In Reply Drs Wilson and Schoenberg provide a number of comments on my Viewpoint on clinical practice guidelines.1 It is a misunderstanding of the IOM’s Clinical Practice Guidelines We Can Trust report that it is a “requirement that every recommendation be supported by a systematic review.” The report says that “trustworthy clinical practice guidelines should be based on a high-quality systematic review of the evidence.”2 The committee intentionally left this as a general statement and stayed away from creating a standard on the optimal tailoring of a systematic review for every guideline recommendation (Sheldon Greenfield, MD, email communication, October 15, 2018).

When the National Guideline Clearinghouse was still in operation, the editorial board and staff often spent many hours discussing how much of a particular guideline submitted to the clearinghouse needed to be supported by a systematic review so the document would meet the IOM definition of a guideline, namely, that the recommendations “are informed by a systematic review.” Some guidelines accepted for the National Guideline Clearinghouse did not have a systematic review for every recommendation (Sheldon Greenfield, MD, email communication, October 15, 2018).

That clarification notwithstanding, I am not in favor of the strategy proposed by Wilson and Schoenberg, namely, that a priori the scope of a guideline can be divided into a small collection of areas that will benefit from a systematic review and many other areas (estimated at up to 80% of the total) for which “there is little or no uncertainty among the panel” and therefore no systematic review is needed. On what basis do the panel members conclude what they think they know and do not know about a particular content area? If it is not based on a systematic examination of the evidence, then what is it based on? If the experts’ certainty is based on an existing systematic review—for example regarding the effectiveness of influenza vaccinations, or β-blockers after myocardial infarction, or inhaled steroids for asthma—then this information needs to be collected and reported as the evidence foundation for the recommendation, which then makes the recommendation “informed by a systematic review.” If the experts’ certainty is not based on existing systematic reviews, then it is subject to the same kinds of errors in information collection and processing that prompted the development of systematic review methods and the acceptance of systematic reviews as superior to ad hoc reviews (whether formal or informal) in terms of estimating benefits and harms. The observation that a collection of experts share the same mistaken certainty about the risks and harms of an intervention has not been unreported in the history of medicine.

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Conflict of Interest Disclosures: Dr Shekelle reported that he is the author of a chapter on practice guidelines for UpToDate and that he served as cochair of the editorial board for the National Guideline Clearinghouse.