Practitioner's role in implementing varying guidelines

I read with great interest the article "Cervical cancer screening for young women. First do no harm" by Dr Phillips and colleagues in the January issue of *Canadian Family Physician*.[1]

Physicians often get mixed messages from various organizations regarding specific tests, screening or otherwise. For example, for cervical cancer screening, how is it possible that different countries or provinces have different guidelines for the same issue? Is it clinically possible for a cervix to change across the border from Ontario to Alberta? Of course not! The article touches on this fact.

Part of the reason guidelines differ is because they are made by different people with different experiences, expertise, and values. However, the article fails to mention another barrier in implementing evidence-based medicine: the practitioner. Individual physicians might have different perspectives on, experiences with, or knowledge of the guidelines, for example. They might be hesitant to not follow their province's guidelines out of the fear of litigation, and they might have time constraints preventing them from discussing screening in the detail required with the patient in front of them. Some suggestions are presented to help my colleagues overcome these barriers in order to serve their patients better.

First, when a difference in guidelines exists, it might be sensible to follow the guideline with the best evidence. This includes the guideline having a thorough discussion about the harms and benefits. Conflicts of interest must also be clearly disclosed. The 2018 article by Dr Dickinson and colleagues helps provide a framework for this.[2]

Second, while I am not a lawyer and I cannot comment definitively on the concerns about litigation, an article by Dr Wilson regarding cancer screening and litigation states that people must be told about the benefits, harms, limitations, and expectations of a screening test before being screened.[3] This resonates with the guidelines from several regulatory colleges in Canada around informed consent. This commentary by Dr Phillips and colleagues is particularly exemplary, as it highlights this need for shared decision making.

It should also be mentioned that the culture of the nation matters, and studies show a trend toward "defensive medicine" in countries with high litigation rates. This is not surprising, and neither is the fact that such medicine comes with unnecessary tests and overdiagnosis leading to harm.[4]

Finally, it is understandable that a family physician might wonder how a shared and informed decision can be made in a 15-minute consultation. Physicians might want to consider having pictorials at hand, such as the Canadian Task Force on Preventive Health Care 1000-person tool (not currently available for cervical cancer, but it is available for breast cancer and prostate cancer),[5,6] or they might consider giving eligible patients information leaflets ahead of their periodic health examinations. They can get feedback from colleagues about their communication skills (eg, are they using lay terms to explain concepts clearly).

For undecided patients, family physicians can consider discussing concerns and delaying a screening Papanicolaou test if it is safe to do so. Patients should be given time to decide, if possible, as the information conveyed is often new and complex. While it is unfortunate that different guidelines exist, part of the solution lies in acknowledging this and understanding these guidelines and then tailoring the solution to the person in front of you.

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Competing interests
None declared

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Advocating for planetary health in medical education

Adding to the huge response to Dr Ladouceur's editorial on climate change,[1] we wish to emphasize one further role for family physicians in planetary health (PH) promotion: leadership in medical education.