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Busting myths about guidelines

All clinical practice guidelines are not created equal. Actually, some are pretty bad. That was the message delivered on Saturday to a packed room of general practitioners at the Family Medicine Forum 2011 in Montreal, Quebec, during a session called "Guideline MythBusters: Exploring the limitations, pitfalls, and appropriate application of clinical practice guidelines."

"There are a lot of people who put their life's work, with good intentions, into guideline development," says Jamie Falk, an assistant clinical professor in the pharmacy faculty at the University of Manitoba in Winnipeg, who co-led the session. "But I think there is just too much blind following of these things and, sometimes, you have to present the bad side."

During the presentation, Falk and Dr. Clayton Dyck, the associate director of undergraduate education in the family medicine department of the University of Manitoba, discussed five myths about clinical practice guidelines:

There is no such thing as a bad clinical practice guideline

"Strong" evidence is always high-quality

You are a bad physician if you don't follow clinical practice guidelines

It must be true if an expert said it

You shouldn't use guidelines sponsored by the pharmaceutical industry

The presenters told the audience that some information from guidelines now considered common sense in family medicine may not be grounded in evidence. Some guidelines are backed by low-quality evidence, while others have little data to back them up. According to Dyck, a popular set of guidelines that doctors often consult on recommended sodium levels references a clinical trial with only 12 participants.

Even if the evidence is strong, that doesn't necessarily mean the guidelines are appropriate for a particular family practice, the presenters suggested. Or they might not be applicable to patients in a certain age range or from a certain demographic.

The presenters recommended that family doctors learn which guidelines are relevant to their practices. They should take note of the medical conditions they most commonly see and search out high-quality guidelines for treating them. They should ensure the guidelines they use are up to date and have clearly stated methodologies. It also wouldn't hurt if they at least skimmed the evidence supporting the guidelines to glean its strengths and weaknesses.

Clinical practice guidelines are important in family medicine because they provide foundational guidance for busy doctors who may not have time to explore the evidence supporting treatments for various ailments in depth, says Dyck. They have little choice but to put a certain amount of trust in the people who do wade through the data. Still, no matter how busy, physicians should critically appraise the guidelines they follow and use them properly. "They're guidelines," says Dyck. "They're not rules."

Other potential problems mentioned during the session include the inescapable creep of opinion into guidelines. The key messages pulled from a set of guidelines, for instance, are decided upon by the authors, and are therefore inherently subjective. Falk also suggested that so much attention is given to a treatment's efficacy in guideline development that patient safety often fails to be properly considered.

Then there are the many conflicts of interest of the people involved in creating guidelines, who often work for or consult for or are otherwise tied to pharmaceutical companies, medical device manufacturers or makers of medical tests. That doesn't mean their recommendations should be automatically discounted, Falk says, as many of the most knowledgeable and trusted people in certain areas of medicine have conflicts of interest. But it is a problem that should be managed, not ignored or accepted as the status quo.

"We have to try to find a better balance," says Falk. "There will always be conflicts of interest. Can we have more panel members who don't have conflicts? Should the lead authors have fewer conflicts? Should we be setting standards on that?"

The presentation appeared to resonate with the audience. One physician in attendance, second-year resident Dr. Michelle Bailes, had already been taught about the limitations of guidelines by Falk and Dyck at the University of Manitoba. "It has helped me to be more skeptical, and to look for the really good guidelines," says Bailes.

Another audience member agreed that a healthy sense of skepticism is appropriate when appraising a set of guidelines. "If you get a 183-page document of guidelines, you might not read it all right away, but you look for the key messages. But those key messages might be based on C-level evidence," says Dr. Tunji Fatoye, an assistant professor in family medicine at the University of Manitoba, referring to the lowest level of evidence cited in clinical practice guidelines. One of the key messages he took from the myth-busting session is that, while guidelines are valuable, physicians must still rely primarily on their brains rather than a document when treating a patient. "You have to think about what you are doing — really think about it." — Roger Collier, *CMAJ*

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