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Guidelines are not evidence

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EDITORIAL:

Guidelines are not evidence

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Guidelines are inherently flawed when caring for an individual patient.

When doctors use guidelines in clinical care, it is far too easy to make the cognitive error that they are helping that patient. Guidelines are misleading because they imply that there is one right management that applies to all patients; and conversely, that all other approaches are wrong. We don't think doctors should use guidelines as a direct mandate for individual patient care. Guidelines, ostensibly, are based on evidence that applies to populations. Physicians are charged with caring for individuals. There is a risk of benefit and a risk of harm in following a guideline. A more accurate portrayal of the role of guidelines is to initiate shared decision-making.

The Patient Centered Medical Home is an oxymoron because it is a hybrid of population management, patient communication protocols, and patient care processes: population management is not patient-centered. Population management follows guidelines that may or may not be in the best interest of our individual patients. For example, at our clinical practice site, our patients receive a requisition for a mammogram and are told to schedule an appointment before ever being seen by a doctor—there is no shared decision making. We are not using guidelines appropriately.

Being able to explain the evidence supporting a guideline is part of the doctor's job. Evidence from clinical research must be applied to an individual patient's circumstance. It is perfectly legitimate to use the same evidence and come to diametrically opposed decisions for two separate patients. Patient values are important when applying evidence. We don't think abrogating that responsibility is in anyone's best interest—neither the patient nor the healthcare system.

Without understanding clinical evidence, an algorithm, flow diagram or computer can replace the doctor. Such a lack of critical thinking is dangerous. An example of blindly following guidelines occurred recently in the precepting room. A resident said, "...and I'm going to check an LDL." When asked why, the resident replied, "I check an LDL on all my patients every year." The resident had internalized an out-of-date guideline and continued to use it for patient care.¹ Additionally, the resident couldn't conceptualize the reason for the recommendation; the resident was unaware of the evidence on which the guideline was based. The preceptor gave a provocative response, saying, "Oh, you must still believe in the cholesterol hypothesis," and gave the resident a flyer describing a medication that failed to improve cardiovascular deaths despite significantly lowering cholesterol levels.²

Then there is the issue of guidelines being out-of-date³, based on poor-quality or biased interpretation of clinical research⁴, or simply a marketing ploy of Big Pharma.⁵⁻¹¹ Doctors need to be familiar with major practice guidelines of their chosen specialty and decide which are trustworthy in practice. To do this, doctors need to be able to read and interpret clinical research. Only then can doctors understand when it's in the best interest of the patient to deviate from the recommendations of the guideline. Guidelines have to be viewed as any other intervention, having a number needed to treat and a number needed to harm.

We are proud that our contributors have demonstrated mastery of these skills.^{12,13}

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