Beyond the Guideline: Lessons in Leadership, Limits, and Legacy from the BSG IBD Process

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Introduction: The Hidden Labour Behind Clinical Guidelines

The British Society of Gastroenterology (BSG)'s latest five-year national guideline for inflammatory bowel disease (IBD) [1] has recently completed. This adjunct commentary to the guideline contains the reflections of two chairs — one methodological, one clinical — who steered the process. It is not written to seek praise or indulgence but rather to lay bare the pragmatic decisions, structural challenges, and emerging questions that surfaced while leading the guideline process.

We offer five key insights, not only to inform future BSG guideline work but to contribute to international dialogue on how we produce, update, and future-proof clinical guidance in increasingly complex evidence environments.

1. Breadth vs. Usability: How Big Is Too Big?

The scope of this guideline is vast — over 100,000 words, 43 recommendations, 114 good practice statements with nearly 800 original manuscripts referenced, prompting peer review to suggest relegating many visual and tabular summaries to supplementary materials. And yet, major areas such as colorectal cancer surveillance and transition of care remain outside its remit.

Should guidelines be broad and exhaustive, or lean and focused? A narrower approach might improve usability, streamline production, and allow more agile updates. For example, separating Crohn's disease and ulcerative colitis guidance could reduce duplication and support real-world implementation. However, smaller documents risk contradictory conclusions, fragmented recommendations, duplication of guidance and the inefficiencies of repeated methodology work.

Future guidelines must balance user needs with methodological coherence and accept that topic modularity — while attractive — may not come without cost.

2. The Guideline Lifecycle Is Broken

Most society guidelines follow a 3–7 year cycle. Teams commit immense effort, produce the document, and move on — often due to burnout, competing professional commitments or changing roles. This loss of continuity means that institutional memory is erased, and subsequent guidelines often begin from scratch, even when labelled as "updates."

Our experience confirms that this model is inefficient and unsustainable. Worse, the lag between submission and publication can render guidance outdated even before it is printed — with this guideline being a case in point, with a last data search undertaken in 2024 and publication occurring in 2025. We have kept a close eye on the field at large to ensure no ground breaking works have occurred that would challenge the validity of the guideline in the meantime, but this is a constant tension when such a large methodologically complex

work needs rigorous review.

A potential solution is the living guideline. This model would retain a standing committee and maintain the rigorous processes used here, applying them in an incremental fashion. As evidence changes, ad hoc updates would be published promptly which is possible due to the smaller and more focused nature of the updates — each peer-reviewed and then incorporated into a larger body of work, culminating in a refreshed full guideline every 3–6 years. This would not replace a publication of a full guideline every 5 years. It would just make it easier as rapidly changing evidence such as the induction and maintenance therapies of Crohn's disease and ulcerative colitis would be updated biannually whereas other more stable sections would only get updated every time a guideline is published.

Though this may sound resource-intensive, in reality, it would demand fewer hours than redoing everything from the ground up. Searches could be run, screened, and incorporated over days, not months. Crucially, the credibility of a living guideline lies in one thing: users knowing that recommendations are truly current.

The American Gastroenterological Association (AGA) has embraced this model. No other major society has. We believe the BSG should lead Europe in considering this transition.

3. Resource Reality: The True Cost of Guidelines

This guideline was only made possible through thousands of hours of voluntary time from clinical and academic professionals. In working time equivalents, the leadership group of this guideline (1 methodology lead, 1 clinical lead, 2 advanced IBD fellows, 1 senior research fellow in gastroenterology and 1 associate professor in evidence synthesis) dedicated a minimum of 10% of their time for 30 months with the associate professor in evidence synthesis working full time on this guideline for a period of 6 months. We calculated that the rest of the guideline development group consisting of over 50 health professionals and 10 patient representatives dedicated 2.5% of their time for 20 months to deliver this guideline. While the BSG supported a face-to-face event — which we deeply valued — the real cost of guideline production is staggering. It is beyond the scope of this guideline to calculate the monetary cost of this endeavor.

This is not sustainable.

Future models must prioritise efficiency. More importantly, we must recognise that investment should not prioritise travel or meetings but the core engine of guideline development: information specialists, evidence reviewers, and the protected time needed to support them.

Moving to a living guideline model, with periodic but light-touch updates, may paradoxically reduce resource demands — especially when combined with international collaboration. Shared evidence syntheses, common quality assessments, and a harmonised central

repository (which still allows for local contextual decision-making) could transform the global evidence landscape. For lower-resourced settings, this may be the only viable route to robust, high-quality guidance.

4. Conflicts of Interest: Time for a Reckoning

The most difficult issue to raise — and one we do so with caution — is the role of conflict of interest (COI) in guideline production.

BSG, like most societies, adheres to established COI procedures. Authors declare potential conflicts, and declarations are reviewed before joining. In our guideline, conflicted members could not vote on relevant therapies — a meaningful step forward. However, they remained present for discussions, unlike in grant or regulatory settings where full recusal is required.

At Digestive Disease Week in 2025, at a fascinating symposia we spoke at comparing international guidelines, it was argued forcefully that guideline authors should be entirely free of conflicts. This aligns with the Cochrane model, which mandates that the first and corresponding authors — and at least two-thirds of all authors — be free of any commercial conflict. Such a move would be disruptive. Most practising gastroenterologists have some level of conflict under current norms. But this makes the risk greater, not lesser — and mitigation strategies weaker, not stronger.

Future guidelines could consider:
- Majority non-conflicted authorship (by role and number).
- Structured management of indirect funding (e.g., channelled through organisations, not individuals).
- Clear separation of conflicted authors from both voting and discussion.

The UK — with its single-payer NHS and cultural emphasis on public service — is uniquely positioned to lead this reform. The BSG has a real opportunity here.

5. Collaboration and Shared Evidence: From Aspiration to Action

We have engaged with colleagues across the AGA, ECCO, and Canadian societies in comparing methodology and synthesising evidence. These conversations have only confirmed what we already sensed: the evidence synthesis component of guideline work is highly replicable and transferable. The judgments — based on feasibility, acceptability, and cost — may differ locally. But the foundational GRADE assessments need not.

Creating a shared global evidence repository, open to all and regularly maintained, is not a utopian dream — it is a practical necessity. The result would be:
- Less duplication of labour.
- Higher quality synthesis.
- More inclusive participation, especially from under-resourced health systems.

It’s time to stop imagining this and start building it. Creating such a collaborative effort

would not make local and national guidelines obsolete. National societies are best placed to analyze the evidence synthesis and produce recommendations and good practice statements for the population they serve, but it would be more efficient and cost-effective to our global stakeholders and ensure true sharing of the highest methodological standards.

Conclusion: Setting the Agenda for the Next Generation

We are proud of this guideline. It was a labour built on rigour and a genuine team achievement. But it is also a snapshot in time and has directly informed this call to action.

The future of guideline development will be shaped not just by methodological integrity, but by structural reform. The issues we raise here — modularity, sustainability, living models, COI policy, and global collaboration — must become the centre of the conversation, not the margins.

For clinical leaders who use guidelines but have never sat in the trenches of producing one, we offer this perspective to highlight what it takes — and how much more efficient, transparent, and impactful the process could be. If we want better guidelines, we need better systems. And if change is coming, the time to plan is now.

References

1. Moran G, Gordon M. BSG guidelines for Inflammatory Bowel disease 2025. Gut. IN PRESS.

Conflict of Interests.

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