



Manual for Clinical Expert Consensus Documents Writing Committees

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Section One: Overview of Methodology and Purpose of the Manual

The creation of this manual has been spearheaded by the ACCF Task Force on Clinical Expert Consensus Documents (CECD) to assist Clinical Expert Consensus Document Writing Committees in the development of clinical expert consensus documents. The bulk of this manual consists of tools to assist writers in interpreting and applying the methodology.

The CECD understands the challenges that may occur when applying a uniform methodology to consensus documents that represent diverse diseases, conditions, diagnostics, and interventions. Writing committee members should familiarize themselves thoroughly with the manual, as these policies and standards provide the framework for consensus document creation. However, if warranted the CECD may allow exceptions to the written policies.

Parent (Oversight) Committee: Task Force on Clinical Expert Consensus Documents

Writing Committee: Specific ad hoc committee selected by the parent Task Force to develop clinical documents about specific topics (e.g., Hypertrophic Cardiomyopathy)

The CECD serves as a central coordinating oversight committee for the development of all ACCF Clinical Expert Consensus Documents that are to be published in the *Journal of the American College of Cardiology*. Clinical expert consensus documents shall be defined as any document that is to the extent possible evidence-based, intended to inform clinical practice of an ACCF opinion or position, and will appear in the medical literature via publication in *JACC* (excluding Guidelines and Competence Statements). Any document request that does not appear to fall into the definition herein described as an Expert Consensus Document will be forwarded to the President for review and action.

The CECD shall:

- 1) select topics for potential development from the proposals received as a result of the annual solicitation of individual members, ACCF committees, and leadership
- 2) define and maintain a rigorous methodological approach for the development of the respective document which may include the convening of a mini-conference which would include selected experts outside of the writing groups
- 3) coordinate the peer and BOT review and approval processes
- 4) coordinate document publication in *JACC* and on the ACCF web site
- 5) perform a periodic review of all ACCF Clinical Expert Consensus Documents and other documents that may exist and fall outside the purview of the ACCF/AHA Task Force on Practice Guidelines and the ACCF/AHA/ACP-ASIM Task Force on Clinical Competence to ensure the content is current, initiate a revision or sunset a document.

Section Two: Defining Document Types, Selecting Topics, and Maintaining Topics

Clinical Expert Consensus Documents

Clinical expert consensus documents are much shorter than ACCF/AHA Guidelines and are developed around a topic that is more narrowly focused, is new or emerging for which a smaller body of evidence is available, and do not duplicate or replace clinical recommendations that are already included in any ACCF/AHA Practice Guideline. These documents are often developed in response to a new technology and do not classify recommendations or evidence in the same way as ACCF/AHA Practice Guidelines.

Consensus Mini-Conferences

Consensus conferences are designed to facilitate consideration of significant and timely issues concerning the practice of cardiovascular medicine and matters affecting patient care. A draft document is developed over an agreed upon period of months by members of a core group of writers. This important activity culminates in a one-day conference of experts and interested individuals and organizations using a modified Delphi approach to develop a consensus and make final recommendations. It is not intended to be a scientific symposium, i.e., a collection of facts on a specific subject but is intended to make recommendations on topics that are critical to cardiovascular medicine, about which absolute or hard data are incomplete. The resulting report and recommendations may be published in the *Journal of the American College of Cardiology*.

Selection of Clinical Document Topics

The Call for Topics for Clinical Expert Consensus Documents is distributed to the ACCF leadership and all ACCF committees on an annual basis. The list of topics received from the annual solicitation is reviewed by the Task Force for consideration as future topics.

Currency of Clinical Expert Consensus Documents

The CECD Task Force periodically reviews documents that fall under its purview to ensure that the documents are current. Documents that fall under its purview include ACCF position and policy statements, clinical expert consensus documents (e.g., ACCF/AHA clinical expert consensus documents and AHA/ACCF scientific statements*), and consensus conference reports (including but not limited to Bethesda conference reports).

If documents are out-of-date or if new College documents (e.g., practice guidelines) have subsequently updated and covered a CECD topic, the TF oversees a process to determine whether CECD documents should be sunsetted or revised. Specifically for ACCF position and policy statements, many of which were originally developed by ACCF's clinical committees, the Task Force requests periodic review of the statements by the appropriate clinical committee(s) to determine if the documents remain current.

*AHA/ACCF Scientific Statements are AHA-lead documents. ACCF may or may not have formal ACCF representatives on the writing committee, but does participate in the peer review and board review process. These documents are approved by the ACCF Board of Trustees and Executive Committee.

Section Three: Selection of Writing Committee Chair and Members

Selection/Role of Writing Committee Chair

Once a topic has been chosen, the CECD will identify suggestions for chair. In following the methodology for practice guidelines, the CECD adopted a policy in the fall of 2002 to select a chair who is not a specialist in the topic area covered by a clinical document. Generally this person will be a senior clinician whose purpose is to facilitate consensus development for the writing committee, apply CECD methodology to the writing effort, manage timely completion of the document including writing committee member adherence to deadlines, enforce the writing committee members relationships with industry policy, write brief executive summary for the document once the text is complete, respond to peer review comments, and review page proofs for publication.

Selection/Role of Writing Committee

The writing committee is composed of a balance of clinician users and content experts on the topic being addressed. The CECD recommends individuals to serve on the writing committee, as well as identifies organizations to be invited to participate in the writing effort. An ACCF Board of Governor (BOG) is invited to serve on the committee. The Chair of the CECD works with the Chair of the writing committee to determine final membership of the writing committee (based on suggestions given by the CECD).

Writing committee members are required to attend meetings and conference calls pertinent to document development, adhere to document deadlines, transfer copyright to the ACCF, and agree to follow CECD methodology, including web publication of all pertinent relationships with industry to the writing effort.

Role of the CECD Task Force Liaison

A member of the parent Task Force serves on each writing committee as the Task Force liaison. The liaison monitors the progress of the effort, participates fully in the committee as a working member, and provides feedback to the parent committee concerning any problems or issues that need to be addressed. This member has the responsibility of ensuring that the document under development is consistent with previously published ACCF documents. This member also maintains close contact with other writing committees in progress pertinent to the topic and shares drafts. If there are significant differences among ongoing writing committees, this should be made known to the parent Task Force Chair and every attempt should be made to reach a compromise to ensure concordance of ACCF documents.

Section Four: Publication of Relationships with Industry

Writing Committees

The ACCF has taken a number of steps to improve the full disclosure of committee members' financial relationships with industry. Writing committee members are required to disclose any relationships with industry that may be perceived as real or potential conflicts of interest. Such relationships will be made known (orally and in writing) to the writing committee at the first meeting and updated at each meeting thereafter.

The importance of strict adherence to this policy will be emphasized at the initial meeting of each writing committee by the Chair of the task force and/or the Chair of the writing committee. In addition, the following language will be included in the preamble of each published clinical document:

The ACCF Task Force on Clinical Expert Consensus Documents makes every effort to avoid any actual or potential conflicts of interest that might arise as a result of an outside relationship or personal interest of a member of the writing panel. Specifically, all members of the writing panel are asked to provide disclosure statements of all such relationships which might be perceived as real or potential conflicts of interest. These statements are reviewed by the parent Task Force, reported orally to all members of the writing panel at the first meeting, and updated at each meeting thereafter as changes occur. (See Appendix __ for committee member relationships with industry pertinent to this document.)

Peer Review

The purpose of publishing peer reviewers relationships with industry is to further strengthen the integrity of the writing effort and make the document development process more transparent to readers. A footnote to the table listing peer reviewer names and relationships with industry would clarify that peer reviewer participation in the review process in no way implies agreement with or endorsement of the final document.

Section Five: Document Development Guidelines

The TF CECD is approved for development of two clinical documents in progress at any one time; including one mini-conference per year. Once a topic begins, it generally takes between 12 to 18 months to develop the document from the time of identification of a writing committee chair to time of delivery for peer review.

Time Line for Document Development

The writing committee staff liaison drafts a time line that is reviewed with the writing committee chair. The proposed time line is shared with committee members and guides the work of the committee. The time line is revised, as needed, to accommodate changes in work flow.

Building Consensus Through Group Decision-Making

Consensus building is an agreement-seeking process that enables a group of people to satisfy everyone's primary interests and concerns.

Writing committee discussions and consensus development are ongoing at all stages of clinical expert consensus document development. The ACCF consensus documents are written by committee whose members agree on the scope, clinical objectives, evidence tables, text, and recommendations that occur throughout document development. Subsection writers often come to consensus through phone calls or e-mail exchanges of information.

Consensus development is often most important around topics that have no literature base. Writing groups are faced with the challenge of addressing an important clinical question despite a lack of data. The document development process allows for the incorporation of minority opinions if consensus cannot be reached.

When consensus cannot be obtained, a statement similar to the following can be used: "The majority of the members of the Writing Group could not come to agreement (would not recommend) ... because" The purpose of the statement is to indicate to the readers of the document that full-committee consensus could not be reached.

Document Length

The targeted document length for clinical expert consensus documents is 35-40 published pages, including tables, figures, and references. The CECD has discretion regarding document length depending on document scope. Writing committees may recommend to the Task Force that additional material not included in the published version of a document (e.g., glossary of terms, additional background material, resource lists) be posted on the web site along with the document. The CECD must approve these requests.

Pharmacotherapy in Clinical Documents

In order to ensure clarity and accuracy of pharmacology information in clinical documents, all clinical documents containing drug dosing information follows the policies identified by the ACC/AHA Task Force on Practice Guidelines (see Table 1).

Table 1. Discussing Pharmacotherapy in Clinical Documents

- Use generic or chemical name not trade name
 - e.g., simvastatin, not Zocor
- Use broadest and most generic name of class appropriate
 - e.g., cholesterol-lowering not “statins”
- List classes of drugs or drugs within classes according to evidence-based rationale and state rationale
 - e.g., first-line, second-line or side effects or cost-effectiveness
 - If no evidence-based rationale, list alphabetically
- List all drugs (or none) within class
 - Indicate whether each is approved for the indication(s) under discussion
 - e.g., statins for primary prevention
 - Indicate whether each has evidence for the indication(s) under discussion
 - e.g., IIb/IIIa’s
- Discuss evidence for or against “class effect”
 - e.g., issue raised by ramipril in HOPE study
- When so-called “alternative medicines” are known to be widely used, discuss the evidence about them and the issues raised by their use
 - e.g., possible interactions
- Avoid the use of symbols and abbreviations when discussing drug dosing and timing.
 - e.g., use “micrograms” or “mcg” instead of “ μg ”
 - The Institute for Safe Medication Practices has issued a drug error alert regarding some commonly used abbreviations (see Table 2)
- Whenever a guideline includes specific drug information, such sections of the guideline should be reviewed by a pharmacologist during peer review.

Table 2. Drug Error Alert

The Institute for Safe Medication Practices advises against using these abbreviations and dose designations.

Abbreviation/Dose Expression	Intended Meaning	Misinterpretation	Correction
Apothecary symbols	dram minim	Misunderstood or misread (symbol for dram misread for “3” and minim misread as “mL”).	Use the metric system.
AU	aurio uterque (each ear)	Mistaken for OU (oculo uterque—each eye).	Don’t use this abbreviation.
D/C	discharge discontinue	Premature discontinuation of medications when D/C (intended to mean “discharge”) has been misinterpreted as “discontinued” when followed by a list of drugs.	Use “discharge” and “discontinue.”
µg	microgram	Mistaken for “mg” when handwritten.	Use “mcg.”
o.d. or OD	once daily	Misinterpreted as “right eye” (OD—oculus dexter) and administration of oral medications in the eye.	Use “daily.”
TIW or tiw	three times a week	Mistaken as “three times a day.”	Don’t use this abbreviation.
per os	orally	The “os” can be mistaken for “left eye.”	Use “PO,” “by mouth,” or “orally.”
q.d. or QD	every day	Mistaken as q.i.d., especially if the period after the “q” or the tail of the “q” is misunderstood as an “i.”	Use “daily” or “every day.”
qn	nightly or at bedtime	Misinterpreted as “qh” (every hour).	Use “nightly.”
qhs	nightly at bedtime	Misread as every hour.	Use “nightly.”
q6PM, etc.	every evening at 6 PM	Misread as every six hours.	Use 6 PM “nightly.”
q.o.d. or QOD	every other day	Misinterpreted as “q.d.” (daily) or “q.i.d.” (four times daily) if the “o” is poorly written.	Use “every other day.”
sub q	subcutaneous	The “q” has been mistaken for “every” (e.g., one heparin dose ordered “sub q 2 hours before surgery” misunderstood as every 2 hours before surgery).	Use “subcut.” or write “subcutaneous.”
SC	subcutaneous	Mistaken for SL (sublingual).	Use “subcut.” or write “subcutaneous.”
U or u	unit	Read as a zero (0) or a four (4), causing a 10-fold overdose or greater (4U seen as “40” or 4u seen as 44”).	“Unit” has no acceptable abbreviation. Use “unit.”
IU	international unit	Misread as IV (intravenous).	Use “units.”

Cc	cubic centimeters	Misread as “U” (units).	Use “mL.”
X3d	for three days	Mistaken for “three doses.”	Use “for three days.”
BT	bedtime	Mistaken as “BID” (twice daily).	Use “hs.”
Ss	sliding scale (insulin) or 1/2 (apothecary)	Mistaken for “55.”	Spell out “sliding scale.” Use “one-half” or use “1/2.”
> and <	greater than and less than	Mistakenly used opposite of intended.	Use “greater than” or “less than.”
/ (slash mark)	separates two doses or indicates “per”	Misunderstood as the number 1 (“25 unit/10 units” read as “110” units)	Do not use a slash mark to separate doses. Use “per.”

References

Generally, references should be limited to one-to-four current, relevant references to support individual statements. A few historical references may be appropriate in a document but should be used selectively.

All references (including journals, abstracts, books, government publications and monographs) included in the reference list are verified either electronically (e.g., PubMed, NLM Locator Plus) or manually. If a journal reference does not appear in PubMed, the writer who included the reference in the document text is asked to provide a copy of the first and last pages of the article to staff for manual verification.

Books and Reports: All whole book and book chapter information must be verified by staff. Whole book references require a specific page number reference to the cited material. Book chapters require chapter information (i.e., chapter title, authors, page range) as well as the publisher information for the book. If this material is unavailable to staff electronically (NLM Locator Plus) or in the ACCF library, authors will be required to forward the book copyright page and the table of contents for manual verification by staff.

In Press Articles: “In Press” articles may not be used in a document unless the article publishes *before* our document publishes *or* staff is provided a copy of the letter of intent to publish from the publisher to the lead author. In Press articles must be clearly identified in the reference list. Staff will update “In Press” citations with full citation information if the article publishes prior to web posting of our document.

Abstracts: When citing abstracts, authors must clarify in the text that the information is “preliminary.” Abstracts should be identified in the reference list by using [abstr] in the citation. Abstract references older than two years must be replaced with a published article. Staff will verify abstracts through using ACCF library resources. If the abstract is unavailable, authors will

be requested to forward the page on which the abstract appears that includes the corresponding journal information (name, year, volume, page number).

Oral Presentations at Major International/Scientific Meetings: Statements referencing a presentation at a major scientific meeting may be included in the document under the following circumstances: 1) the statement must indicate that it is based on preliminary information; 2) the *presenter* must review and verify the accuracy of the statement in the document prior to publication; and 3) the statement must be referenced in parentheses in the text (e.g., Lamas G, oral presentation at North American Society for Pacing and Electrophysiology Scientific Sessions, Boston, MA, May, 2001).

Personal Communication: Personal communication is not to be cited in the reference list but may be referenced in parentheses in the text of the document (e.g., personal communication from identify person, company, and date). A copy of the communication should be forwarded to staff for manual verification.

Instructions for Adding and Deleting References: Staff use a reference manager database (RefMan) to manage references for all clinical documents. Therefore, when editing references, authors are asked to follow the attached instructions. Authors should not renumber references.

Finalizing the Document

At the final stages of document development, writers should re-examine the original goals regarding the scope of the clinical document. Any identified gaps should be addressed before the document is sent to peer review. The writing group will be asked to give formal approval of the document both before peer review and after peer review edits have been incorporated.

Industry Support for Clinical Expert Consensus Documents

The College does not accept money from pharmaceutical and device companies for development of any clinical documents or policy statements. Financial assistance is accepted only for printing and dissemination of derivative works of clinical documents which by nature must be consistent with the source document, e.g., pocket guidelines, pda versions of pocket guidelines. These works include a disclaimer, “Distributed through an educational grant from <co. name>. <Co. name> was not involved in the development of this publication and in no way influenced its contents.”

Section Six: Review Processes

I. Pre-Consensus Peer Review

At the discretion of the writing committee chair/co-chairs, individuals with specific expertise may be invited to read, review, and comment on specific sections of a draft document to provide the committee with additional insights that are not present among the writers or when writers request additional clarification on an issue. *The pre-consensus review occurs prior to final writing committee sign-off on the document in preparation for peer review.*

II. Peer Review (see flow chart at end of this section)

Prior to forwarding a document for board review/approval, the document must undergo external peer review. Official, content, and organizational peer reviewers participate in the process. Official and content reviewer panels should be comprised of an appropriate mix of experts, general cardiologists, practitioners, academia, geography, and age.¹

TYPES OF CECD DOCUMENT REVIEW

Writing Committee Model

PRE-CONSENSUS REVIEW
<ul style="list-style-type: none"> •Optional •Need additional expertise to supplement Writing Committee •Conducted prior to peer review •Acceptance of reviewer's suggestions is at discretion of chair •Conducted by outside experts •Before peer review •Collect RWI and obtain approval to publish name and RWI

Consensus Mini-Conference Model

PEER REVIEW
<p>Consensus conference documents do not undergo a formal, external peer review process. Conference participants, including guests who are not authors of TF reports, contribute to shaping final document recommendations.</p>

PEER REVIEW
<ul style="list-style-type: none"> •Required •Official, content and organizational review •Post-consensus •Response required to official reviewers •Equal representation by cosponsoring organizations •Collect Relationships with Industry (RWI) and obtain approval to publish names and RWI •Before Board Approval

¹ An appropriate balance on peer review panels will help to ensure that perspectives of different end users and those with various backgrounds can provide feedback on the guidelines. There has been little research into who makes a good peer reviewer, but the qualifications listed above are reflective of the end users of the guideline. In addition, a recent study looking at the question of reviewer qualifications did find that age influenced the quality of a review. (Black, N. "What makes a good reviewer and a good review for a general medical journal." JAMA 1998; 280:231-3.)

Peer Reviewer Categories

Official

CECD TF Lead Reviewer
ACCF Board of Trustees (BOT) Reviewer
ACCF Board of Governors (BOG) Primary Reviewer²
ACC/AHA Task Force on Practice Guidelines Reviewer
Cosponsoring Organization Reviewers (equal number of reviewers from cosponsoring organization, if applicable)

Content Experts

Relevant Scientific Committees and Task Forces
BOG Secondary Reviewers²
Individual Content Reviewers
Pharmacology Reviewer (required for documents containing drug dosing information to ensure accuracy)

Organizational

Organizations represented on the writing committee or that are pertinent to the topic

Official Reviewers: Three official reviewers from the ACCF are identified. ACCF official reviewers include one from the BOT (selected by the ACCF President), one from the Board of Governors² (selected by the BOG Chair), and one from the ACCF/AHA Task Force on Practice Guidelines (selected by the Chair of the Guideline Task Force; may be a Guideline Task Force member or Guideline Writing Committee Member from corresponding guideline). These reviewers in effect serve as a subcommittee of the Board and Executive Committee to review the documents. The CECD Task Force also provides an official reviewer—the lead Task Force reviewer—who coordinates CECD Task Force review (see #5 below). The writing committee chair must provide a detailed response to all official reviewers regarding the handling of their comments (see #6 below).

Role of the CECD Task Force Lead Reviewer

The Task Force Lead Reviewer assumes the responsibility to conduct a thorough review of a particular document on behalf of the Task Force. All Task Force members have the opportunity

² The Board of Governors' review process includes one *official* reviewer on behalf of the BOG, supported by up to five secondary reviewers representing a geographical diversity (these may be a BOG member or the member's designee within his/her state). Secondary reviewers of the guideline forward their comments to the primary reviewer who assimilates the information into one master BOG review. The master review is then forwarded to the writing committee chair for consideration.

to review the document, but the lead reviewer reviews the document as an “official” peer reviewer on behalf of the Task Force.

Subsequently, the Task Force Lead Reviewer receives a copy of:

- All peer review comments on the document (official, organizational and content)
- The detailed response to official reviewers prepared by the writing committee chair
- The revised document that has addressed all peer review comments

The Task Force Lead Reviewer reviews this material and makes a recommendation to the Task Force Chair whether the document is ready for board review, or whether there are outstanding issues that require resolution. The Task Force Lead Reviewer and/or the Task Force Chair then follow up with the writing committee chair to provide feedback if further revision is necessary. Once the Lead Reviewer believes the document is ready for board review, the reviewer either sends a brief letter (and copies staff) or e-mail message to the Chair (and copies staff) to indicate that the document is ready for board review.

The Task Force Chair then provides staff with final approval to send the document for board review.

Content Reviewers: Appropriate ACCF scientific committees participate in content review of the document. Writing committee chairs have the option of sending the document to additional content experts to further strengthen the review process. Chairs may solicit suggestions for content reviewers from their writing committees. Responses to content reviewers are not required; a thank you letter for reviewing the document is sent.

Organizational Reviewers: If an organization participates in a writing effort through providing a representative to serve on the writing committee, the organization is invited to peer review the document. A form asking the organization whether it would like to see the final, board-approved document for endorsement consideration also accompanies the peer review draft. Organizations that did not have a representative on the writing committee may also be requested to peer review the document and consider potential endorsement. The writing committee and/or parent task force should identify these organizations.

Review Process

Copies of the clinical expert consensus documents are provided to reviewers who are asked to respect a two- to three-week turn-around time (depending on the length of the document) and informed that reviews received after the deadline *may* not be incorporated into the document. Organizations are given a three- to four-week turn-around time to coordinate their review.

The writing committee chair will prepare a “response to official reviewers.” This may be in the form of individual letters or may be combined into one response for all reviews. ACCF staff will disseminate the response to the official reviewers, as well as to the lead reviewer from the parent task force who ensures that official peer review comments have been adequately addressed.

A primary reviewer from the parent task force will be appointed and assume the following roles:

- Conduct an initial comprehensive review of draft on behalf of the parent task force

Once the post-peer review draft is complete:

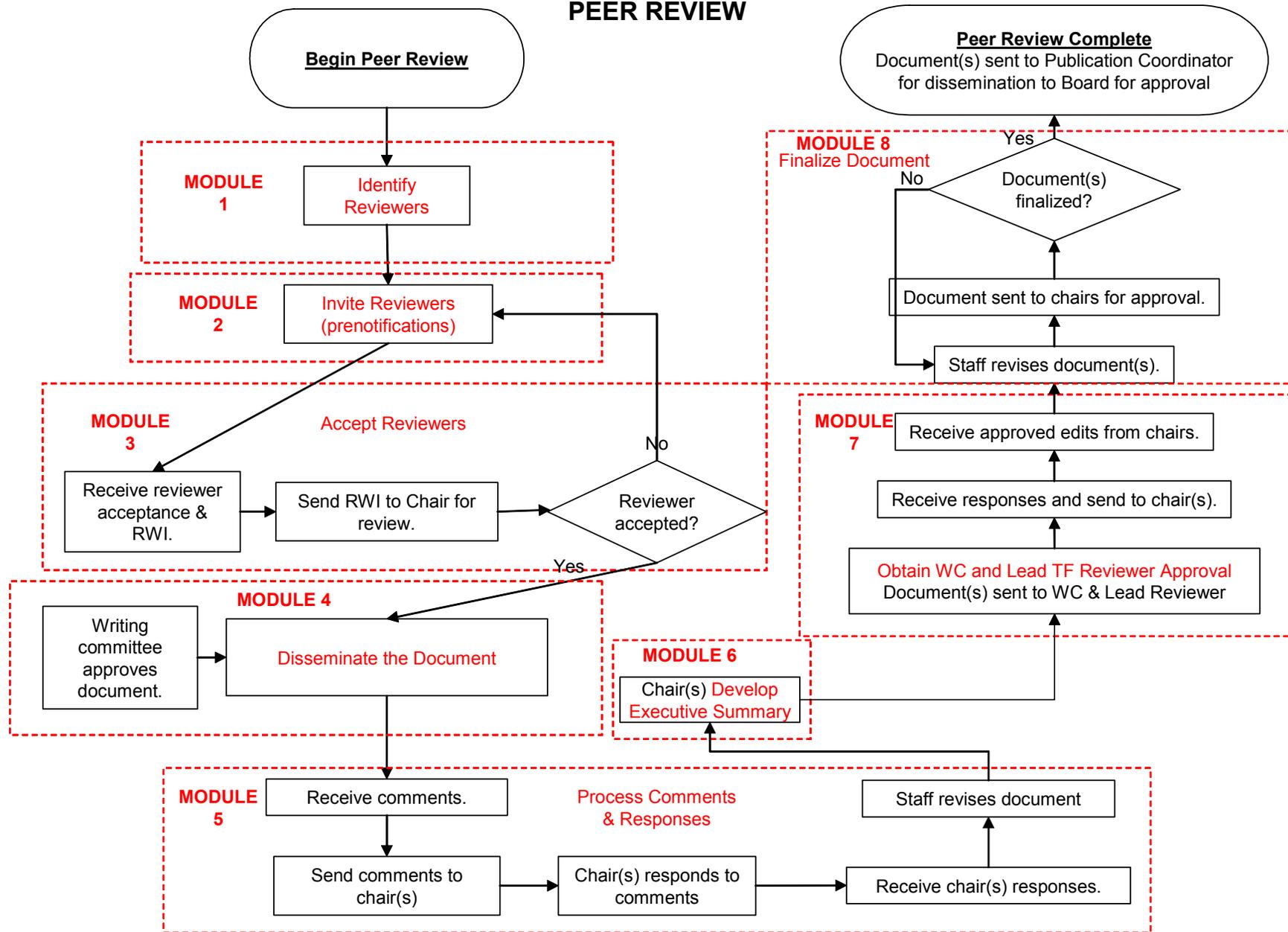
- Review all peer review comments
- Review the revised draft to ensure that peer review comments have been adequately addressed
- Review the response to official reviewers to ensure that all issues have been adequately addressed
- Recommend to parent task force chair whether the document is ready to go forward for board review or identify remaining issues that require resolution. If there are remaining issues, work with writing committee chair and/or task force chair to resolve final issues.
- Sign off on the document on behalf of parent task force should be done in writing (brief letter or e-mail to task force chair with a copy to staff).
- Participate in the ACCF Board of Trustees conference call to discuss the document

Publication of Peer Review Process

A brief description of the peer review process will be included in the introduction of the document that highlights the number of official reviewers from cosponsoring organizations, the number of content reviewers, as well as names organizations that participated in the review process.

The purpose of publishing peer reviewers relationships with industry is to further strengthen the integrity of the writing effort and make the document development process more transparent to readers. A footnote to the table listing peer reviewer names and relationships with industry would clarify that peer reviewer participation in the review process in no way implies agreement with or endorsement of the final document.

PEER REVIEW



III. Board Review and Approval Process (see flow chart at end of this section)

Board of Trustees' (BOT) Review

Clinical documents are forwarded to the Board of Trustees (BOT) by mail ballot for review, discussion, and preliminary vote. A conference call is scheduled to offer Board members opportunity to raise concerns they may have about a document. Materials forwarded to the Board include 1) the document to be published, as well as any supplementary material to be web posted only 2) responses to official peer reviewers, and 3) a tracking form identifying writing committee chair/members, official peer reviewers, content peer reviewers, and a list of organizations that have peer reviewed the document. Although the conference call is open to all Trustees, participation is not required unless Trustees have a specific concern that needs to be addressed. If Trustees want to participate but are unable due to scheduling difficulties, they are instructed to FAX comments to the writing committee chair (via staff) so that conference call participants may discuss the concern on the call.

All Board members are asked to return their Consensus Form to indicate preliminary approval of or opposition to the document by a designated date following the conference call. The ACCF President decides whether any changes made at the board level warrant board revote (e.g., substantial changes) or whether the changes do not substantially alter the intent of the document (e.g., clarifying changes) and therefore do not require further review by the BOT.

Present on the call are:

- President, American College of Cardiology
- Chair, CECD Task Force
- Lead Reviewer, CECD Task Force
- Chair, Writing Committee
- Board members with concerns or interest in document discussion

Formal ACCF Approval of Clinical Documents

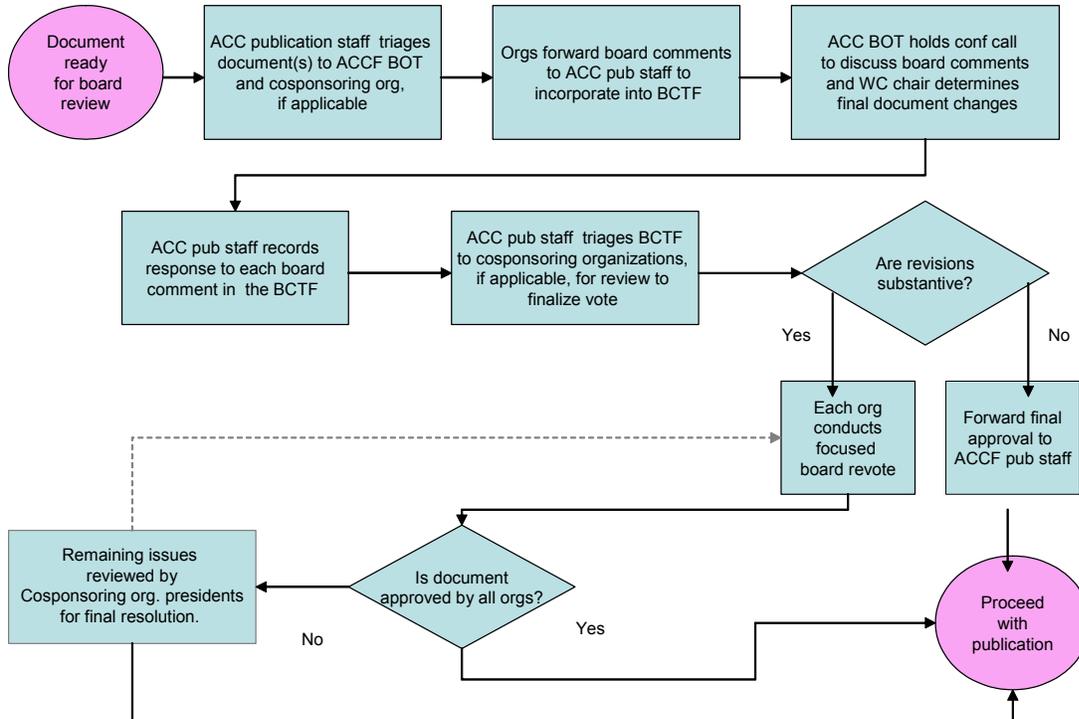
The ACCF Executive Committee formalizes approval of clinical documents via teleconference based on the results of preliminary approval by the BOT.

Joint Approval of Cosponsored Documents (if applicable)

If a document is cosponsored by another organization (e.g., ACCF/ESC CECD on Hypertrophic Cardiomyopathy), the cosponsoring organization receives a copy of the same information that was sent to the ACCF BOT. The cosponsoring organization conducts its own board review/approval process simultaneously with ACCF. If board concerns are raised by either organization, ACCF staff facilitates a process to reconcile final issues by working with the Presidents and staff of both organizations and the writing committee chair. Depending on the

nature of the board concerns, the writing committee chair may need to confer with writing committee members via mail ballot or conference call to resolve final issues.

Board Approval Process



BCTF = Board Comment Tracking Form; Cosponsoring orgs = ACC, AHA, and 3rd org, if applicable; Pub = publication; WC = writing committee

Section Seven: Publication Process

The Clinical Expert Consensus Document publications are published in *JACC*. The document is web posted prior to publication to expedite the availability of medical information to the clinician. Web posting occurs approximately one month after BOT approval. The document is published approximately two months after BOT approval.

Clinical Expert Consensus Documents Publication Process

