



Guidelines — not always an easy answer

The Oct. 6, 1998, edition of *CMAJ* included 3 seemingly unrelated articles, which, on reflection, I believe are very much connected. The article that started it all was the editorial on the use (or non-use) of clinical practice guidelines by family physicians.¹

The modern approach to solving problems in teaching is to ask those receiving the message what is wrong with the message or the communicator. The article by Claude Beaudoin and colleagues² illustrates this point: investigators studying the acquisition of humanistic skills and attitudes by trainees asked the students to judge their mentors on these attributes. Yet this approach is not being applied to clinical practice guidelines. Although investigators recognize that such guidelines are not unanimously accepted by medical practitioners, they always seem to ask "What is wrong with the docs?" or "How can they be 're-educated'?" We need more research into how the guidelines themselves might be deficient.

The answer might lie in the editorial by John Hoey about science's attitude toward alternative medicine.³ As he states in the first sentence, "When passion edges into zeal and frustration becomes arrogance, scientists lose credibility and risk depriving us of their considerable and unique understanding of the intricacies of biology." And, I might add, they risk not asking the right questions in their pursuit of the truth.

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1. Tudiver F, Herbert C, Goel V, for the Family Physician Study Group, Sociobehavioral Cancer Research Network, National Cancer Institute of Canada. Why don't family physicians follow clinical practice guidelines for cancer screening? *CMAJ* 1998;159(7):797-8.
2. Beaudoin C, Maheux B, Côté L, Des Marchais JE, Jean P, Berkson L. Clinical teachers as humanistic caregivers and educators: perceptions of senior clerks and second-year residents. *CMAJ*

1998;159(7):765-9.

3. Hoey J. The arrogance of science and the pitfalls of hope. *CMAJ* 1998;159(7):803-4.

Fred Tudiver and colleagues discuss the reasons why family physicians fail to comply with clinical practice guidelines for cancer screening.¹ As an example, they present data illustrating the rapid increase in screening for prostate-specific antigen (PSA), despite the fact that the Canadian Task Force on the Periodic Health Examination [now the Canadian Task Force on Preventive Health Care — Ed.] recommends its exclusion as a screening manoeuvre.² An important reason why family physicians do not follow the task force guidelines in this and other areas is the dissemination of conflicting recommendations by various expert interest groups.

Conflicting recommendations for the same cancer screening manoeuvre are well illustrated in the issue in which the editorial by Tudiver and colleagues appears. In the Clinical Basics article appearing a few pages after the editorial, Richard Gallagher and Neil Fleshner³ describe individual risk factors for prostate cancer in men, ending their article with the following unreferenced statement: "Although there are no firm guidelines regarding screening, the American Urological Association recommends that digital rectal examination and testing for prostate-specific antigen begin at age 40." Hence my confusion about which recommendation on PSA screening is based on the best available evidence and which I should follow in my own practice.

Although there are many reasons why family physicians perform cancer screening that is not recommended by expert organizations, a discussion of possible noncompliance is incomplete without acknowledging the systemic issues that result in diverse recommendations about the same screening manoeuvre.

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2. Canadian Task Force on the Periodic Health Examination. *The Canadian guide to clinical preventive health care*. Ottawa: Health Canada; 1994.
3. Gallagher RP, Fleshner N. Prostate cancer: 3. Individual risk factors. *CMAJ* 1998;159(7):807-13.

[Richard Gallagher and Neil Fleshner respond:]

James Goertzen's letter describes a serious concern among physicians attempting to interpret conflicting scientific evidence about the usefulness of a test or procedure. In the case of PSA testing for prostate cancer screening, discernment is yet more difficult, given that even the so-called "experts" disagree on use of this test.

To clarify our recommendations in the Clinical Basics article, some background is in order. One of us (N.F.) is a practising urologist with training in epidemiology, and the other (R.G.) is an epidemiologist. Fleshner would have preferred a direct recommendation for screening; Gallagher would have preferred a recommendation against screening. From our different perspectives, each of us felt that his own recommendation was correct, Gallagher because he feels there is little evidence that PSA screening reduces mortality rates, Fleshner because even in the absence of benefit in terms of mortality rates, early diagnosis and treatment with curative intent is the best way of ensuring cure and long life, particularly in a patient known to be at high risk for the disease. After much discussion, we compromised by simply stating the position of the American Urological Association.¹

Unfortunately, this type of controversy is likely to become even more common in the future, as physicians attempt to practise evidence-based medicine.

We think that, ultimately, the answer for the practising physician is to describe to the patient the pros and



cons of the test, find out what is important to the patient and — perhaps of more value in such a decision — what is *not* important to him, and then allow him to make the decision for himself.

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1. American Urological Association. Early detection of prostate cancer [policy statement]. Baltimore: The Association; 1997. Available: [aunet.org/pub_pat/policies/urosservices.html#Early detection of prostate](http://aunet.org/pub_pat/policies/urosservices.html#Early%20detection%20of%20prostate) (accessed 8 Mar 1999).

[Fred Tudiver and colleagues respond:]

Tom Vandor makes the interesting point that we frequently blame the user (the physician) when a clinical practice guideline is not “unanimously” followed, yet there is little research examining the deficiencies of guidelines. As outlined in our editorial, we believe that there are many other factors that affect the adoption of guidelines: physician and patient characteristics, social influences and practice characteristics.

James Goertzen addresses what we believe is an important factor in guideline adoption, the issue of conflicting guideline recommendations from different agencies. He drives this point home by directing our attention to the article on prostate cancer¹ that appears in the same issue as our editorial. It seems almost impossible not to step into the quagmire of conflicting guidelines when examining the recommendations for a common cancer, such as cancer of the prostate. We agree with Goertzen’s conclusions: that many clinicians face almost daily difficulties as they discuss with their patients which guidelines to follow.

It is for these reasons that our group is now working on a project, funded by the Medical Research Council of Canada, to determine how family

physicians make decisions about cancer screening when the guideline is uncertain or when the guidelines from different agencies conflict.

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Which curriculum?

I share the concerns of Claude Beaudoin and colleagues¹ about medical education but must ask, “Are these results surprising?” Although we tend to assume that a curriculum is a singular entity, most introductory textbooks on curriculum studies² describe a framework in which 3 different curricula, each with its own historical roots and purpose, are always in operation.

The *explicit curriculum* is the dominant concept of curriculum stated in a curriculum document. It is a management tool, a standardization technique, rooted in a scientific and reductionist paradigm that has served researchers in the biological sciences well. It is this curriculum that undergoes reform in

response to criticism or societal change.

The *hidden or enacted curriculum* is that which actually takes place between teachers and learners, what happens in the “real world.” It differs significantly from that which is described in explicit documents. Faculties of medicine rarely look at what they enact.

The *experienced curriculum* is the curriculum that Beaudoin and colleagues have studied, the curriculum as experienced by the learners themselves. Not surprisingly, the outcome data for the experienced curriculum differ from the intended outcomes of the explicit curriculum.

Many curricular theorists argue that curricula are about cultural transmission and not about pedagogical techniques. In writing about medical education, Bloom asks “How can one explain this history of reform without change, of modifications of the medical school curriculum that alter only very slightly or not at all the experiences of the clinical participants, the students and the teachers?”³ Beaudoin and colleagues have provided just the type of evidence that is needed to help us look at ourselves in the mirror.

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3. Bloom SW. Structure and ideology in medical education: an analysis of resistance to change. *J Health Soc Behav* 1988;29(4):294-306.

Antimotility agents and *E. coli* infection

To the objections you have already received¹⁻³ regarding your recommendation for the use of antibiotics in the treatment of *Escherichia coli* infec-