that. Clearly, we could never account for the patient's own personal values and preferences. What guidelines represent, therefore, are a foundation to which a skilled clinician can add the details and nuance that represent the best in "clinical judgment," and not a substitute for the same.

Clinical practice guidelines are a good thing. Those who synthesize them bear a considerable burden to be thorough in their research of the data and balanced in their interpretation. We must be honest and transparent about the strengths and limitations of those data and the recommendations derived from them. At the same time, the consumer bears a responsibility to use them intelligently and with an appreciation for their inherent limitations. Accordingly, the phrase "the guidelines say" should be applied at the beginning, not the end, of the discussion.

Conflict of Interest Statement

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EDITORIAL COMMENTARY

Finding the truth in the guidelines and gospels

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Truth is the state of being the case (www.merriam-webster.com/dictionary/truth), but a philosophical concept that depends on the knowledge, beliefs, experience, and perspective of the person wishing to be enlightened. Guidelines and the gospels are similar in that they describe concepts that to some are the absolute truth, but to others are general ideas or methods without a preconceived notion of the absolute. The American College of Cardiology (ACC)/American Heart Association (AHA) clinical guidelines are important treatises and arguably some of the most important and impactful works that these organizations create. They "guide" us in making correct clinical decisions. I had the privilege of serving as the surgical representative on the

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Central Message

Clinical guidelines are valuable documents that recommend treatment for the majority of patients, but should not be used in the absence of clinical judgment for the individual patient.

See Article page 1472.

ACC/AHA Guidelines Taskforce for the past several years, and found the experience rewarding and enlightening. I would like to discuss the process and truth of these guidelines and gospels, and to put these things into perspective.

In this issue of the *Journal*, Thor Sundt¹ very nicely summarizes his perspective on the role of guidelines, and on how they should be used to treat patients with various medical or surgical conditions. I generally agree with his statements.

The process involves the creation of a writing group that accumulates and assesses all relevant published information on a topic. This group makes recommendations as to whether the data support the use or avoidance of this therapy, basing these recommendations on the strength of the data. At first glance, it would appear that the results of such as assessment would be clear-cut and allow us to treat all of our patients based on these guidelines; however, in most cases, the published papers used to construct such guidelines do not discriminate one group of patients (eg, elderly, diabetic) from another. Although some subgroup analysis does take place, writing group members have to come up with recommendations on how to treat all patients with a certain condition. It is impractical to subdivide every patient group, because multiple studies comparing all different groups with different methods of treatment have not been performed. Thus, clinical judgment, based on experience and the best available information, is still required to treat patients with medical and surgical conditions.

Another issue is that certain groups, including cardiovascular surgeons and interventional cardiologists, may have a vested interest in how patients with multivessel coronary artery disease are treated. An interventional cardiologist may believe that a diabetic patient with multivessel coronary artery disease can be treated with percutaneous intervention, whereas a surgeon may believe that coronary artery bypass surgery is the only good option. This issue is well known to members of the recent writing groups dealing with ischemic heart disease.

After the recommendations are developed and the supporting publications graded, the guidelines are sent out for extensive review, and changes are made. The guidelines are then again sent out for review. Finally, the ACC/AHA Guideline Taskforce reviews the guidelines and sends them to the leadership of the sponsoring organizations for

final approval. The process can be shortened, but doing so diminishes the impact and legitimacy of the recommendations. Very narrow guideline topics, such as determining whether on-pump or off-pump coronary artery bypass grafting should be performed, tend to be of very limited interest to most clinicians, but may be of considerable interest to cardiothoracic surgeons. There is growing interest in the nearly continuous updating of guidelines; however, this would require revision of the review process, which might compromise this process. In addition, the cost effectiveness of various treatments is being considered, but this evaluation would greatly increase the workload of the writing groups.

With regard to the gospels, there are considerable contradictions in the historical data among these 4 books of the New Testament. This is not all that surprising, considering that they were first written down between 40 and 90 years after the events occurred. According to Matthew, Jesus was born during the time of Herod the Great, whereas Luke states that Jesus was born during a census ordered by Quirinius, governor of Syria. Both cannot be possible, considering Herod died in 4 CE and the only known census took place around 6 CE, or about 10 years later. Even the dates of the last supper and crucifixion differ among the gospels. Matthew, Mark, and Luke state that the last supper took place on the first day of the Jewish Passover, whereas John contends the last supper occurred a day earlier and that Jesus was crucified on the first day of Passover. The authors of the gospels viewed themselves as inspired interpreters of God's message, not just scribes recording the life and teachings of Jesus, and added commentary in an attempt to improve the message, as was the style of the day. Thus, even the gospels are subject to interpretation.

For both guidelines and gospels, the bigger picture needs to be examined. If one wishes to discredit either, it is easy to do so; but if one uses these as the basis on how to live, worship God, or take care of patients, both can be very valuable resources. In other words, guidelines should be just that—guidelines—and not a description of an absolute method of treatment devoid of judgment that takes into consideration the individual patient.

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