

Canadian Medical Association. *Guidelines for Clinical Practice Guidelines*. CMA, Ottawa, 1994, 12 pp. (bilingual), no price indicated.

The idea of a Guideline for writing Guidelines is on first contact faintly reminiscent of the annual Congress for the Organizers of Congresses; but it deserves to be taken very seriously.

In Canada (and to a rather lesser extent elsewhere), Clinical Practice Guidelines have become an essential part of efforts to improve the quality of care. Even within that one country there is a risk that efforts to provide standards of practice in this way will result in contradictions and discrepancies, if only because more than forty health organizations are producing them, in consultation with the CMA and other bodies. In fact Canada has always made efforts to provide this venture with a solid theoretical foundation; when it started in 1992, a series of research papers was produced to determine how it should proceed. The first set of individual guidelines appeared in draft at that time.

The present document stresses that guidelines for practice must be flexible, that the primary interests of the individual patient may need in some ways to be balanced against the needs of other individuals and of society as a whole, and that informed decision making both by patient and physician is basic. The task of developing these standards, it is stated, remains primarily with the medical profession, though in consultation with other parties; one is inclined to comment that this may be the case in a society as progressive as Canada, but that where the profession fails to define standards there will be a place for other groups to take the initiative. Commendably, "Guideline 13" underlines the fact that there has to be a systematic monitoring process for clinical guidelines, to ensure that they are in fact having an effect; nothing is more misleading than high declarations of principle which remain a dead letter.

I am not aware of anything comparable to this booklet in other countries; anyone who is engaged in setting practice standards should write to the CMA for a copy.

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Buckman R. *How to Break Bad News*. Macmillan and Co., Basingstoke, 1993, ISBN 0-333-54864-7, price £9.99.

I was barely into my second month of clinical clerkships when, in the middle of a ward-round, the registrar paused and pointed back at a patient in the

corner whom we had just seen. “By the way”, she said, “Does he know his cancer is inoperable? Has anyone told him?” We shook our heads. “Just a moment” she said, and disappeared in his direction, drawing the curtains around the bed. A moment it was; within a minute she was back on the round, leaving us to peer surreptitiously back at him and see how he had taken it. It was not the way to break bad news.

Robert Buckman would do it better. First, he says, one must get the conversation started in the right way, so that the patient has no premonitions one way or the other. Then, unless the questions have been answered earlier, one must determine how much the patient knows about his prospects — and how much he wants to know. Sharing the bad news, if the patient is ready for it, will follow, and it must not be rushed, but nor must one extend the process unduly. Immediately one must try to sense the patient’s reaction, and then respond to it; he may simply want to be left alone for a while. Finally one will have to arrange for follow-up — by oneself, the chaplain, the nursing staff — whoever is most appropriate.

All these things Robert Buckman discusses and shows how they can best be handled. He is as helpful, too, in dealing with the way to convey bad news to the family. Medical undergraduates, for whom these papers were originally intended, need to be much better prepared for these things than I was.

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