

The objective of clinical guidelines is a universalistic one. Yet as a goal universalism can be translated in many ways. Those promulgating clinic guidelines, an important element of evidence-based medicine, have seen them primarily as guiding and constraining clinicians themselves. Clinical guidelines are supposed to distill scientific knowledge about the best ways to manage a wide variety of conditions so that physicians and other health care providers can stand on the shoulders of science. With clear guidance about what is scientifically settled and what the science implies about what doctors should do, inequalities among medical practitioners should be reduced, the argument goes, and patients can be confident that they will get good care whether their doctor was trained at a premier medical center or a less prestigious institution.

A key assumption of this argument is that the main source of variance is doctor competence. Publications such as the *Scientific American* (or *Consumer Reports*, or Berg's book *Rationalizing Medical Work*) regularly point out that medical treatment of some conditions (e.g., prostate cancer) is far from uniform and it is not entirely clear that uniformity in guidelines will much reduce this variability. Whether this is a pessimistic conclusion or not I am not sure.

My argument in this paper is that those looking for the salutary effect of clinical guidelines may be looking in the wrong place. The effect of clinical guidelines is there and it is large, I suggest, but it may not come not through changes in the practices of physicians. Rather, a key effect of guidelines is in convincing other parties that they must supply the resources to equalize access to healthcare.

This paper uses the case of HIV/AIDS and access to antiretroviral therapy to show how consensus about the efficacy of treatment, embodied in clinical guidelines, added support to claims that the poor should have equal access to antiretroviral therapy. I trace the evolution of the debate on access, showing the intertwined paths of guideline development, discussions of the ethics of clinical research, and discourse on drug access. In essence my argument is that clinical guidelines were used strategically as a legal resource, in effect a legislative endowment (Lempert & Sanders) that could now be deployed on behalf of the disadvantaged. In the paper I show not only how the endowment was created, but also how it came to be deployed, including how the international system of clinical trials created an opening for the earliest claims about fairness in drug access. But however universalistic they sound, rules do not by any stretch of the imagination always lead to increased equality. The legalism of the WTO thus offers an interesting counterpoint to the legalism of clinical guidelines as two different ways that the "rule of law," extended into medicine, has shaped access to healthcare.