Article:
Torres-Cuellar, J.C., Pérez-Muñoz, D.A., Florez, I.D. et al. (2026) Transparency and methodological quality of clinical practice guidelines in palliative care. Scoping review. Journal of Evaluation in Clinical Practice, 32 (2). e70392. ISSN: 1356-1294

https://doi.org/10.1111/jep.70392

Journal of Evaluation in Clinical Practice

WILEY

Journal of Evaluation in Clinical Practice
International Journal of Public Health Policy and Health Services Research

REVIEW ARTICLE OPEN ACCESS

Transparency and Methodological Quality of Clinical Practice Guidelines in Palliative Care. Scoping Review

Julio Cesar Torres-Cuellar[1] | Daniel Alejandro Pérez-Muñoz[1] | Ivan D. Florez[2,3] | Sam H. Ahmedzai[4] | Esther de Vries[5,6] | Jose A. Calvache[1,7]

[1]Department of Anesthesiology, Universidad del Cauca, Popayán, Colombia | [2]Department of Pediatrics, Universidad de Antioquia, Medellín, Colombia | [3]School of Rehabilitation Science, McMaster University, Hamilton, Ontario, Canada | [4]Medical School, University of Sheffield, Sheffield, UK | [5]Department of Clinical Epidemiology and Biostatistics, Pontificia Universidad Javeriana, Bogotá, Colombia | [6]School of Nursing and Midwifery, Queen's University Belfast, Belfast, UK | [7]Department of Anesthesiology, Erasmus MC Rotterdam, Rotterdam, the Netherlands

Correspondence: Jose A. Calvache (j.calvacheespana@erasmusmc.nl)

Received: 8 October 2025 | **Revised:** 12 February 2026 | **Accepted:** 16 February 2026

Keywords: AGREE II | clinical practice guidelines | end-of-life care | methodological quality | palliative care | RIGHT checklist | transparency

ABSTRACT

Background: Palliative care (PC) and End-of-Life Care (EOLC) focus on improving the quality of life of patients with life-threatening illnesses by addressing physical, psychosocial, and spiritual needs. Clinical practice guidelines (CPGs) are essential for standardising care and supporting evidence-based clinical decision-making to improve patient outcomes but despite their importance, the methodological quality, transparency, and overall trustworthiness of CPGs require systematic evaluation. Given the limited assessment of CPGs in these areas, this study aimed to assess the methodological quality and transparency of CPGs in PC and EOLC for adult patients using the AGREE-II tool. Additionally, we evaluated the completeness of reporting using the RIGHT checklist.

Methods: We conducted a scoping review to map the existing clinical CPGs in PC and EOLC. A comprehensive search of MEDLINE, EMBASE, and multiple international guideline repositories was performed to identify relevant CPGs endorsed by professional organisations. Two reviewers independently screened, extracted data, and assessed the methodological quality and transparency using the AGREE II tool and the completeness of reporting using the RIGHT checklist. Discrepancies were resolved by consensus or a third reviewer. Descriptive analyses and inter-rater agreement were calculated.

Results: A total of 6430 citations were identified and screened, resulting in the final inclusion of 23 CPGs. Over half (52.2%) focused exclusively on PC and were developed by governmental institutions. Based on AGREE-II assessment, 60.9% were classified as 'Recommended', 30.4% as 'Recommended with modifications'. The highest-scoring domains were Scope and Purpose (89%) and Clarity of Presentation (83%), while Applicability scored lowest (25%). Among the CPGs, 'IETS 2016 (Institute for Technological Assessment in Health, Colombia)' had the highest overall quality score (mean 96%), while 'CHPCA 2013 (Canadian Hospice Palliative Care Association, Canada)' had the lowest (mean 22%). Interrater agreement was good to excellent across most AGREE II domains, with the highest agreement for editorial independence (ICC = 0.87; 95% CI: 0.71–0.94) and the lowest for stakeholder involvement (ICC = 0.61; 95% CI: 0.29–0.81).

Conclusion: Several CPGs in PC and EOLC demonstrated significant gaps in applicability and transparency. To enhance their relevance and impact in clinical practice, improvements are needed in addressing real-world implementation challenges and providing clearer information on methodology, funding sources, and conflict of interest management.

1 | Introduction

Palliative care (PC) is a patient and family centred care approach that 'improves the quality of life of patients and their families who are facing problems associated with life-threatening illness especially in advanced diseases' [1, 2]. It aims to prevent and relieve suffering through early identification, impeccable assessment and treatment of pain and other problems, whether physical, psychosocial, or spiritual and facilitating patient autonomy, access to information, and choice [3]. Continuous medical advances have led to treatment strategies that extend survival in advanced diseases, including during End-of-Life Care (EOLC). Although EOLC resembles PC, and is often part of PC, it focuses on multidisciplinary care provided in the final days or hours of life with the goal of offering patients the best possible quality of death and dying [4].

Clinical practice guidelines (CPGs) are systematically created documents, based on the best scientific evidence available in order to support the delivery of high-quality medical care. Its development requires a rigorous methodological process conducted by multidisciplinary teams, designed to incorporate evidence from the literature, expert opinions, patient values, preferences (including patient needs and priorities), all while considering costs within the local healthcare system [3–6]. Additionally, CPGs must include a comprehensive process of development, adequate methodological quality and rigorous strategies in the development of recommendations for practice [6, 7], where methodological quality is focused on the proper conduct, analysis and interpretation of studies to minimise biases and enhance validity, whereas methodological transparency emphasises the degree of clarity, completeness, and accessibility with which the CPG development process is reported and documented. The AGREE II instrument is widely used to assess the methodological quality of CPGs, ensuring that their development is robust, transparent, and evidence-based. Its application helps identify strengths and weaknesses in guideline design, supporting informed use in clinical practice [8]. In addition, the RIGHT (Reporting Items for Practice Guidelines in Healthcare) checklist helps ensure completeness and transparency in CPG reporting [9].

In 2019, Irajpour et al., evaluated the methodological rigour of CPGs specifically focused on EOLC in cancer patients, using the AGREE-II tool [10]. They identified eight guidelines, of which only three were classified as strongly recommended for implementation. The domain with the highest average score was 'Clarity of presentation', while the lowest was 'Editorial independence' [10]. To our knowledge, this remains the only study that has systematically assessed the methodological quality of CPGs in this field. Although numerous CPGs related to PC are available, many focus on specific clinical domains without providing comprehensive guidance on PC or the EOLC process. A clear example of this trend is the existence of guidelines dedicated exclusively to the management of specific symptoms such as pain and dyspnoea, or to the care of particular conditions including chronic obstructive pulmonary disease (COPD), heart failure, and specific types of cancer [11–14]. More recently, guidelines have also addressed interventions like palliative sedation, which is used during the dying phase to relieve refractory suffering by deliberately reducing the patient's level of consciousness [15, 16]. While these CPGs offer useful and relevant recommendations for specific symptoms or clinical conditions, they are often narrow in scope, limited to national or institutional contexts, and may not meet the rigorous methodological standards needed for broader implementation.

Therefore, our objective was to identify and evaluate current CPGs addressing PC and EOLC in adult patients, assessing their transparency, methodological quality and the completeness of their report.

2 | Methods

2.1 | Study Design and Search Strategy

We conducted a scoping review to map existing CPGs in PC and end-of-life care EOLC. We followed the standards established in the Preferred Reporting Items for Systematic Review and Meta-Analysis (PRISMA) Statement and its extension for Scoping Reviews [17]; the protocol was registered and is publicly available in the Open Science Framework (OSF) (https://osf.io/k2pgr/).

A scoping review was selected instead of a systematic review because the primary objective was to map the breadth, characteristics, and methodological diversity of existing CPGs, rather than to assess the effectiveness of specific interventions or to synthesise outcomes. Given the heterogeneity of the sources, development processes, and reporting standards, a scoping approach was more appropriate to identify gaps in the literature and to provide an overview of the available guidelines.

2.2 | Eligibility Criteria and CPGs Selection

We used a definition for CPGs previously established by the Institute of Medicine [18]. For CPGs to be included, they had to fulfil all the following criteria: (1) CPGs focused on general PC or EOLC, (2) focused on a population comprising adults aged 18 and over, and (3) endorsed by a national or international professional organisation. If multiple CPGs existed from the same developer, only the latest version was included.

We excluded CPGs under the following criteria: (1) CPGs focused on PC including only a single dimension of care (i.e., pain management or delirium), (2) CPGs focused on specific diseases (i.e., specifically lung cancer or other pathology-related guidelines, such as those for COPD or heart failure), (3) CPGs without treatment recommendations, (4) unavailable papers that we could not retrieve in full text to verify their eligibility, after multiple attempts, including contacting authors. Disease-specific guidelines were excluded because they are developed for clinical trajectories, prognoses, therapeutic options, and symptom profiles, and therefore differ in objectives, evidence bases, and methodological approaches. Their inclusion would introduce substantial conceptual and clinical heterogeneity, as observed differences might reflect variations in disease type, stage of illness, clinical trajectory, and target populations.

Two authors conducted an initial screening (JT and DP) using Covidence platform [19]; duplicates were removed, and titles and abstracts were reviewed. Discrepancies between appraisers were resolved through discussions or consultation with a third author (JAC). From each CPG, two independent authors (JT and DP) extracted data using a standardised REDcap

version 12.0.3 [20], sheet and collected the year of publication, country of publication, guideline version, guideline update number, journal of publication, and guideline developer.

2.3 | Appraisal of the Selected CPGs Using AGREE II and RIGHT

AGREE-II is a validated and widely used tool for assessing the transparency and quality of the development of CPGs [8]. It comprises 23 items grouped into six quality domains and two global rating items (overall assessment): (1) Scope and purpose (items 1–3), (2) Stakeholder involvement (items 4–6), (3) Rigour of development (items 7–14), (4) Clarity of presentation (items 15–17), (5) Applicability (items 18–21), and (6) Editorial independence (items 22 and 23). Each item is scored on a seven-point Likert-type scale: ranging from 1 (Strongly disagree) to 7 (strongly agree) [21]. Finally, AGREE II includes two overall appraisal items [1]: the global quality of the guideline, rated on a seven-point Likert scale where 1 represents the 'lowest possible quality' and 7 the 'highest possible quality', and [2] the recommendation for guideline use, categorised as 'recommended', 'recommended with modifications', or 'not recommended' [22].

AGREE-II evaluation was independently conducted by two reviewers (JT, DP). Prior to the evaluation, reviewers received a standardised training in the use and application of the AGREE-II by using the available online materials provided by Agreetrust.org.

We evaluated the completeness and quality of the CPGs report by using the Reporting Items for Practice Guidelines in Healthcare (RIGHT) checklist. It consists of 35 items organised into seven domains, covering basic information, background, evidence, recommendations, review and quality assurance, funding, and declaration and management of interests, along with general information [9]. Each item was evaluated as 'Yes' (if the guideline reported the majority of the required information), 'No' (if the relevant information was not reported), or 'Unclear' (if the reporting was insufficient or ambiguous, preventing a clear judgement about whether the item was adequately addressed). In case of discrepancies, a third reviewer (JAC) was consulted to resolve them after a thorough discussion.

2.4 | Data Analysis

Descriptive analyses were performed by estimators' central tendency and dispersion including mean and standard deviation (SD) or median and interquartile ranges (IQR). For each AGREE-II domain, the score was obtained by summing the individual item scores within the domain and standardising the result as a percentage of the maximum possible score for that domain, yielding a final value between 0% and 100%. The following formula was applied: (score obtained – minimum possible score)/(maximum possible score – minimum possible score) × 100. A summary table was designed to generate mean values for the domain. We also calculated the degree of concordance of the evaluation in which 'the score obtained was the sum of the scores by individual evaluators', maximum score = 7 (strongly agree) × 2 (evaluators) × number of items in the domain and minimum score = 1 (strongly disagree) × 2 (evaluators) × number of items in the domain [23, 24].

AGREE-II lacks explicit score interpretation guidelines, so we followed the methodology of previous studies, this approach was chosen to maintain methodological consistency and to facilitate comparison with the existing literature. We emphasise that these categories are intended to support the interpretation of results rather than to represent absolute measures of guideline quality [25]. The overall mean score classified the CPGs as 'recommended' (> 60%), 'recommended with modifications' (30%–60%), or 'not recommended' (< 30%) to be applied and used in clinical practice. Guidelines classified as 'Recommended with modifications' can still be applied in clinical settings, especially when there are no other guidelines available for the specific clinical issue in question. Finally, an absolute interrater agreement among the reviewers was determined by using the intraclass correlation coefficient (ICC) with a 95% confidence interval (CI), based on a mean-rating (k = 2), using a two-way random-effects model. This model was selected because both reviewers and guidelines were considered random samples from larger populations, and the objective was to estimate absolute agreement that could be generalised beyond the specific raters included. A standardised score was calculated separately for each of the six domains, and it was classified as a poor agreement (< 0.50), moderate (0.50–0.75), good (0.75–0.90), and excellent (> 0.90) [26, 27].

Regarding the completeness of the reporting, we calculated the domain reporting rate for each included CPG, which was equal to the number of items reported divided by the total number of items in the domain, and calculated the mean reporting rate of each domain for all included guidelines. Data was analysed using the RStudio software including boxplot and ggplot2 packages [28].

3 | Results

We screened a total of 6430 references from our entire search. After assessing eligibility, we included 23 CPGs in our analysis. During the identification process, CPGs were collected through two main pathways: Identification of CPGs via databases and registers; and identification of CPGs via other methods. Initially, 34 CPGs were selected, however, after the final review, 11 were excluded, leaving 23 CPGs for analysis (Figure 1).

Most of the included CPGs originated from the United States ($n = 6$, 30.4%), followed by the United Kingdom ($n = 5$, 21.7%). Spain, Australia, and Canada. The regional distribution of available CPGs in PC is illustrated in (Figure 2). All included CPGs were general guidelines for PC, most focused exclusively on PC ($n = 12$, 52.2%), six in EOLC (26.1%) and five (21.7%) addressed both topics. Twelve CPGs (52.2%) were produced by governmental institutions, 17 (73.9%) were new guidelines (first versions), and nine (39.1%) explicitly reported their funding sources (Supporting Information S1: Table 1). Based on AGREE II overall assessments, 14 CPGs (60.9%) were classified as 'Recommended', seven (30.4%) as 'Recommended with modifications', and two (8.7%) as 'Not recommended' (Table 1).

Across AGREE II domains, the highest median scores were observed for Scope and Purpose (89%) and Clarity of Presentation (83%), whereas the lowest median score was found for

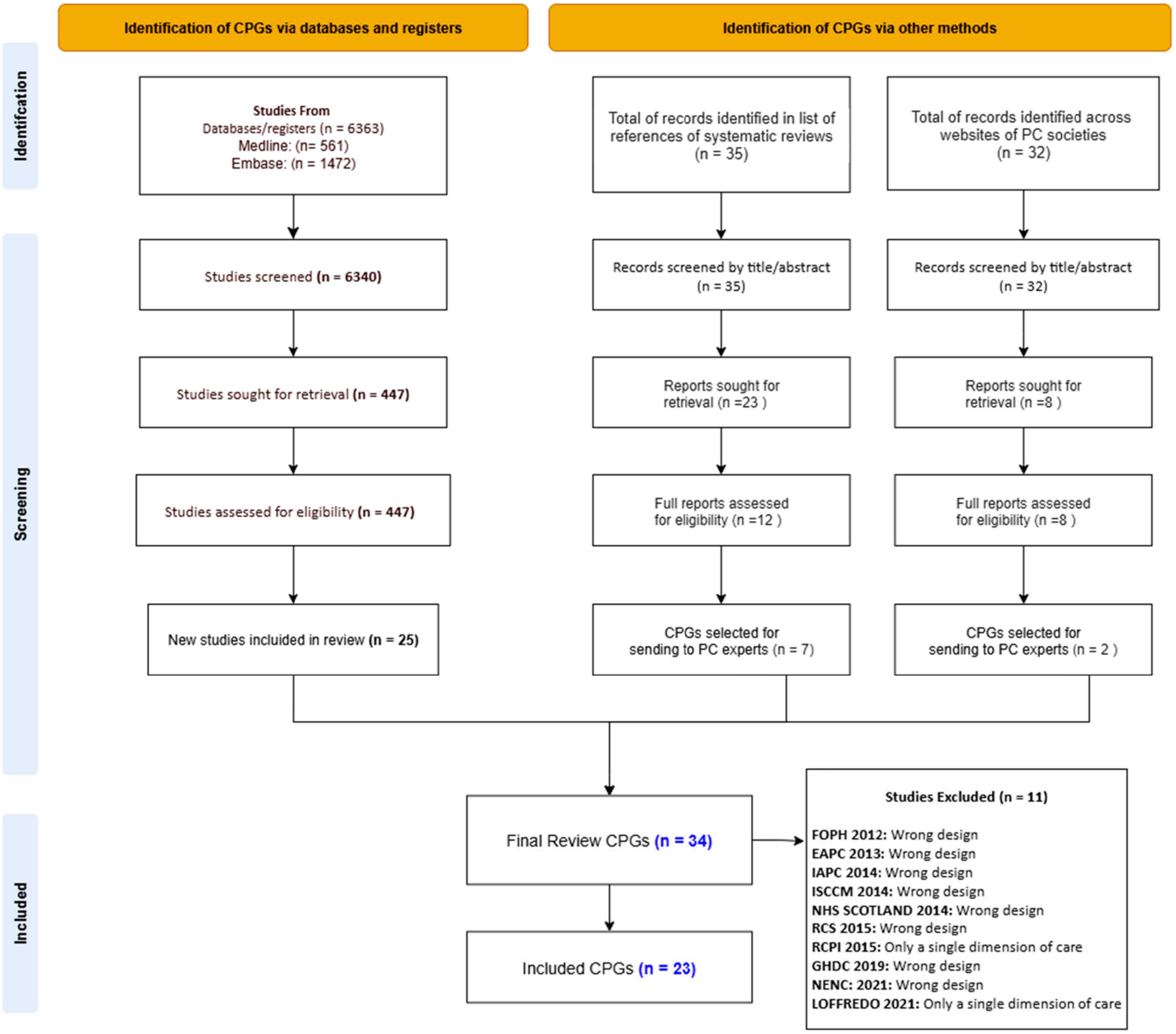

FIGURE 1 | Flow diagram of inclusion of CPGs.

Applicability (25%) (Table 1, Figure 3). Median scores for the remaining domains ranged from moderate to high (Table 1). Among the individual CPGs, the guideline developed by the Colombian Institute of Health Technology Assessment (IETS, Colombia, 2016) was the highest-rated, with a mean score across all domains of 96%, followed by the guideline from the German Guideline Program in Oncology (GGPO, Germany, 2015) with 89%, and the American Society of Clinical Oncology (ASCO, USA, 2024) guideline with 88%. The lowest-rated guideline was that of the Canadian Hospice Palliative Care Association (CHPCA, Canada, 2013), with a mean score of 22% (Table 1).

Absolute interrater agreement was rated as moderate for the Stakeholder involvement domain, and good for the remaining domains (Table 2).

Completeness of the reporting of the included CPG was assessed by using RIGHT checklist (Supplementary material). The total number of items evaluated between the two evaluators was 805 and the number of disagreements categorised as Yes/No was 20 (2.5%), while disagreements categorised as Unclear/No was 41 (5.1%). Over 90% clearly indicated the type of document (Item 1a), the year of publication (Item 1b), and included clear, precise, and actionable recommendations (Item 13a). However, reporting was notably low—below 30%—for items related to transparency and development processes. These included funding sources and conflicts of interest (Items 18a, 18b, 19a, 19b), consideration of patient values, preferences, and resource implications (Items 14a, 14b, 14c), as well as quality assurance and external review procedures (Items 16 and 17).

4 | Discussion

We aimed to evaluate the transparency and methodological quality of the development of published CPGs in PC and EOLC of adult patients by using the tool AGREE-II and their completeness of the report by using the RIGHT tool. Overall, our findings indicate that most available guidelines demonstrate acceptable methodological quality, although important

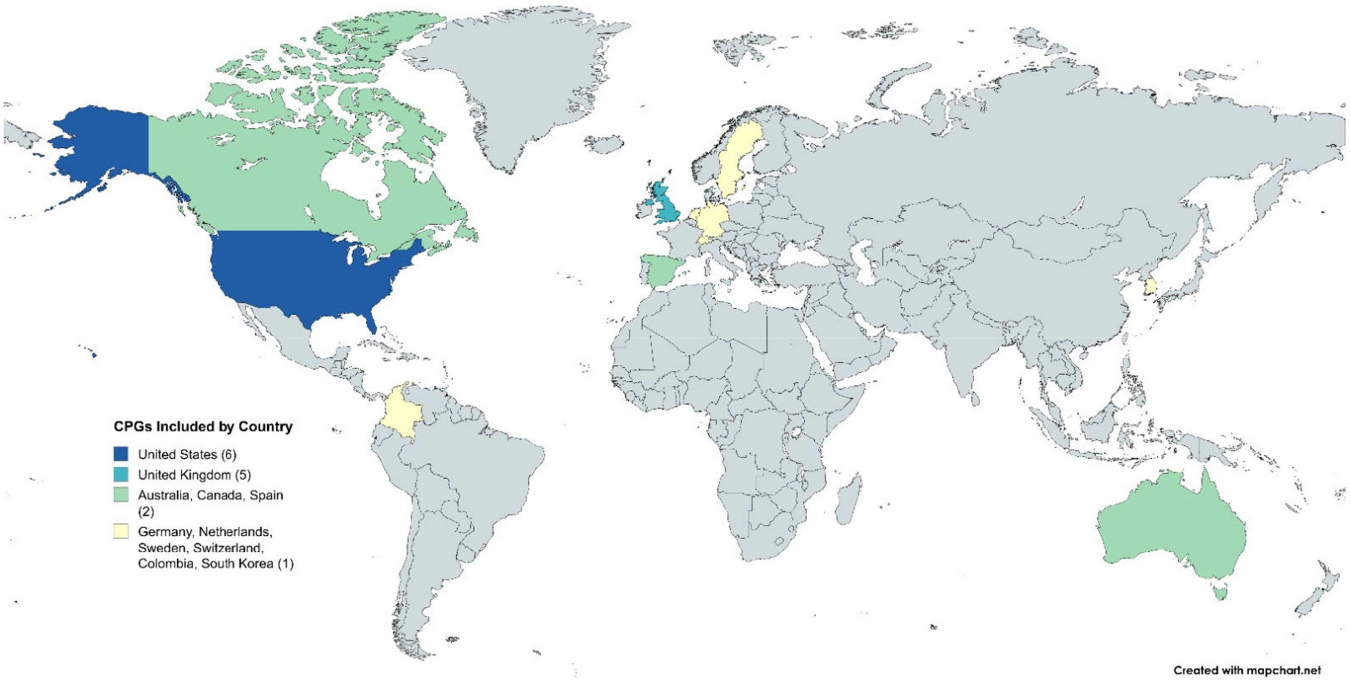

FIGURE 2 | Regional distribution of included Clinical Practice Guidelines (CPGs). The figure illustrates the geographic origin of the 23 included CPGs, highlighting the number of guidelines contributed by each country.

weaknesses persist, particularly in domains related to implementation and transparency.

Compared with the evaluation conducted by Irajpour et al. [10], which reported a lower proportion of guidelines classified as recommended, our findings suggest a potential improvement in the methodological rigour of PC and EOLC CPGs over recent years. This apparent progress may reflect increasing awareness among guideline developers of the importance of standardised development processes, clearer reporting, and alignment with international methodological frameworks. Such improvements are encouraging, as higher-quality guidelines may enhance clinician confidence, support educational initiatives, and provide a stronger evidence base for policymakers. For clinicians, it can enhance confidence in making informed decisions; for educators, it offers reliable, up-to-date content for PC training programmes; and for policymakers and stakeholders, it provides a solid evidence base to use CPGs that may improve healthcare delivery and resource use.

Across guidelines, strengths were consistently observed in domains related to scope and purpose and clarity of presentation. These findings show that most CPGs clearly define their objectives, target populations, and key clinical questions, and present recommendations in an understandable format. In contrast, limitations in the applicability domain were common. This pattern may reflect persistent challenges in addressing real-world implementation issues, such as resource availability, feasibility, cost considerations, and contextual adaptation, which are often underdeveloped during guideline development. Only a small subset of CPGs achieved high performance across all AGREE II domains, indicating that excellence in methodological rigour, stakeholder involvement, applicability, and editorial independence remains difficult to achieve simultaneously. Similar patterns have been reported in previous evaluations, suggesting that these challenges are not unique to PC and EOLC guidelines but represent broader issues in guideline development.

Among the CPGs included in this study, only five achieved high scores (> 80%) across all domains, a finding that is consistent with the results reported by Irajpour et al., where only three guidelines reached similarly high overall scores (> 80%) [8]. In our analysis, the domains of 'scope and purpose' (89%) and 'clarity of presentation' (83%) received the highest scores among the evaluated CPGs related to PC, EOLC, or both. Conversely, Irajpour et al. reported the highest scores in the 'clarity of presentation' domain, followed by 'stakeholder involvement' and 'scope and purpose'. [10]. Scope and purpose and clarity of presentation domains are directly related to an appropriate focus and precise scope of the guidelines, suggesting strengths in these areas across all the included CPGs [10].

In our study, the domain with the lowest median AGREE-II score was 'Applicability' (25%), reflecting a common limitation in many CPGs [25]. This result may stem from the contextualised nature of guideline development, wherein each country—especially those with low- and middle-income settings—designs its own national guidelines and implementation strategies based on specific clinical, structural, and systemic realities. In these contexts, barriers such as limited or inadequately trained healthcare personnel, weak inter-level coordination, insufficient infrastructure, and constrained financial resources hinder the translation of guideline recommendations into practice. CPG developers often prioritise the scientific rigour and methodological validity of recommendations, while overlooking implementation needs, which are highly context dependent. The 'Applicability' domain of AGREE-II, in fact, primarily assesses whether guidelines provide tools for implementation, such as facilitators and barriers, performance indicators, and strategies. Yet many guidelines omit these elements—not necessarily due to poor quality, but

TABLE 1 | Summary of standardised domain scores of the AGREE II and the overall quality rating of the included CPGs.

CPG	Scope and Purpose (%)	Stakeholder Involvement (%)	Rigour of Development (%)	Clarity of presentation (%)	Applicability (%)	Editorial independence (%)	Mean Score (%)	Classification
AACN 2020 [29]	86	42	22	89	2	0	40	Recommended with modifications
ACIS 2019* [30]	97	72	84	94	63	79	82	Recommended
ACP 2008 [31]	86	44	32	75	17	88	57	Recommended with modifications
ASCO 2024* [32]	100	94	92	92	73	79	88	Recommended
CHPCA 2013 [33]	42	17	6	36	8	25	22	Not recommended
ESICM 2024* [34]	92	56	73	75	31	88	69	Recommended
ESMO 2021 [35]	53	22	40	92	13	67	48	Recommended with modifications
FESEMI 2021* [36]	83	78	36	97	10	100	67	Recommended
GAIN 2013 [37]	67	25	2	83	10	25	35	Not recommended
GGPO 2015* [38]	100	100	85	100	46	100	89	Recommended
GMMG 2019 [39]	67	53	10	75	8	21	39	Not recommended
ICSI 2019* [40]	89	75	70	83	67	92	79	Recommended
IETS 2016* [41]	100	97	92	97	90	100	96	Recommended
JCP 2012* [42]	94	53	49	81	6	88	62	Recommended
KJHPC 2020* [43]	64	28	26	64	0	46	38	Not recommended
MISSOURI 2003 [44]	58	33	2	56	4	8	27	Not recommended
MJA 2007* [45]	92	94	60	94	27	25	65	Recommended
NCCN 2024* [46]	78	78	70	97	52	63	73	Recommended
NCP 2018* [47]	100	58	61	83	48	92	74	Recommended
NICE 2004* [48]	97	92	86	100	81	63	87	Recommended
NICE 2015* [49]	100	94	79	81	58	63	79	Recommended

(Continues)

TABLE 1 | (Continued)

CPG	Scope and Purpose (%)	Stakeholder Involvement (%)	Rigour of Development (%)	Clarity of presentation (%)	Applicability (%)	Editorial independence (%)	Mean Score (%)	Classification
RNAO 2011* [50]	92	67	53	89	25	46	62	Recommended
SOCIAL 2013 [51]	81	56	17	69	8	4	39	Not recommended
Median Score	89	58	53	83	25	63		
IQR	72.5–97	43–85	24–76	75–94	8–55	25–88		

Note: Rapid signal for quality of CPGs: Low quality: Red < 40%, Moderate quality: Yellow 40%–59%, High quality: Green ≥ 60%. *Classified as recommended to be implemented CPGs.

Abbreviations: AACN, American Association of Critical-Care Nurses; ACIS, Galician Agency for Health Knowledge Management; ACP, American College of Physicians; ASCO, American Society of Clinical Oncology; CHPCA, Canadian Hospice Palliative Care Association; ESICM, European Society of Intensive Care Medicine; ESMO, European Society for Medical Oncology; FESEMI, Federation of Spanish Societies of Internal Medicine; GAIN, Guidelines and Audit Implementation Network; GGPO, Clinical Guidelines for Cancer Patients; GMMG, Greater Manchester Medicines Management Group; ICSI, Institute for Clinical Systems Improvement; IETS, Institute of Technological Evaluation in Health; JPC, Journal of Palliative Medicine; KJHPC, Korean Journal of Hospice and Palliative Care; MISSOURI, Missouri Department of Health and Senior Services; MJA, Medical Journal of Australia; NCCN, National Comprehensive Cancer Network; NCP, National Consensus Project for Quality Palliative Care; NICE, National Institute for Health and Care Excellence; RNAO, Registered Nurses' Association of Ontario; SOCIAL, Socialstyrelsen (Swedish National Board of Health and Welfare).

because implementation may fall outside the developers' scope or be delegated to separate institutions responsible for adaptation and deployment. Therefore, low applicability scores do not inherently indicate deficiencies in the intrinsic quality of a guideline, as effective implementation frequently depends on the development of context-specific tools and processes by local institutions, as well as on the degree of integration of PC across diverse healthcare systems.

The domain with the lowest median score in our study differs from previous studies [10], where the lowest-scoring domain was 'Editorial Independence'. This discrepancy may be attributed to the fact that many of the CPGs in that study did not clearly report whether conflicts of interest were disclosed and handled during their development, raising concerns about transparency and potential bias in the guideline creation process.

The degree of inter-rater agreement was generally good across most domains, with the exception of the 'Stakeholder Involvement' domain, where agreement was only moderate. This lower level of agreement may be attributed to the limited inclusion of professionals from the various disciplines involved in PC, the lack of input from patients or the populations affected, or the absence of a clear definition of the intended target audience during the development of the CPGs. Such gaps or lack of transparency in reporting may have contributed to the lower level of agreement in this particular domain.

Finally, we used the RIGHT tool to check for completeness of the reporting of included CPGs [22]; The CPG domains with the lowest completeness were Recommendations, Review and Quality Assurance, and Funding and Conflicts of Interest. These areas often lacked clear or detailed reporting, leading to uncertainty among evaluators. Many guidelines did not specify the strength of recommendations or the quality of supporting evidence, nor did they describe external review processes. Transparency about funding and conflicts of interest was also frequently missing, raising concerns about potential bias and limiting the trustworthiness of the recommendations. Similarly, few CPGs described whether and how external reviews or quality assurance processes were conducted. Additionally, transparency regarding funding sources and conflict of interest declarations was often lacking, which raises concerns about potential biases and limits users' ability to critically appraise the trustworthiness of the recommendations.

The integration of the RIGHT checklist with the AGREE II instrument adds significant value by enabling a more comprehensive evaluation, particularly regarding the completeness of reported information. While AGREE II focuses on methodological rigour and applicability, RIGHT complements this assessment by clarifying the completeness and transparency of reporting—elements that are essential for reproducibility and that facilitate users' ability to appraise the credibility and applicability of guidelines. Together, these tools offer an integrated perspective on both methodological quality and reporting transparency of CPGs. Deficiencies in the reporting of funding sources, conflicts of interest, and development processes may compromise users' ability to assess the independence and transparency of guideline development. When such information is incompletely reported, clinicians and decision-makers may have limited capacity to judge whether

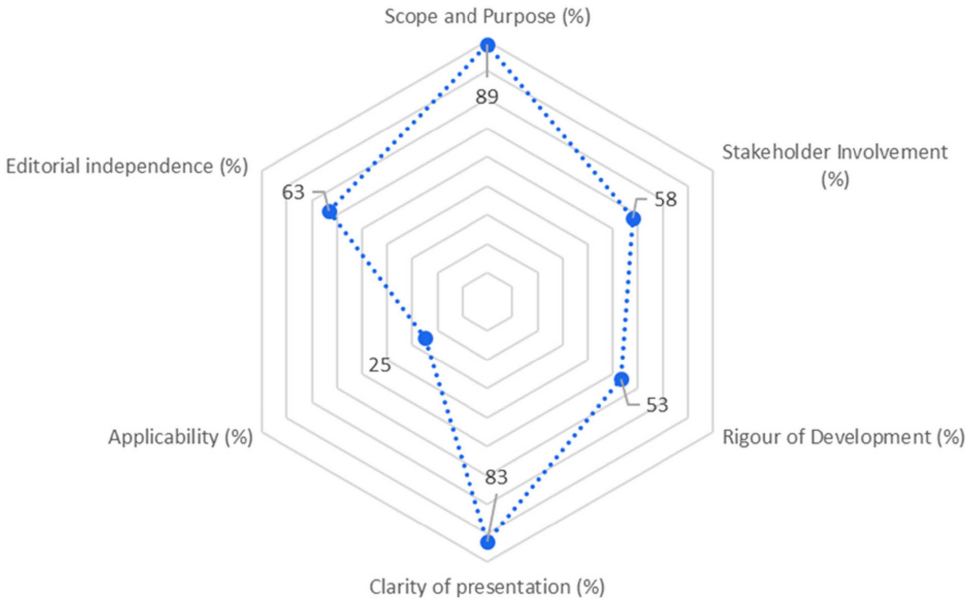

FIGURE 3 | Median scores of CPGs appraised against six domains of the AGREE II instruments ($n = 23$).

TABLE 2 | Inter-rater agreement of AGREE-II domains.

	Inter-rater agreement[a]		
Domain	**Intra-class correlation coefficient ICC[a]**	**95% CI**	**Degree of agreement**
Scope and objective	0.79	0.58–0.90	Good
Stakeholder involvement	0.61	0.29–0.81	Moderate
Rigour of development	0.84	0.70–0.92	Good
Clarity of presentation	0.78	0.56–0.90	Good
Applicability	0.83	0.71–0.92	Good
Editorial independence	0.87	0.71–0.94	Good

[a]Intra-class correlation coefficient. Poor agreement (< 0.50), moderate (0.50–0.75), good (0.75–0.90), and excellent (> 0.90).

recommendations are potentially influenced by external interests or whether appropriate methodological safeguards were applied. To the best of our knowledge, this is the first study to apply both instruments to the evaluation of CPGs.

This study has several limitations that should be acknowledged. First, although guidelines in all languages were included, the reliance on translation services or collaborators for non-English documents may have introduced inconsistencies in interpretation. Second, by excluding disease-specific guidelines and focusing solely on general PC and EOLC, the study may have overlooked high-quality recommendations applicable to specific clinical populations which should be addressed in detail in future studies. Finally, although we employed standardised tools (AGREE-II and RIGHT) and involved multiple independent reviewers to reduce bias, some degree of subjectivity in scoring may have influenced the results. It is also important to recognise that the AGREE-II instrument, while widely accepted, has inherent limitations—such as the absence of domain weighting and the reliance on subjective judgement for item evaluation [25].

Future research should focus on developing and evaluating strategies to enhance the applicability and implementation of CPGs in PC and EOLC, particularly in low- and middle-income countries. Further studies are needed to explore barriers and facilitators to the implementation of PC and EOLC guidelines in diverse healthcare systems, and to identify effective methods for improving stakeholder involvement, including patient and caregiver perspectives, during the guideline development process. CPGs should be viewed as living instruments that require regular updates, external validation, and continuous critical review. This dynamic approach ensures that guidelines remain relevant, trustworthy, and responsive to emerging evidence and evolving clinical contexts. Strengthening the reporting and implementation components of CPGs will be key to maximising their impact on patient care.

5 | Conclusions

CPGs are documents based on the best available scientific evidence, designed to support healthcare personnel's decision-making in their clinical practice. In this review, we assessed the quality of CPGs in PC and EOLC and found that several guidelines met criteria for recommendation. At the same time, opportunities for improvement were identified, particularly in the domains of applicability and transparency. Greater clarity in guideline development processes, including reporting of

funding sources and conflict of interest management, may further strengthen clinician confidence and support broader implementation. These findings highlight the urgent need to enhance how guidelines address real-world implementation challenges, including clarity on resources, feasibility, and contextual factors.

Acknowledgements

The authors wish to thank Dr. Maarten (M.F.M.) Engel from the Erasmus MC Medical Library for developing and updating the search strategies. The authors received no specific funding for this work. Open access publication was supported by the Erasmus MC Library through national open-access agreements (openaccess.nl). The funding source had no role in the study design; data collection, analysis, or interpretation; manuscript preparation; or the decision to submit the article for publication.

Ethics Statement

This scoping review of existing literature does not involve primary data collection. As the review relies exclusively on published data and does not involve human participants or the collection of individual-level information, informed consent was not required.

Conflicts of Interest

Ivan D. Florez was the coordinator of the Colombian CPGs programme at the IETS from 2012 to 2014. The remaining authors declare no conflict of interest.

Data Availability Statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

References

1. World Health Organization, Palliative Care [Internet], https://www.who.int/europe/news-room/fact-sheets/item/palliative-care.

2. A. Arango-Gutiérrez, S. Moreno, M. Rondón, et al., "Factors Associated With Suffering From Dying in Patients With Cancer: A Cross-Sectional Analytical Study Among Bereaved Caregivers," *BMC Palliative Care* 22, no. 1 (2023): 48.

3. M. Lugtenberg, J. S. Burgers, and G. P. Westert, "Effects of Evidence-Based Clinical Practice Guidelines on Quality of Care: A Systematic Review," *Quality and Safety in Health Care* 18, no. 5 (2009): 385–392.

4. S. P. Chakraborty, K. M. Jones, and D. Mazza, "Adapting Lung Cancer Symptom Investigation and Referral Guidelines for General Practitioners in Australia: Reflections on the Utility of the ADAPTE Framework," *Journal of Evaluation in Clinical Practice* 20, no. 2 (2014): 129–135.

5. T. Y. Choi, J. Choi, J. A. Lee, J. H. Jun, B. Park, and M. S. Lee, "The Quality of Clinical Practice Guidelines in Traditional Medicine in Korea: Appraisal Using the AGREE II Instrument," *Implementation Science* 10, no. 1 (2015): 104.

6. R. Bužgová, N. Špatenková, E. Fukasová-Hajnová, and D. Feltl, "Assessing Needs of Family Members of Inpatients With Advanced Cancer," *European Journal of Cancer Care* 25, no. 4 (2016): 592–599.

7. X. Bonfill and M. Marzo, "Guías de práctica clínica: tenerlas, que sean de calidad y que salgan del armario," *Medicina clínica* 120, no. 13 (2003): 496–497.

8. National Collaborating Centre for Methods and Tools, Appraisal of Guidelines for Research & Evaluation (AGREE) II Instrument | NCCMT [Internet], https://www.nccmt.ca/knowledge-repositories/search/100.

9. Y. Chen, K. Yang, A. Marušić, et al., "A Reporting Tool for Practice Guidelines in Health Care: The RIGHT Statement," *Annals of Internal Medicine* 166, no. 2 (2017): 128–132.

10. A. Irajpour, M. Hashemi, and F. Taleghani, "The Quality of Guidelines on the End-of-Life Care: A Systematic Quality Appraisal Using AGREE II Instrument," *Supportive Care in Cancer: Official Journal of the Multinational Association of Supportive Care in Cancer* 28, no. 4 (2020): 1555–1561.

11. D. Kavalieratos, A. M. Georgiopoulos, L. Dhingra, et al., "Models of Palliative Care Delivery for Individuals With Cystic Fibrosis: Cystic Fibrosis Foundation Evidence-Informed Consensus Guidelines," *Journal of Palliative Medicine* 24, no. 1 (2021): 18–30.

12. B. Moeller, E. H. Balagamwala, A. Chen, et al., "Palliative Thoracic Radiation Therapy for Non-Small Cell Lung Cancer: 2018 Update of an American Society for Radiation Oncology (ASTRO) Evidence-Based Guideline," *Practical Radiation Oncology* 8, no. 4 (2018): 245–250.

13. R. Souchon, F. Wenz, F. Sedlmayer, et al., "DEGRO Practice Guidelines for Palliative Radiotherapy of Metastatic Breast Cancer: Bone Metastases and Metastatic Spinal Cord Compression (MSCC)," *Strahlentherapie und Onkologie* 185, no. 7 (2009): 417–424.

14. V. Morel, "Recommandations sur la mise en œuvre de la démarche palliative chez les patients qui présentent une exacerbation aiguë de BPCO," *Revue des Maladies Respiratoires* 34, no. 4 (2017): 492–498.

15. C. Klein, R. Voss, C. Ostgathe, and J. A. Schildmann, "Sedation in Palliative Care—A Clinically Oriented Overview of Guidelines and Treatment Recommendations," *Deutsches Ärzteblatt International* 120 (2023): 235–242, https://www.aerzteblatt.de/10.3238/arztebl.m2023.0034.

16. S. M. Surges, E. Garralda, B. Jaspers, et al., "Review of European Guidelines on Palliative Sedation: A Foundation for the Updating of the European Association for Palliative Care Framework," *Journal of Palliative Medicine* 25, no. 11 (2022): 1721–1731.

17. M. J. Page, J. E. McKenzie, P. M. Bossuyt, et al., "The PRISMA 2020 Statement: An Updated Guideline for Reporting Systematic Reviews," *BMJ* 372 (2021): n71.

18. Committee on Standards for Developing Trustworthy Clinical Practice Guidelines, Board on Health Care Services, Institute of Medicine, *Clinical Practice Guidelines We Can Trust [Internet]*, eds. R. Graham, M. Mancher, D. M. Wolman, S. Greenfield, and E. Steinberg (Washington, D.C: National Academies Press, 2011), https://www.nap.edu/catalog/13058.

19. G. Goulas How Can I Cite Covidence? [Internet], 2022, https://support.covidence.org/help/how-can-i-cite-covidence.

20. P. A. Harris, R. Taylor, B. L. Minor, et al., "The REDCap Consortium: Building an International Community of Software Platform Partners," *Journal of Biomedical Informatics* 95 (2019): 103208.

21. M. C. Brouwers, M. E. Kho, G. P. Browman, et al., "AGREE II: Advancing Guideline Development, Reporting and Evaluation in Health Care," *Canadian Medical Association Journal* 182, no. 18 (2010): E839–E842.

22. E. Loder, R. Burch, and P. Rizzoli, "The 2012 AHS/AAN Guidelines for Prevention of Episodic Migraine: A Summary and Comparison With Other Recent Clinical Practice Guidelines," *Headache: The Journal of Head and Face Pain* 52, no. 6 (2012): 930–945.

23. A. M. Merchan-Galvis, J. P. Caicedo, C. J. Valencia-Payán, and J. A. Calvache, "Methodological Quality and Transparency of Clinical Practice Guidelines for Difficult Airway Management Using the Appraisal of Guidelines Research &; Evaluation II Instrument: A Systematic Review," *European Journal of Anaesthesiology* 37, no. 6 (2020): 451–456.

24. M. F. Delgado-Noguera, Á. M. Merchán-Galvis, A. Y. Mera-Mamián, D. M. Muñoz-Manquillo, and J. A. Calvache, "Evaluación de la calidad metodológica de las Guías Colombianas de Práctica Clínica en Pediatría," *Pediatría* 48, no. 4 (2015): 87–93.

25. M. C. Brouwers, K. Spithoff, J. Lavis, M. E. Kho, J. Makarski, and I. D. Florez, "What to Do With All the AGREEs? The AGREE Portfolio of Tools to Support the Guideline Enterprise," *Journal of Clinical Epidemiology* 125 (2020): 191–197.

26. P. Alonso-Coello, A. Irfan, I. Solà, et al., "The Quality of Clinical Practice Guidelines Over the Last Two Decades: A Systematic Review of Guideline Appraisal Studies," *Quality & Safety in Health Care* 19, no. 6 (2010): e58.

27. G. Angel, C. Trujillo, M. Mallama, P. Alonso-Coello, M. Klimek, and J. A. Calvache, "Methodological Transparency of Preoperative Clinical Practice Guidelines for Elective Surgery. Systematic Review," *PLoS One* 18 (2023): e0272756.

28. RStudio Team [Internet], https://www.rstudio.com/authors/rstudio-team/.

29. H. I. Jensen, K. Halvorsen, H. Jerpseth, I. Fridh, and R. Lind, "Practice Recommendations for End-of-Life Care in the Intensive Care Unit," *Critical Care Nurse* 40, no. 3 (2020): 14–22.

30. R. Bugarín, J. A. Fernández, and Y. Triñanes, "Guía de Práctica Clínica sobre atención paliativa al adulto en situación de últimos días [Internet]," *Unidad de Asesoramiento Científico-técnico, Avalia-t* (Agencia de Conocimiento en Salud (ACIS), 2021), https://portal.guiasalud.es/gpc/atencion-paliativa-ultimos-dias/.

31. A. Qaseem, V. Snow, P. Shekelle, et al., "Evidence-Based Interventions to Improve the Palliative Care of Pain, Dyspnea, and Depression at the End of Life: A Clinical Practice Guideline From the American College of Physicians," *Annals of Internal Medicine* 148, no. 2 (2008): 141–146.

32. J. J. Sanders, S. Temin, A. Ghoshal, et al., "Palliative Care for Patients With Cancer: ASCO Guideline Update," *Journal of Clinical Oncology* 42, no. 19 (2024): 2336–2357.

33. Canadian Hospice Palliative Care Association., *A Model to Guide Hospice Palliative Care* (Canadian Hospice Palliative Care Association, 2013).

34. J. Kesecioglu, K. Rusinova, D. Alampi, et al., "European Society of Intensive Care Medicine Guidelines on End of Life and Palliative Care in the Intensive Care Unit," *Intensive Care Medicine* 50, no. 11 (2024): 1740–1766.

35. G. B. Crawford, T. Dzierżanowski, K. Hauser, et al., "Care of the Adult Cancer Patient at the End of Life: ESMO Clinical Practice Guidelines," *ESMO Open* 6, no. 4 (2021): 100225.

36. J. Díez-Manglano, L. Á. Sánchez Muñoz, R. García Fenoll, et al., "Guía de práctica clínica de consenso sobre buenas prácticas en los cuidados al final de la vida de las Sociedades Española y Portuguesa de Medicina Interna," *Revista clínica española* 221, no. 1 (2021): 33–44.

37. Guidelines and Audit Implementation Network (GAIN) Guidelines for Palliative and End of Life Care in Nursing Homes and Residential Care Homes, GAIN, 2013, https://www.rqia.org.uk/RQIA/files/8f/8f15f600-211a-4707-ac0e-d193d78e195c.pdf.

38. German Guideline Programme in Oncology (German Cancer Society, German Cancer Aid, AWMF): Palliative Care for Patients With Incurable Cancer, Short Version 1.1., 2015 Awmf-registration Number 128/001OL, http://leitlinienprogrammonkologie.de/Leitlinien.7.0.html.

39. Greater Manchester and Eastern Cheshire Strategic Clinical Networks Palliative Care Pain and Symptom Control Guidelines for Adults: for Staff Providing Generalist Palliative Care, NHS England North West, 2019, https://www.england.nhs.uk/north-west/wp-content/uploads/sites/48/2020/01/Palliative-Care-Pain-and-Symptom-Control-Guidelines.pdf.

40. M. McCusker, M. Jolkvosky, R. Ruff, et al., *Palliative Care for Adults: Public Comment* (Institute for Clinical Systems Improvement (ICSI), 2019).

41. Ministerio de Salud y Protección Social Guía de práctica clínica para la atención integral en cuidados paliativos (Adopción) [Internet], Ministerio de Salud y Protección Social, 2016 [Internet], https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/DE/CA/gpc-completa-cuidados-paliativos-adopcion.pdf.

42. P. Hudson, C. Remedios, R. Zordan, et al., "Guidelines for the Psychosocial and Bereavement Support of Family Caregivers of Palliative Care Patients," *Journal of Palliative Medicine* 15, no. 6 (2012): 696–702.

43. J. Shin, Y. J. Chang, S. J. Park, et al., "Clinical Practice Guideline for Care in the Last Days of Life," *Korean Journal of Hospice and Palliative Care* 23, no. 3 (2020): 103–113.

44. Missouri Department of Health and Senior Services, Division of Senior Services and Regulation; Missouri End-of-Life Coalition's End-of-Life in the Nursing Home Task Force., *Guidelines for End-of-Life Care in Long-Term Care Facilities: Emphasis on Developing Palliative Care Goals* (Missouri Department of Health and Senior Services, 2003).

45. J. M. Clayton, K. M. Hancock, P. N. Butow, M. H. N. Tattersall, and D. C. Currow, "Clinical Practice Guidelines for Communicating Prognosis and End-of-Life Issues With Adults in the Advanced Stages of a Life-Limiting Illness, and Their Caregivers," supplement, *Medical Journal of Australia* 186, no. S12 (2007): S77–S105, https://onlinelibrary.wiley.com/doi/abs/10.5694/j.1326-5377.2007.tb01100.x.

46. A. M. Walling, T. Campbell, R. Agarwal, A. C. Beck, and T. C. Campbell, NCCN Guidelines Index Table of Contents Discussion. Palliative Care (2024).

47. National Consensus Project for Quality Palliative Care., *Clinical Practice Guidelines for Quality Palliative Care, 4th edition* (Richmond, VA: National Coalition for Hospice and Palliative Care, 2018), https://www.nationalcoalitionhpc.org/ncp.

48. National Institute for Health and Care Excellence., "Improving Supportive and Palliative Care for Adults With Cancer," *NICE* (NICE Clinical Guideline, 2004), 27.

49. National Clinical Guideline Centre, *Care of Dying Adults in the Last Days of Life: Clinical Guideline NG31 Methods, Evidence and Recommendations* (National Institute for Health and Care Excellence (NICE), 2015), https://www.nice.org.uk/guidance/ng31/evidence/full-guideline-pdf-2240610301.

50. Registered Nurses' Association of Ontario, *End-of-Life Care During the Last Days and Hours* (Registered Nurses' Association of Ontario, 2011).

51. *Nationellt kunskapsstöd för god palliativ vård i livets slutskede: vägledning, rekommendationer och indikatorer: stöd för styrning och ledning* (Socialstyrelsen, 2013), 105.

Supporting Information

Additional supporting information can be found online in the Supporting Information section.
Supplementary information revised.