



Outside the guidelines, no salvation! Really?

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Can a family physician practise good medicine without following clinical practice guidelines? Obviously, you have the right to come back with, "What do you mean by *good medicine*?" Let's define it for our present purposes as that promoted by the 4 principles of family medicine: a family physician is a skilled clinician, family medicine is a community-based discipline, a family physician is a resource to a defined practice population, and the patient-doctor relationship is central to family medicine.¹ These principles can be augmented by up-to-date interdisciplinary competencies.

The question could seem trivial, even ridiculous, so widely are guidelines distributed and generally used. But it merits being posed as Drs David Gass and Ross Upshur have done in the debate on pages 518-519. Dr Gass suggests that a family physician is hard pressed to practise good medicine without them. In his argument, he reminds us of the phenomenal increase in knowledge in medicine and the difficulty, perhaps the impossibility, of any one person being able to review and evaluate all the published research, basing his argument on the fact that the recommendations are rigorous and credible. Dr Upshur, on the other hand, argues that the guidelines do not cover all the fields of the practice of family medicine, that the empirical data evaluating the use of guidelines are not convincing, and finally, that even the definition of *good guidelines* raises numerous conceptual problems.

Do we give too much credence to guidelines?


Without taking sides in this debate, one can say that it remains true nonetheless that these days we accord a great deal of importance and credibility to guidelines. Perhaps too much? You need only to imagine a disagreement between 2 practitioners regarding patient care to know that one of them will come up with the crushing argument "Well, anyway, the guidelines say so!" and wipe out the debate. The other practitioner has no choice but to find solid arguments to defend his position; otherwise he will have lost the exchange and will be considered in the wrong until he can prove his point, just as if the guidelines were the only and unique truth, the absolute truth. Pity the "misguided" doctor who does not follow the guidelines. He will have to answer for his actions and justify his conduct, particularly if things go badly and people question his practice, to his colleagues, to regulatory committees, to government and professional bodies, and ultimately, to his patients.

As Upshur reminds us, however, the guidelines are not always beyond question. We must agree with him that there are too many. If you type *clinical practice guidelines* into Google, you get more than 3 000 000 entries. How absurd! In fact, there are more topics related to clinical practice guidelines than there are diseases themselves. There could be a hundred times or a thousand times fewer guidelines, and there would still be too many. It is hardly surprising that, among the assortment, there are good guidelines and not-so-good guidelines. It is an open secret that guidelines represent a veritable gold mine for the pharmaceutical industry, which has strongly promoted them. Another thing, guidelines change too often. We hardly get time to assimilate the first set before a new version sees the light of day. And it is not rare for guidelines on the same subject to differ from one another. We need only look at the recommendations on prostate cancer screening to find contradictory recommendations.

Are the recommendations founded on evidence-based data?

The strongest objection we can make in regard to clinical practice guidelines is that they are not perhaps founded as much on evidence-based data as we claim. Recently, Tricoci et al² conducted a systematic review of all the guidelines put out by the American College of Cardiology and the American Heart Association—worthy organizations!—between 1984 and 2008 with the intention of evaluating their scientific rigour. They discovered that in the 16 guidelines reporting levels of scientific evidence, only 245 of the 1305 class I recommendations were supported by level A evidence (median 19%). The authors concluded that the recommendations put out by those organizations were based on low levels of scientific evidence or expert opinion. Really!

Finally, another irritant to consider with guidelines is the vocabulary used, which is universally based on "recommendations." So, rather than announcing that the guidelines are rubbish and calling on epidemiologic gobbledegook when we don't know the answer, can we not just simply say, "We don't know"?

After all, practising family medicine is certainly much more than knowing how to apply a collection of clinical practice guidelines. 

Competing interests

None declared

References

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2. Tricoci P, Allen JM, Kramer JM, Califfe RM, Smith SC Jr. Scientific evidence underlying the ACC/AHA clinical practice guidelines. *JAMA* 2009;301(8):831-41.

Cet article se trouve aussi en français à la page 511.