td>RSS</td>
<td>Rich Site Summary - a web feed format</td>
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<tr>
<td>SIGN</td>
<td>Scottish Intercollegiate Guidelines Network</td>
</tr>
<tr>
<td>SNOMED</td>
<td>Systematized Nomenclature of Medicine Clinical Terms</td>
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<tr>
<td>S Classification</td>
<td>Classification into AWMF &quot;S&quot; classes for practice guidelines by applying the systematic methodology</td>
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<tr>
<td>S2k</td>
<td>S2 consensus-based</td>
</tr>
<tr>
<td>S2e</td>
<td>S2 evidence-based</td>
</tr>
<tr>
<td>SGB V</td>
<td>Fifth Book of the German Social Code</td>
</tr>
<tr>
<td>TED system</td>
<td>Tele-Dialog system = Term referring to a format that enables listeners to interact anonymously via a wireless voting device</td>
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<tr>
<td>U.S.</td>
<td>United States</td>
</tr>
<tr>
<td>WWW</td>
<td>World Wide Web</td>
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