As early critics of guidelines, it is heartening to witness the current debate. Previously raised problems such as timeliness and conflicts of interest (1) are now being aired, but larger issues remain.

Coyne provides a valuable service by highlighting the financial relationships between industry, the National Kidney Foundation and the potential implications to industry of certain guidelines, particularly relating to the treatment of anemia (2). Narins and Bennett suggest that conflicts of interest can be resolved by placing contributions in a “common pool for all guidelines, not just those that are related to the contributor’s commercial interests.” This makes only a cosmetic difference. They also point to the Joint National Committee (JNC) on hypertension as a role model for guideline development. Although not funded directly by industry, many of the committee members and reviewers have commercial ties to industry and these are not documented. Interestingly, the definition of hypertension seems to move lower with each JNC report. We need to accept that conflicts of interest, whether potential, apparent, or actual, may be impossible to avoid and strive to bathe them in sunlight. Narins and Bennett discuss the considerable potential for abuse of guidelines by payers and lawyers, but have no plans to deal with this (3). Van Wyck’s detailed description of the guideline process confirms our suspicions—it’s a labor and time-intensive nightmare (4).

Despite these concerns, all authors share a belief that the guidelines are, on the whole, good, and that they should be maintained. But if we’re going to be evidence-based, then this point needs to be proven. Unless it can be demonstrated convincingly that guidelines benefit patients (rather than their creators), we should not be spending the considerable time, energy, and money on them. That the figure in Coyne’s article shows no change in dialysis mortality rate over the last ten years, in spite of the guidelines, with rising doses of erythropoietin (and vitamin D analogs), suggests guidelines convey no benefit. Worse, with evidence of harm in patients with hemoglobin >12 g/dl, and the epidemic of adynamic bone disease and vascular calcification associated with the Kidney Disease Outcomes Quality Improvement parathyroid hormone target of 150 to 300 pg/ml (5), guidelines may have provoked iatrogenesis. When a physician makes an error, it typically affects one or a few patients and can often be quickly remedied. When guidelines are wrong, thousands can be harmed, and they are extremely difficult to reverse! Once issued, we are powerless to prevent them from being used for clinical performance measures and pay-for-performance (6).

Guidelines promote a “one size fits all” approach to treatment which is the antithesis of good individualized medical care. Practice variations, decried by guideline proponents, are in fact desirable, since patients vary so much in manifestations of their disease process.

Problems with guidelines are extensive and go beyond the narrowly-drawn debate over anemia management. The damage potential of guidelines exceeds their theoretical benefit. They should be abandoned.

Disclosures

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References