immediately we need to balance the control of setting clinical priorities between the clinician–patient dyad and systems setting quality measurement mandates. This might include a requirement that mandates come with an impact statement of the health improvements that are expected and the underlying rationale, as well as the specific patients for whom these expectations are evidence based. For instance, do they apply to both middle-income patients who have been receiving care and those just obtaining insurance and care? Improvements should be described at the patient level (ie, in keeping with Patient-Oriented Evidence that Matters) rather than at the level of disease or process of care. Providing such information is a reasonable expectation given the possible effect, including unintended consequences.

The limits of patients' capacity to adopt care recommendations should also be considered when setting quality measurement mandates. For instance, during the first 12 months a patient is enrolled with a physician, should only the physician-designated top few priority conditions contribute to the practice's quality metrics? Practices and payers also should limit the number of new guidelines mandated during any period of time.

Ganiats and Kempster are not suggesting we abandon guidelines. Ultimately, guidelines have great potential to improve the value of care and the health of patients and populations. Key to realizing such benefit is controlling how they are introduced to practices and the influence implementation has on either improving or distorting the decisions clinicians and patients make.

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Re: Counterpoint: Rationing on the Fly: The Opportunity Cost of Clinical Guidelines

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We are happy to see that Dr. Larry Culpepper agrees with our basic premises. Importantly, we appreciate his correct clarification that "the care we provide patients is driven by the number of problems they have, not by the number of guidelines available." However, he misrepresents some of our key tenets. We believe the adoption of a new guideline *may* increase care (not that it necessarily will); when the workload is increased, barring other interventions, something must be taken away.

We are happy that medicine is complex enough that we do not know a priori all the problems that will be addressed in a given day, even though this means we cannot plan a learned response to the day's challenges. This means that real-world practice has excitement and challenges that force to us to make decisions on the fly. Thus we disagree with Culpepper when he suggests the decision on what care to provide "is done concurrently as the clinician and patient seek to maximize value." In addition, when these decisions are made, whether ad hoc or through thoughtful deliberation, we call it rationing. He does not. That is just semantics.

A major premise of our Commentary is that without more work "the true impact of clinical guidelines cannot be known." We agree with some of Culpepper's proposed solutions, though many have a long-term horizon, but the basic problem persists. In the end, we hoped to spur debate and discussion and are pleased that this has started.

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