## 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 colleagues[2] 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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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 Fleshner[3] 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