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Evidence-based vs. 'impressionist' medicine: how best to implement guidelines

Bassand *et al.*[1] make a good case for increased use of guidelines. However, they underestimate the role for clinical judgement, patient choice, and physician concerns about cost effectiveness and polypharmacy. Randomized clinical trials and meta- analyses have enormously improved the data base to allow guidelines to be formulated and improve knowledge in pathophysiology and therapeutics in so many countless areas. For this, all clinicians are grateful. However, on a daily basis, the clinician has to make decisions for the individual patient and does not always have the same confidence as the guideline makers that the patient fits the criteria for a specific pathway. Even more importantly, because the morbidity/mortality benefit is likely to be so small, the odds are very strong and the individual patient is most unlikely to benefit. When one presents the numbers needed to treat (NNT) for a benefit to the patient, they are frequently unimpressed and opt not to proceed. Clinicians will regularly opt to compromise, sensibly in our view, with the patient and choose a more user friendly regime to facilitate compliance.

All will agree that the health authorities and the professionals should collaborate to facilitate guideline development and rationalization to guard against guideline overload. We have reservations about industry being involved in guideline development and promotion, as historically their promotions have emphasized relative risk reduction with little reference to absolute reduction and NNT. We would suggest that information on numbers treated effectively and ineffectively should also stand side by side. For a counter opinion, we would recommend the work of James Penston.[2]

References

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Evidence-based vs. 'impressionist' medicine: how best to implement guidelines: reply

Drs Fennell and Worrall make interesting and valuable comments on our recent paper,[1] which was intended only as an editorial, stressing the wide discrepancy between the recommendations to treat and the actual implementation of guidelines. This lack of implementation can result in loss of benefit for patients who are under treated. The impact of under use of medical therapies or strategies with proven efficacy on immediate and long-term outcome has been amply documented. We based our assumptions on some of the critical areas of our discipline, particularly acute coronary syndromes, where the life of the patient is at stake, and also heart failure. Registries have proven that in the field of acute coronary syndromes, poor compliance with guidelines can result in a two-fold increase in mortality at 1 month and 1 year. It is, therefore, the duty of every physician to implement guidelines, when one is absolutely certain that they will have a positive impact on the life expectancy of the patient.

This said, we understand the concerns of Drs Fennell and Worrall about the involvement of the industry in the development of implementation programmes. From a purely pragmatic point of view, it can be acknowledged that little or no funds are provided by health authorities to promote best practice through implementation programmes for guidelines, although some initiatives supported by health authorities are beginning in Europe.

The most important remark by our colleagues Fennell and Worrall is about the strength of evidence of recommended therapies included in guidelines. They propose that it could be based more on the number needed to treat (NNT), which may reflect the cost effectiveness of a given treatment. This comment is certainly valid, and indeed, NNT and also number needed to harm will be incorporated in a future set of guidelines to be