A guideline is like a prescription

Before we write a prescription, we review the patient's diagnosis, the known evidence, and our own experience. Then we discuss the risks and benefits with the patient. If he or she chooses to fill the prescription, we are responsible for the outcome. But patients may choose to not take the medication, feeling that the accumulated evidence does not apply to them or not fully understanding the balance of potential benefit and harm.

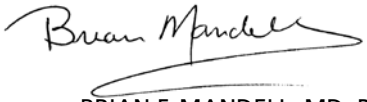
When a group of expert physicians writes practice guidelines, they review the literature and their own experience and then summarize key practices that they believe should be followed or avoided. These guidelines are offered to practicing physicians to accept or reject. Unlike the physician writing an individual prescription, the authors of the guidelines are not held directly responsible for the outcome in a specific patient.

Guidelines seem to be accepted on an academic level, not as a prescriptive approach to care but as a way of evaluating the relevant evidence and its practical application. But many practicing clinicians fear that guidelines are leading to the algorithmic practice of medicine and to reimbursement according to adherence to the guidelines, regardless of patient outcomes.

In this issue, on page 26, Roland Moskowitz, an expert in osteoarthritis, comments on the 2012 American College of Rheumatology "recommendations" for the treatment of this disease.[1] He notes that these recommendations are not a cookbook, points out areas in which his own practices differ from them, and emphasizes the need to individualize our recommendations. For instance, he notes that some of his patients have relief of pain after hyaluronan injections into their osteoarthritic knees, even though the guidelines do not recommend this therapy[1] and structured reviews suggest it has little benefit (in groups of patients) beyond that of placebo injections. This apparent paradox suggests that this therapy is not appropriate for everyone, but also that it should not be removed from our toolkit. Certainly, the patient's response to an injection (outcome) should be evaluated before repeating this therapy.

We should not worship the idol of guidelines alone, but neither should we ignore them and make decisions only on the basis of anecdote and experience. When making individual treatment decisions, we must assess external validity before applying pooled trial data. And administrators need to understand that clinicians may choose to not follow practice guidelines in individual patients for very valid reasons.

Most studies of the impact of guidelines have focused on how well physicians comply with them, not on patient outcomes. Compliance—of patients with physicians' advice and of physicians with guidelines—is a complicated process. Compliance should not be considered a cookbook expectation—for patients or for doctors.



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1. **Hochberg MC, Altman RD, April KT, et al; American College of Rheumatology**. American College of Rheumatology 2012 recommendations for the use of non-pharmacologic and pharmacologic therapies in osteoarthritis of the hand, hip, and knee. Arthritis Care Res (Hoboken) 2012; 64:465–474.

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