Physicians are a notoriously independent lot. They have long guarded the sanctity of the doctor-patient relationship, and cherished the right of physicians to determine medical management based on their own personal experience and clinical judgment. In large measure this sentiment was based on the recognition that multiple variables are present in every case and each patient presents a relatively unique set of circumstances. Therefore, the initial development and dissemination of guidelines for medical management were often greeted with caution and aloofness by the profession.

Over the years a number of factors have resulted in the general acceptance of the need for guidelines. The emergence of randomized clinical trials provided clear evidence of the superiority of certain management approaches over others. As compared with other sectors of society such as consumer electronics and fast food, where a reproducible product was regularly available throughout the world, studies consistently found considerable variability in medical management regardless of the disorder examined. Several reports brought focus upon the problem of medical errors. Last, but not least, it was recognized that we were approaching the point where we could deliver more care than resources would permit, that more care did not always yield better outcomes, and that it was imperative to practice the most cost-effective medicine possible.

Thus, it was with considerable care and caution that the process of writing guidelines was initiated. The earliest guidelines dealt with issues for which the greatest evidence and consensus existed. These documents stressed that they represented general recommendations and acknowledged the existence of considerable room for individual discretion. Of significance, these documents were invariably produced by professional organizations with broad memberships. The papers produced were the output of experts both within and outside the area of interest, and they underwent scrutiny, input, and approval by a number of governing boards. The concept was that the broadest representation would lead to the widest acceptance.

As time has passed, guidelines have received general acceptance. They have evolved to cover an expansive list of disorders and procedures, have taken a firmer position with regard to classifying approaches as recommended or not, and have undergone periodic updating to become living documents. They have assumed a place in standard medical practice. They have undergone periodic updating to become living documents. They have assumed a place in standard medical and have become an integral part of medical practice. They have evolved to cover an expansive list of disorders and procedures, have taken a firmer position with regard to classifying approaches as recommended or not, and have undergone periodic updating to become living documents. They have assumed a place in standard medical practice.

One recent development that has occurred has been a bit of a surprise, that is, the proactive development of guideline-type documents by groups of individuals independent of broad-based professional organizations. The new activism in the creation of guideline documents has taken a variety of forms. The Journal of the American College of Cardiology (JACC) has received a number of manuscripts written by independent groups of individuals recommending management strategies. Often these papers have had their origin in the work of committees of national societies. However, two recent articles relating to guidelines have attracted particular notice and have drawn attention to the increased populism in the creation of these documents.

The first of these documents was a response written by the Ad Hoc International Syncope consortium to an American Heart Association/American College of Cardiology Foundation (in collaboration with the Heart Rhythm Society) Guideline on The Evaluation of Syncope. Although not a spontaneous guideline creation itself, responding to that produced by the national societies it did make specific recommendations for the approach to syncope. As with other such independently created papers, JACC declined publication. However we did accept a letter summarizing the major issues the consortium raised about the guideline, and the full article has been placed online by another party. The consortium comprises recognized experts in the field, and they are certainly qualified to critique the guidelines. Moreover, they were not members of the writing committee, and as acknowledged by our acceptance of their revised letter, they are entitled to express their opinion regarding the document. Nevertheless, they do not have the advantage of representing a large professional organization, of having broad impact from multiple sectors of the profession, and from having extensive review by representatives of nearly all cardiovascular disciplines. Of particular interest to me is that guidelines, which have previously been thought to have little impact on practice and to be often ignored, were of such great interest and provoked such a spirited reaction among independent specialists.

The second document that recently appeared was produced by the Screening for Heart Attack Prevention and Education (SHAPE) Task force of the Association of the Eradication of Heart Attack (1). This report presented guidelines for cardiovascular screening and called for non-invasive screening (carotid ultrasound or CT) of all asymptomatic men (45 to 75 years) and women (55 to 75 years)
except those at very, very low risk. Again, the Task Force comprised international authorities who were well qualified to address the issue of cardiovascular screening. In this case an organization was involved, although one which appears to have a limited membership. The effort was aided by direct industrial support. The recommendations were aggressive, provocative, and received considerable media exposure. They address an issue of extreme importance to society, and their merits will be almost certainly widely discussed. From my perspective, however, the most interesting aspect of this “populist” guideline is that it represents a virtual 180° change from the circumstances in which the initial guidelines were drawn up. Then a reluctant profession felt that external factors made it incumbent upon them to have their professional societies create relatively loose recommendations about issues for which both evidence and general consensus existed. The SHAPE guidelines are a proactive effort on the part of a group of expert physicians to provide a specific management flow sheet for a strategy for which the evidence of efficacy remains unestablished.

On a tangential note, the SHAPE project also brought to light one of the thorniest dilemmas I have encountered in my own career. Specifically, it raised the issue of the rights and responsibilities of those who serve in leadership positions of professional societies. I recall that shortly after being installed as President of the American College of Cardiology (ACC), I received a very attractive invitation to lecture at the inauguration of a cath/surgical program at a hospital which was in heated competition with another in the same city. Clearly, my appearance could have been interpreted as an endorsement of the new program by the College. The title of Past President entails similar concerns, although the impact has nearly disappeared with the passage of years. The position of Editor-in-Chief probably carries an analogous potential to convey an ACC endorsement upon activities in which I participate. So it seems to me that I have an obligation to take this into account when evaluating activities in which to engage. On the other hand, those involved in leadership positions should not have to forfeit their right to individual thoughts and actions. It is unreasonable to expect that every action of a former leader implies approval of the entire organization. Thus, I believe a tension exists for those of us who have held high office between our obligations to the organization and our rights as individuals. This tension is greatly amplified with respect to guidelines.

In regard to the SHAPE guidelines, several individuals who hold or have held leadership positions in national/international medical societies authored the document. Rightly or wrongly, some may conclude that their participation conveys the approval of the organization. This is obviously not the case. As stated earlier, I am not sure of the answer to this dilemma. Although not necessary, perhaps it would have been wise for them to issue a disclaimer that they were expressing personal opinions. The individuals involved had every right to act as they did, and I have no doubt that they took into consideration the implication of their participation. Nevertheless, it is likely that their authorship will convey a degree of credibility upon these guidelines that they would not have enjoyed had those individuals not served in leadership positions in prominent cardiovascular societies.

In returning to the issue of guidelines, it would appear that the landscape has changed considerably in recent years. Guidelines have become an accepted, even expected, part of the medical landscape. Whereas once they were viewed as necessary, it would seem they are now sometimes seen as desirable. The creation of guidelines seems to be transitioning from the providence of national organizations to that of interested individuals. Although there is clearly an advantage to having knowledgeable and motivated individuals identify areas where guidelines are needed, and participate in writing such documents, I believe there are also significant disadvantages. While having recommendations for practice patterns produced by experts in the field may seem attractive, issues related to self-interest are often involved and convey the potential for bias. Guidelines prepared by national organizations enjoy broad-based input and extensive review and approval, and are therefore afforded high credibility and widespread acceptance. It is less certain that populist guidelines would be similarly viewed. I would encourage those who are interested and stimulated to produce guidelines to indeed be proactive. However, it would seem wise to work through national organizations.

To be effective in improving clinical care, guidelines must not only be based on evidence, but also be viewed as objective and reflecting broad consensus. Anything less may be inadequate to overcome the rugged individualism inherent to physicians.

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