

and self-determination on the patient,”<sup>9</sup> and that the popular discourse of breast self-examination “blames women for not doing their part to reduce high breast cancer mortality statistics, establishes the locus of all reasons for refraining from the activity with the woman, and chastises these women for failing to engage in the activity.”<sup>10</sup> In the future, sound evidence should be available before population screening is promoted, particularly when such screening may be associated with harm.

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## References

1. Baxter N, with the Canadian Task Force on Preventive Health Care. Preventive health care, 2001 update: Should women be routinely taught breast self-examination to screen for breast cancer? *CMAJ* 2001;164(13):1837-46.
2. Strickland CJ, Feigl P, Upchurch C, King DK, Pierce HI, Grevstad PK, et al. Improving breast self-examination compliance: a Southwest Oncology Group randomized trial of three interventions. *Prev Med* 1997; 320-32.
3. McPherson CP, Swenson KK, Jolitz G, Murray CL. Survival of women ages 40-49 years with breast carcinoma according to method of detection. *Cancer* 1997;79:1923-32.
4. Harvey BJ, Miller AB, Baines CJ, Corey PN. Effect of breast self-examination techniques on the risk of death from breast cancer. *CMAJ* 1997; 157:1205-12.
5. Barratt A, Irwig L, Glasziou P, Cumming RG, Raffle A, Hicks N, et al. Users' guide to the medical literature: XVII. How to use guidelines and recommendations about screening. Evidence-Based Medicine Working Group. *JAMA* 1999; 281:2029-34.
6. Thomas DB, Gao DL, Self SG, Allison CJ, Tao Y, Mahloch J, et al. Randomized trial of breast self-examination in Shanghai: methodology and preliminary results. *J Natl Cancer Inst* 1997;89:355-65.
7. Miller AB, To T, Barnes CJ, Wall C. Canadian National Breast Cancer Screening Study. 2: 13-year results of a randomized trial in women aged 50-59 years. *J Natl Cancer Inst* 2000;92:1490-9.
8. Lerner BH. *The breast cancer wars: hope, fear, and the pursuit of a cure in twentieth-century America*. New York: Oxford University Press; 2001.
9. Breast cross-examination [editorial]. *CMAJ* 2001;165(3):261.
10. Kline KN. Reading and reforming breast self-examination discourse: claiming missing opportunities for empowerment. *J Health Commun* 1999;4:119-41.

## Assessing the quality of clinical practice guidelines

Assessment of the quality of clinical practice guidelines (CPGs) is essential, and a systematic review of these

guidelines is strongly encouraged. To that end, Ian Graham and colleagues have taken an important step in trying to assess the quality of a number of Canadian CPGs.<sup>1</sup>

The authors state that CPGs are “systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances.” However, 38 (17.5%) of the 217 “guidelines” reviewed for this article were letters produced by the Therapeutics Initiative. In our opinion, these letters should have been considered as systematically developed reviews of evidence, not CPGs.

Since 1994, 41 Therapeutics Initiative letters have been produced. In general, our objective is to provide clinicians with an assessment and synthesis of published (and, whenever possible, peer-reviewed) evidence from clinical trials. The information is primarily, although not exclusively, a synopsis of the evidence from randomized controlled trials. We occasionally make recommendations in our letters for the “optimal” clinical use of drugs when supported by evidence from randomized controlled trials. We hope that clinicians combine these synopses with clinical judgement when making decisions about drug therapy for individual patients. Evidence from randomized controlled trials should also be the underpinning of all CPGs; however, in order to generate bottom-line recommendations, authors of CPGs often have to resort to less rigorous evidence or clinical opinion or both, owing to the limited availability of high-quality evidence.

For example, the most recent Canadian guidelines for initial management of community-acquired pneumonia furnish an exhaustive review of this condition; however, there is no clear evidence from randomized controlled trials favouring any one antibiotic regime.<sup>2</sup> In fact, the authors urge recognition that “these recommendations [for the selection of antibiotics] are derived by the consensus of experts and not entirely based on evidence from randomized clinical trials.”<sup>2</sup>

These important differences be-

tween systematically developed recommendations (e.g., CPGs) and systematically developed reviews of the evidence (e.g., Therapeutics Initiative letters, Cochrane Library) render an appraisal instrument for clinical guidelines less appropriate for assessing systematically developed reviews of evidence. Many of the criteria in Table 1 of the article by Graham and colleagues are not relevant to the latter process. Nonetheless, these authors have presented a number of criteria relevant to both guidelines and systematic reviews of the evidence; we will review these to see if there are areas in which we can improve.

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## References

1. Graham ID, Beardall S, Carter AO, Glennie J, Hébert PC, Tetroe JM, et al. What is the quality of drug therapy clinical practice guidelines in Canada? *CMAJ* 2001;165(2):157-63.
2. Mandell LA, Marrie TJU, Grossman RF, Chow AW, Hyland RH, and the Canadian Community-Acquired Pneumonia Working Group. Canadian guidelines for the initial management of community-acquired pneumonia: an evidence-based update by the Canadian Infectious Diseases Society and the Canadian Thoracic Society. *Clin Infect Dis* 2000;31:383-421.

Clinical guidelines have a more fundamental flaw than those discussed recently in *CMAJ*.<sup>1,2</sup> This flaw was expressed by the pioneer Harvard endocrinologist Fuller Albright. In his introduction to a textbook of medicine popular many years ago, he wrote that medicine can be practised by the rules

(read guidelines) and they may help 90% of the time but the other 10% the rules will do more harm than they do good in the 90%.

Guidelines are helpful to those who have knowledge but are dangerous in the hands of those who do not, a group to whom guidelines may give confidence to exceed their knowledge. A physician without knowledge but with guidelines is like a monkey in a tree with a machine gun.

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#### References

1. Graham ID, Beardall S, Carter AO, Glennie J, Hébert PC, Tetroe JM, et al. What is the quality of drug therapy clinical practice guidelines in Canada? *CMAJ* 2001;165(2):157-63.
2. Lewis SJ. Further disquiet on the guidelines front [editorial]. *CMAJ* 2001;165(2):180-1.

#### [Two of the authors respond:]

In response to our paper showing that the quality of drug therapy guidelines in Canada is quite variable,<sup>1</sup> Marc Baltzan has argued that the more fundamental flaw with clinical practice guidelines relates to their potential to be used indiscriminately by some physicians, thereby causing more harm than good. The point is well taken, but it is inappropriate to single out guidelines. Practice guidelines are “systematically developed statements to assist practitioner and patient decisions about *appropriate* health care for *specific clinical circumstances* [italics added].”<sup>2</sup> All health care technologies, be they drugs, procedures, diagnostic testing, surgical techniques or practice guidelines, must be applied judiciously using clinical judgement that is individualized to the patient’s circumstances. Doing anything less constitutes at best negligence and at worst malpractice. Well-developed and valid practice guidelines that are appropriately applied have been shown to improve both the process of care and patient health outcomes.<sup>3-5</sup> We are unaware of any evi-

dence about the extent to which physicians lacking the necessary knowledge are using guidelines inappropriately and causing harm. However, if this is the real concern then the focus must be on improving medical education and evidence-based practice generally, and not rejecting out of hand evidence-based practice guidelines.

James McCormack and colleagues suggest we should not have evaluated the quality of Therapeutic Initiative letters catalogued in the CMA Infobase because they are systematically developed reviews, not practice guidelines. Our study protocol involved assessing the quality of all drug therapy guidelines listed in the CMA Infobase ([mdm.ca/cpgsnew/cpgs/index.asp](http://mdm.ca/cpgsnew/cpgs/index.asp)), which is clearly intended to be a repository of Canadian practice guidelines. We assumed that all documents included in the CMA Infobase were practice guidelines as they had to meet the CMA’s criteria for being a guideline, i.e., that the document include information to help patients and physicians make decisions about appropriate health care for specific clinical circumstances. We also understand that the developers of documents considered for inclusion in the CMA Infobase were contacted and asked whether they agreed their document should be included.

We thank Baltzan and McCormack and colleagues for raising these issues and we hope our findings will generate further debate that ultimately will lead to improvements in the quality of practice guidelines produced in Canada.

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#### References

1. Graham ID, Beardall S, Carter AO, Glennie J, Hébert PC, Tetroe JM, et al. What is the quality of drug therapy clinical practice guidelines in Canada? *CMAJ* 2001;165(2):157-63.
2. Committee on clinical practice guidelines. *Guidelines for clinical practice: from development to use*. Washington: Institute of Medicine National Academy Press; 1992.
3. Grimshaw JM, Russell IT. Effect of clinical guidelines on medical practice: a systematic review of rigorous evaluations. *Lancet* 1993;342:1317-22.
4. Grimshaw J, Freemantle N, Wallace S, Russell I, Nurwitz B, Watt I, et al. Developing and implementing clinical practice guidelines. *Qual Health Care* 1995;4:55-64.
5. Thomas L, Cullum N, McColl E, Rousseau N, Soutter J, Steen N. *Guidelines implementation in professions allied to medicine* [Cochrane review]. In: The Cochrane Library; Issue 3. 1999. Oxford: Update Software.

#### Tell me what troubles you most

The article by Donald Redelmeier and colleagues on eliciting an insightful history of present illness<sup>1</sup> reminded me of a time, years before the advent of blank-cheque medicine, when I was called to a rural cottage, bare as a doghouse, the home of an elderly couple. Clean and impecunious, the old lady related that her husband had been bedridden for 10 days and that she was worried. During examination, the patient’s responses to repeated questions were uniformly and charmingly vague. From his high fever, rigid abdomen and racing pulse, I surmised that septicemia from acute cholecystitis had brought him to a lucid period at death’s door.

Trying one last time, I said, “Tell me what troubles you most.”

“Ah that I will know — let me see, ah yes, I would say, yes that’s it, I’ve got that unsartin feeling.”

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#### Reference

1. Redelmeier DA, Schull MJ, Hux JE, Tu JV, Ferris LE. Problems for clinical judgement: 1. Eliciting an insightful history of present illness. *CMAJ* 2001;164(5):647-51.