

Ministry of Health/Ontario Medical Association, Toronto, 1989

2. Canadian Consensus Conference on Cholesterol: Final Report. *Can Med Assoc J* 1988; 139 (11, suppl): 1-8
3. National Diet-Heart Study Research Group: The National Diet-Heart Study final report. *Circulation* 1968; 37 (suppl 1): 1-428
4. National Cholesterol Education Program: Report of the Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (NIH publ 88-2925), US Dept of Health and Human Services, Bethesda, Md, 1988

[The task force replies:]

Criticism of the task force's initiative has focused on the process used. Dr. Horlick feels that there was inadequate consultation with experts in lipid disorders and too little "consensus". We did consult international experts in the field, including Dr. Alan Garber, Dr. Scott Grundy, Dr. Thomas Kottke and, indeed, Dr. Horlick, as chairman of the CCCC. Opinions among these experts differed, so that not all their recommendations could be included in the report. Producing practical guidelines for optimal practice patterns called for a group trained in evaluation of medical data rather than a group of experts in various aspects of lipid metabolism. The guidelines were intended to provide Ontario physicians with a practical guide for deciding who should be tested and who should be treated that is based on the best analysis of the best current scientific evidence.

This exercise represents a major advance in collaborative efforts to develop therapeutic recommendations that are based on impartial and critical review of all scientific evidence available in the hope of reducing inappropriate use of drugs or techniques. The Ontario Ministry of Health must be commended for endorsing the recommendations and accepting the fact that the implementation of these guidelines will substantially increase the costs of the diagnosis and treatment of asymptomatic hypercholesterolemia over present levels. The expected benefit will come from avoidance of the ex-

cessive or unnecessary testing and drug use that might result if not constrained by coherent scientific recommendations.

The OMA also endorsed the guidelines, signalling its willingness to cooperate with government in initiatives aimed at improving the quality of health care. The task force recommendations do advocate some restraint in testing and treatment of hypercholesterolemia, but these are based on clinical considerations that balance the adverse effects of medical intervention with the benefits expected. Like any guidelines supported by the OMA these are voluntary, flexible and subject to immediate modification when new evidence appears.

The members of the task force confirm their support for the policy document, which we believe provides guidance for physicians based on complex data analysis that would be beyond the capabilities of virtually any individual physician. We did not expect that the report would be universally accepted, and we welcome debate both on its scientific conclusions and on the development of better methodology with which to address similar problems in the future.

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[The working group replies:]

The mandate of the Toronto Working Group on Cholesterol Policy was to review the evidence concerning the potential benefits, side effects and costs of detecting and treating elevated serum cholesterol levels in the diverse adult subpopulations at risk for CHD. We were also required to weigh the respective roles of community-wide health promotion strategies and individualized medical strategies. These tasks are not within the usual domain of either bench research in lipid biochemistry or sub-

specialty referral practice in lipid disorders.

As case-finding becomes commonplace, testing and treatment of asymptomatic persons for elevated serum cholesterol levels will take place almost exclusively in the offices of those engaged in adult primary care. Indeed, when Blue Cross-Blue Shield in the United States sought an external review of the cholesterol testing conundrum it turned to a group not unlike ours — ambulatory care practitioners with expertise in clinical epidemiology and health economics.¹

The important point is a willingness to appraise the relevant evidence critically. Dr. Horlick, for example, claims that the NDHS showed an "average 10% reduction in cholesterol levels" with a diet similar to the AHA level 1 recommendations.² The treatment group actually followed diets much higher in polyunsaturated fats than recommended for the AHA level 1 diet. The average decreases of 8.4% and 9.3% were observed relative to a control group consuming prepared foods with high saturated fat and low polyunsaturated fat contents. The NDHS subjects were a self-selected volunteer group comprising only 11% of all those asked to participate. More important still, the subjects were randomized to obtaining one of three varieties of all fat-containing foods at *study distribution centres*. The difference in the decrease in cholesterol levels over 1 year between the single cohort randomized to dietary instruction, who obtained their food on the open market, and the "control" group in the same city, who obtained fatty foods at a distribution centre, was less than 4% averaged over the last 40 weeks of the year and 2% at the end of the year. We suggest that such analyses are not "gloomy" but a realistic prerequisite to policy formulation.

Horlick misrepresents the Ontario policy. The poster mailed to Ontario physicians states: "Regardless of whether serum cholesterol is measured, practitioners should encourage all patients to