GUESTEDITORIAL

Clinician reflections on how to provide personalised healthcare while using generalised guidelines

To **medical doctors**
To patients
To neuroscientists
To **therapists**

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Treatment guidelines can be useful for the busy clinician. Someone else has synthesised and critiqued the most recent research evidence available on a given topic. Being aware of and applying this is vital to providing high quality **healthcare**. But personalising care is also crucial. So how do we translate generalised guidelines into use with unique individuals, in specific settings, in a meaningful way?

First, we must recognise the limits of treatment guidelines in the rehabilitation setting. Guidelines intend to group; however, people fall on both ends of the bell-shaped curve. Rigid applications of guidelines risk being a one size fits all approach, missing outlying individuals who don't fit neatly into recommendations. Further, it is challenging to design objective, generalisable research about therapy. Such designs are resource intensive; therapy occurs in a dynamic interaction between real humans in the real world, drawing on multiple elements that are difficult to disentangle and study in isolation, because humans are complex. Thus, the highest quality intervention studies may therefore be the ones with the greatest funding or access opportunities, not necessarily the ones with greatest clinical utility. And finally, therapy doesn't end in the clinic: people ultimately return to their world with all the uncertainty, complexity and variability unique to each one of us, while continuing to employ strategies introduced during therapy. When we understand that this is the context within which our standardised therapies and guidelines are developed and implemented, we interpret research findings more cautiously. We become both more critical - and more flexible - when considering the relevance of results to our practice setting and the **life of the person**. The situation liberates us to develop creative approaches, developed from strong evidence-based principles, but applied with flexibility and sensitivity.

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We must further recognise that observing guidelines is not all there is to evidence-based practice. In the past decade much effort has been dedicated to analysing factors influencing clinician application of research to practice (Krueger et al., 2020). However, evidence-based practice, by definition, is a decision-making process which combines the best available research evidence, patient factors (including values and goals), and the clinician's own experience (Sackett et al., 1996). By this definition, applying research evidence in the form of guidelines and listening to the person's voice are not mutually exclusive. Whatever guidelines exist, our role as clinicians is to take the broad principles from research evidence and collaborate with people to make it about them and their life. True evidence-based practice then requires elevating the **person's voice** in the clinical decision-making process, considering contextual and personal factors to be as vital to the appropriateness of any given therapy as the research evidence supporting it.

Finally, truly providing personalised care requires prioritising whole-person care. As clinicians, we are not just treating a body part or a diagnosis, but a person, in a specific moment of their life, in their world. Human health itself is a whole comprised of many parts; a dynamic interplay between health conditions (*e.g.* diseases, disorders, and injuries) and contextual factors at multiple levels, including "the level of body or body part, the whole person, and the whole person in a social context" (World Health Organisation, 2002, p. 10). Truly personalised care thus involves taking the time to listen to and understand the whole person in front of us and what makes them uniquely them, partnering with them to codesign a rehabilitation process that is right for them in that **moment of their lives**. This involves sharing principles from treatment guidelines, tailored to them as a whole person, and not purely to the mechanisms of their disease or disorder. It is a delicate dance that requires an ongoing and deliberate commitment to listening, self-reflection, and humility. Because with experience we learn that we are not the experts, but rather, that there is always more to learn about other people.

References

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