

## Can family physicians practise good medicine without following clinical practice guidelines?

YES

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*The art of the practice of medicine is to be learned only by experience; 'tis not an inheritance; it cannot be revealed. Learn to see, learn to hear, learn to feel, learn to smell, and know that by practice alone can you become expert.*

Sir William Osler

Should we add “learn to follow clinical practice guidelines” (CPGs) to Osler’s list? Sir William Osler is widely recognized as one of the most influential physicians of the past 2 centuries, yet he never used a CPG. I suspect most of us would agree that Sir William Osler practised good medicine despite not using CPGs. The obvious riposte is, of course, that Osler practised at a time when CPGs did not exist, and had they existed that he would have duly followed them as a good physician. I think he might well have been somewhat sceptical. In this brief essay, I will argue against the claim that good medicine requires the use of CPGs. I will do so on the following grounds:

- CPGs do not fully encapsulate all domains of the practice of good medicine.
- The empirical data examining the use of CPGs are not persuasive.
- Multiple conceptual problems remain with respect to the definition of a good CPG.

### Encapsulating all domains of good medicine

I am not certain that an agreed upon definition of what it means to practise good medicine exists. I would resist equating good practice with adherence to CPGs. Much of what it means to be a good practitioner falls in the realms of behavioural traits, virtues, and practices that are not included in the scope of CPGs. Consider, for example, the 4 principles of family medicine and the CanMEDS framework.<sup>1,2</sup> Clinical practice guidelines are largely silent on a range of roles that constitute good medicine: CPGs are likely related to being a skilled clinician or medical expert, but they are silent on the roles of advocate, communicator, community resource,

collaborator, relationship-builder, manager, etc—all of which are seen as part of what constitutes good medical practice.

Second, much medicine occurs outside the scope of CPGs. Patients presenting with simple cases are easily managed, but CPGs fail to illuminate important aspects of the management of undifferentiated conditions or to provide direction for managing complex chronic disease. Both of these categories are increasingly common in family medicine. As my colleague Shawn Tracy and I noted in a recent commentary in *Canadian Family Physician*, optimal management lies outside the scope of CPGs for, or CPGs are silent with respect to the management of, a vast number of patients.<sup>3</sup> Therefore, if CPGs are necessary for the practice of good medicine then it must be asserted that much of the care being currently provided in family medicine is not “good” simply because there are no guidelines. I would submit, however, that the opposite is true. Good medicine often starts precisely when one engages in an honest encounter with a patient, facing the limitations of what is known about his or her condition. In these instances, abiding with and “being there” for the patient is good care, notwithstanding the absence of a CPG.

### Empirical data are not persuasive

It is evident that there has been a proliferation of guidelines by numerous medical bodies of various stature and standing. A quick journey through the “guidelines world” takes one on a tour of various CPG websites. In fact, a Google search for *clinical practice guidelines* yields more than 3000000 hits. Many government agencies and professional associations have developed specific guidelines or collections of CPGs. For example, the Canadian Medical Association has produced the CMA Infobase,<sup>4</sup> which includes thousands of different CPGs.

From the point of view of a practising physician, the issue often confronted is which guideline to use and how to apply it to a particular case. Family practice is subject to a staggering array and volume of guidelines, and most CPGs have not been systematically evaluated

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to determine their utility and effectiveness in practice. It is as if by summarizing evidence, CPGs are immune to evaluation themselves. Most of what passes for evaluation of CPGs consists of studies seeking to determine whether family physicians are adherent to some sponsoring agency's preferred CPG.

Studies of physician adherence to CPGs indicate that adherence is often difficult in practice. A study by Østbye and colleagues demonstrated that primary care providers with reasonably sized practices would scarcely have sufficient time in clinic to adhere to CPGs for the 10 most common chronic conditions if those conditions were stable. When conditions are modeled as poorly controlled, the time management issues become almost intractable.<sup>5</sup> The real issue, as argued recently by Richard Horton, is not the provision of new guidelines and evidence digests, but carving out sufficient time to think and make good clinical decisions.<sup>6</sup>


Equally important to the practice of good medicine is consideration of the effect of treatment regimens on patients' lives. A study by Boyd et al documented the difficulties faced in adhering to complex regimens.<sup>7</sup>

**Conceptual problems**

Finally, there are still issues in determining the legitimacy and validity of CPGs. It is not uncommon that 2 different CPGs make contradictory recommendations within a disease category. Moreover, CPGs often force trade-offs in terms of which disease or organ system to privilege. In my view, this is inimical to good medicine.

Much ink has been spilt on providing guidance on how to separate the wheat from the chaff with regard to the proliferation of CPGs. There is no shortage of snappily acronymed groups claiming to provide guidance (eg, AGREE, GRADE). Such exercises almost always leave undisturbed deeper epistemological problems that remain unresolved in CPGs. These relate to a set of intersecting difficulties that arise out of the ranking of evidence via the invocation of hierarchies and the trustworthiness of the groups creating and disseminating CPGs. I will not dwell on these here, as I have made these arguments elsewhere.<sup>8,9</sup>

**Conclusion**

Good medicine can and always will be practised without CPGs. Guidelines must remain in their proper place—that is, as an aid to—not the instantiation of—good medical practice. 

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**Competing interests**

None declared

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**References**

- College of Family Physicians of Canada. *Four principles of family medicine*. Mississauga, ON: College of Family Physicians of Canada; 2006. Available from: [www.cfpc.ca/English/cfpc/about%20us/principles/default.asp?s=1](http://www.cfpc.ca/English/cfpc/about%20us/principles/default.asp?s=1). Accessed 2010 Apr 12.
- Frank JR, editor. *The CanMEDS 2005 physician competency framework. Better standards. Better physicians. Better care*. Ottawa, ON: Royal College of Physicians and Surgeons of Canada; 2005. Available from: <http://meds.queensu.ca/medicine/obgyn/pdf/CanMEDS2005.booklet.pdf>. Accessed 2010 Apr 12.
- Upshur RE, Tracy S. Chronicity and complexity. Is what's good for the diseases always good for the patients? *Can Fam Physician* 2008;54:1655-8 (Eng), CFPlus (Fr).
- CMA Infobase: clinical practice guidelines (CPGs) [online database]. Ottawa, ON: Canadian Medical Association. Available from: [www.cma.ca/index.cfm/ci\\_id/54316/la\\_id/1.htm](http://www.cma.ca/index.cfm/ci_id/54316/la_id/1.htm). Accessed 2010 Apr 12.
- Østbye T, Yarnell KS, Krause KM, Pollak KI, Gradison M, Michener JL. Is there time for management of patients with chronic diseases in primary care? *Ann Fam Med* 2005;3(3):209-14.
- Horton R. Common sense and figures: the rhetoric of validity in medicine (Bradford Hill Memorial Lecture 1999). *Stat Med* 2000;19(23):3149-64.
- Boyd CM, Darer J, Boulton C, Fried LP, Boulton L, Wu AW. Clinical practice guidelines and quality of care for older patients with multiple comorbid diseases: implications for pay for performance. *JAMA* 2005;294(6):716-24.
- Upshur RE. Are all evidence-based practices alike? Problems in the ranking of evidence. *CMAJ* 2003;169(7):672-3.
- Upshur R. Making the grade: assuring trustworthiness in evidence. *Perspect Biol Med* 2009;52(2):264-75.

**CLOSING ARGUMENTS**

- Clinical practice guidelines (CPGs) do not fully encapsulate all domains of the practice of good medicine.
- The empirical data examining the use of CPGs are not persuasive.
- Multiple conceptual problems remain with respect to the definition of a good CPG.