professional society’s imprimatur and the appearance of quantitation inherent in an alphanumeric rating system may convey the impression of an action that is thoroughly evidence-based and ought to be performed, despite any number of layers of equivocation that might be deployed as a hedge against that impression.

To risk a tautology, we advocate that guidelines provide guidance. The National Academy of Medicine (formerly the Institute of Medicine) confronted this issue directly 27 years ago in its initial 1990 report on practice guidelines: “When the evidence is extremely strong and professional judgment is virtually unanimous, the guideline may be treated as a standard of practice permitting few if any exceptions. When the evidence is equivocal, the guideline may only identify currently acceptable practice options.”

We agree that the use of clinical practice guidelines for inculpatory purposes strays from the intent of the framers. Practice guidelines afford opportunity for extraction of divergent statements that, when used selectively to infer a standard of care in a court of law, may be construed as supporting conclusions that are frankly incorrect. Intermediate-grade recommendations are particularly prone to such interpretations, as they appear to lend support to actions that may only be applicable to a minority of patients.

We think that it is best for clinical guidelines to call out uncertainty explicitly when it exists and to deem such recommendations as the purview of the treating physician in the exercise of his or her clinical judgment. Although practice guidelines were conceived to bring rigor to clinical judgment, it would be a mistake to conclude that the current body of scientific knowledge is sufficient to govern clinical practice in areas of sparse or conflicting evidence.

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