



Guest editorial

Sailing to the port of best practice on the A/I practice parameters Mayflower



“To reach a port we must sail, sometimes with the wind, and sometimes against it. But we must not drift or lie at anchor.”

—Oliver Wendell Holmes, Sr

The word *parameter* is derived from the Greek words *para* “beside” and *metron* “measure” and is defined by the Oxford Dictionary as “a numerical or other measurable factor forming one of a set that defines a system or sets the conditions of its operation.”¹ More generally, it is “a limit or boundary that defines the scope of a particular process or activity.” The term *best practice* is the process of developing and following a standardized methodology that can be emulated to reliably achieve a desired outcome. In health care, it refers to activities, disciplines, and methods that distill scientific evidence into rational guidelines. Taken together, *best practice* and *parameters* constitute evidence-based practice parameters that are essential to optimize health care.

The Joint Task Force on Practice Parameters (JTF) was formed in 1989 to develop practice parameters for the diagnosis and management of allergic and immunologic diseases. This initiative was conceived in response to requests by allergists and immunologists for an evidence-based synthesis of the medical literature and guidance on “best practice” using available information. Members of the JTF represent the national allergy organizations (American Academy of Allergy, Asthma & Immunology; American College of Allergy, Asthma and Immunology; and Joint Council of Allergy, Asthma and Immunology) and serve to commission, coordinate, and guide workgroups that create the documents. Practice parameters have been developed for (1) clinical conditions such as asthma, rhinitis, atopic dermatitis, and immunodeficiency; (2) procedures such as diagnostic testing and immunotherapy; and (3) related topics such as environmental control. To date, 15 discrete practice parameters have been produced by the JTF (available at <http://www.allergyparameters.org>), which are updated at 5- to 8-year intervals.

A practice parameter includes a series of actionable summary statements that are qualified by a “strength of recommendation” based on the nature of evidence (ranging from “highest-quality evidence” to “expert opinion”). Each summary statement is followed by a block of text with references citing the supporting evidence. The format and process for developing practice parameters have changed over the years, most recently guided by recommendations

from the Institute of Medicine and Council of Medical Specialty Societies. Practice parameters that meet strict criteria are eligible for inclusion in the National Guideline Clearinghouse that is managed by the Agency for Healthcare Research and Quality. Notably, all practice parameters developed by the allergy profession are included in that database.

The strategy used to develop a practice parameter reflects the overarching goal of its developers. If the goal is to create the most rigorous and statistically valid set of recommendations possible, then the developers will tend to consider only the highest-quality evidence. This may restrict the practice parameter to answering only a few focused key questions. Conversely, if the goal is to provide guidance to clinicians about a broad range of important clinical issues, then less compelling evidence may be considered. Although not ideal, this strategy provides direction to clinicians on a larger variety of questions. Therefore, the number of recommendations in a practice parameter and the quality of evidence that supports them tend to mirror the reason for the creation of the parameter. Although a more rigorous set of standards for unequivocal evidence could be adopted, the JTF has philosophically chosen to guide allergy and immunology (A/I) specialists over a wider spectrum of clinical situations.

Although surveys of allergists have confirmed the undeniable utility of allergy practice parameters,² a detailed comparison with other specialties has not been performed. In the current issue of the *Annals of Allergy, Asthma, and Immunology*, Banks et al³ present an intriguing comparative analysis (a type of meta-parameter-analysis, if you will) of guideline documents developed by A/I, otolaryngology, internal medicine, and pediatrics. They identify several differences that show the underlying ideologies that shaped the design of the respective parameters.

Banks et al reported that the proportion of controlled trials–based recommendations is smaller for A/I and otolaryngology parameters compared with the primary care specialties internal medicine and pediatrics. This observation, although startling, is understandable when viewed in context that subspecialty guidelines need to address issues that may have a paucity of published data; the intent is to provide guidance to practitioners even if evidence is scant. This limitation is acknowledged in many of the A/I parameter documents and clearly visible in the varying strengths of recommendations. Banks et al noted that some A/I parameters had a disproportionately larger number of summary statements with lower levels of evidence. Closer scrutiny shows that some of these particular parameters are akin to subspecialties by themselves, often involving rare but challenging medical problems for which standardization of care would be beneficial.^{4–6}

Practice parameter groups that limit statements to only issues for which high-quality evidence is available will, of necessity, be

Disclosure: Dr Dinakar has served on the speaker's bureaus of Teva Pharmaceuticals, GlaxoSmithKline, and Aerocrine; the board of regents for the American Academy of Allergy, Asthma & Immunology; and chair of the Yellow Zone Practice Parameter Workgroup for the Joint Task Force on Practice Parameters. Dr. Portnoy is co-chair of the Joint Task Force on Practice Parameters.

able to provide guidance only for a smaller set of topics. This is borne out by the observation that the number of recommendations was largest for the A/I practice parameters and smallest for internal medicine. The latter had the second smallest number of practice parameters, with each presenting 3 to 7 recommendations. Although the fewest parameters were found for otolaryngology (a specialty that is larger but similar to allergy), the number of recommendations with lower levels of evidence was larger.

Many practice parameters reviewed in this study were published before the 2008 Institute of Medicine recommendations. Given the tradeoff between the rigor and scope of practice parameters, the structure is expected to evolve. For instance, recent publications, such as the yellow zone practice parameter,⁷ have fewer summary statements.

The JTF has unstintingly volunteered time and energy to distill meaningful guidelines from evidence that is sometimes cogent and at other times subtle. The A/I community is indebted to them for their Herculean efforts and expertise in ceaselessly steering the bow toward better health care.

“I have not told half of what I saw.”
—Marco Polo

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