To the Editor:

Practice guidelines, particularly those originating from the American Heart Association/American Stroke Association, have come a very long way since the traditional GOBSAT (“good old boys sat at table”) methods of the 1980s. The best of recent guidelines are systematic, transparent, reproducible, with recommendations stratified by strength of evidence and with timely updating.1

But they could be even better by wider representation on guideline panels and by the incorporation of patient values and preferences. The views of medical subspecialty experts who often generate guidelines do not necessarily reflect those of general physicians who are intended to implement recommendations for primary prevention. Guideline panels should optimally include representatives of those at whom they are aimed. Although experts are required to scientifically evaluate efficacy and safety, how best to apply this knowledge is not the exclusive domain of medical experts, who cannot claim sole authority to make valid judgments on behalf of individual patients or society. Patient preferences regarding the magnitude of benefit warranting treatment are seldom considered, and this likely contributes to the under-implementation of practice guidelines.2

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