



22- 23 marzo 2018

IRCCS Istituto di Ricerche Farmacologiche Mario Negri

**Il Sistema Nazionale Linee Guida e le raccomandazioni di
Choosing Wisely Italy.**

Primiano Iannone

**National Center for Clinical Excellence Healthcare Quality &
Safety**





THE SUNDAY TIMES

5 FEBRUARY 1995

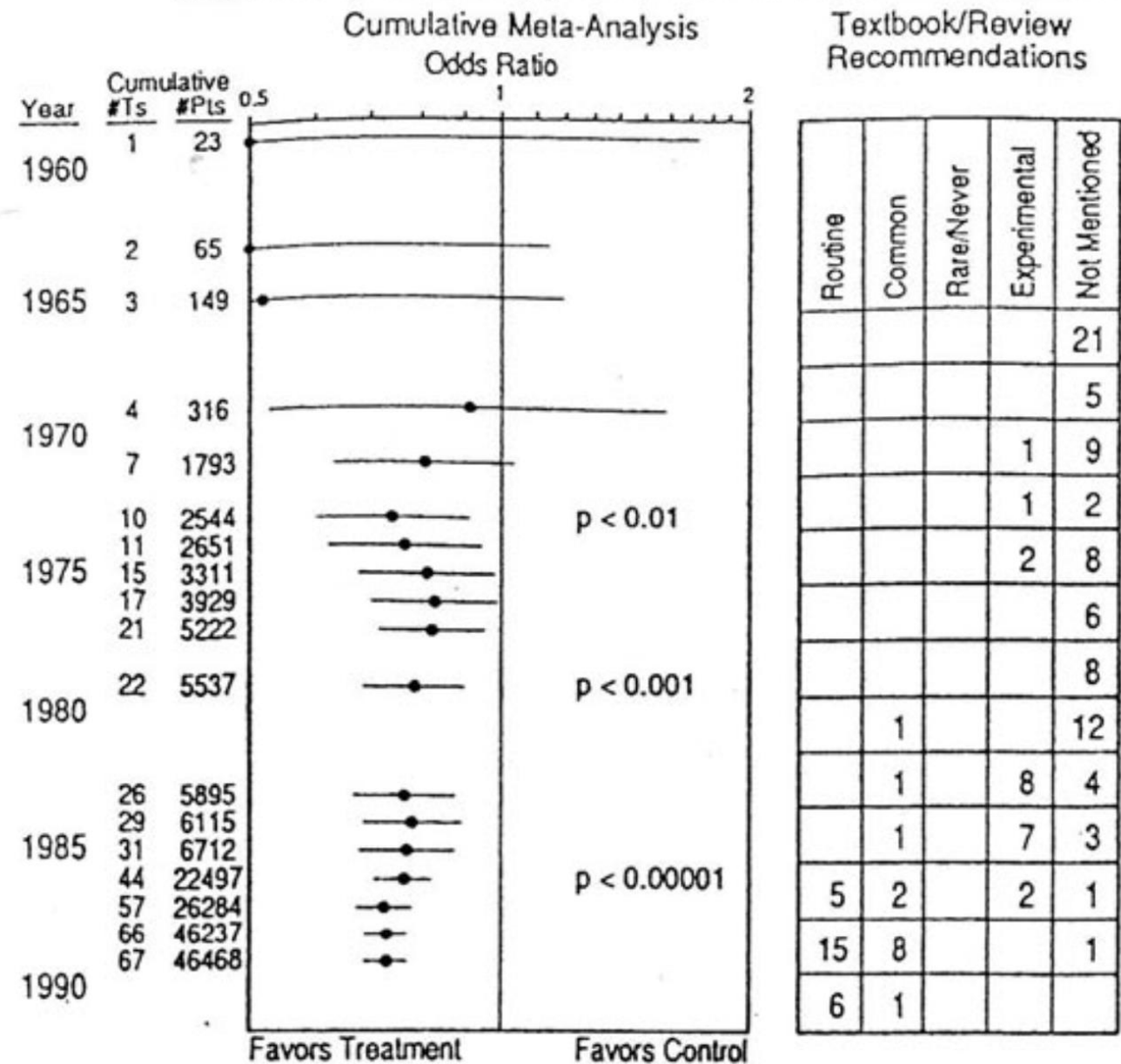
Hundreds killed by doctors relying on outdated manuals

[JAMA](#). 1992 Jul 8;268(2):240-8.

A comparison of results of meta-analyses of randomized control trials and recommendations of clinical experts. Treatments for myocardial infarction.

[Antman EM](#)¹, [Lau J](#), [Kupelnick B](#), [Mosteller F](#), [Chalmers TC](#).

Thrombolytic Therapy in Acute Myocardial Infarction



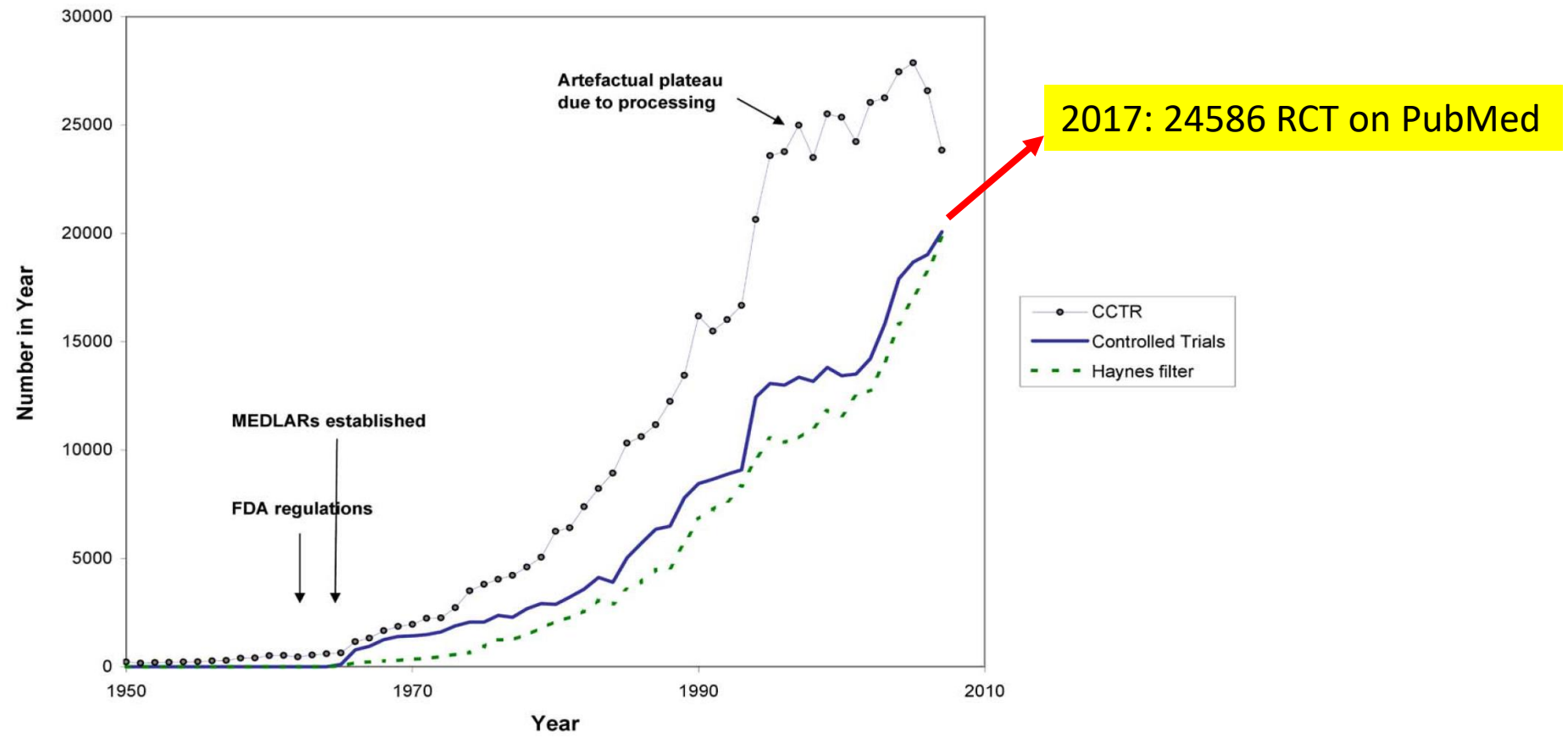


Figure 2. The number of published trials, 1950 to 2007. CCTR is the Cochrane Controlled Trials Registry; Haynes filter uses the “narrow” version of the Therapy filter in PubMed:ClinicalQueries; see Text S1.
doi:10.1371/journal.pmed.1000326.g002

Citation: Bastian H, Glasziou P, Chalmers I (2010) Seventy-Five Trials and Eleven Systematic Reviews a Day: How Will We Ever Keep Up? PLoS Med 7(9): e1000326. doi:10.1371/journal.pmed.1000326

Published September 21, 2010

OPEN ACCESS Freely available online

PLoS MEDICINE

Policy Forum

Seventy-Five Trials and Eleven Systematic Reviews a Day: How Will We Ever Keep Up?

Hilda Bastian^{1*}, Paul Glasziou², Iain Chalmers³

1 German Institute for Quality and Efficiency in Health Care (IQWiG), Cologne, Germany, **2** Centre for Research in Evidence-Based Practice, Faculty of Health Sciences, Bond University, Gold Coast, Australia, **3** James Lind Library, James Lind Initiative, Oxford, United Kingdom

discoveries to reach clinical practice. It takes an estimated average of 17 years for only 14% of new scientific discoveries to enter day-to-day clinical practice.⁴ McGlynn et al⁵ reported that Americans only receive 50% of the

Balas EA, Boren SA. *Yearbook of Medical Informatics: Managing Clinical Knowledge for Health Care Improvement*. Stuttgart, Germany: Schattauer Verlagsgesellschaft GmbH; 2000.



MAY 2010

Issue Brief

Blueprint for the Dissemination of Evidence-Based Practices in Health Care

health care systems has been to spread these advances broadly and rapidly.¹ The literature suggests that it takes an average of nine years for interventions that are recommended as evidence-based practice in systematic reviews, guidelines, or textbooks to be fully implemented.^{2,3} Such a sizeable research–practice gap raises the question of why new ideas and actions are not spread and adopted faster.



The Rational Clinical Examination 

Evidence-Based Medicine

A New Approach to Teaching the Practice of Medicine

Evidence-Based Medicine Working Group

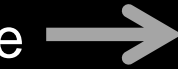
JAMA, November 4, 1992—Vol 268, No. 17



Type of study

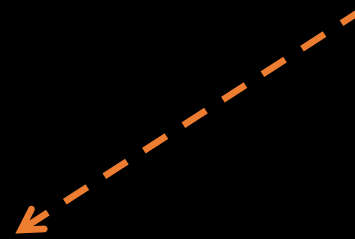


Quality of evidence



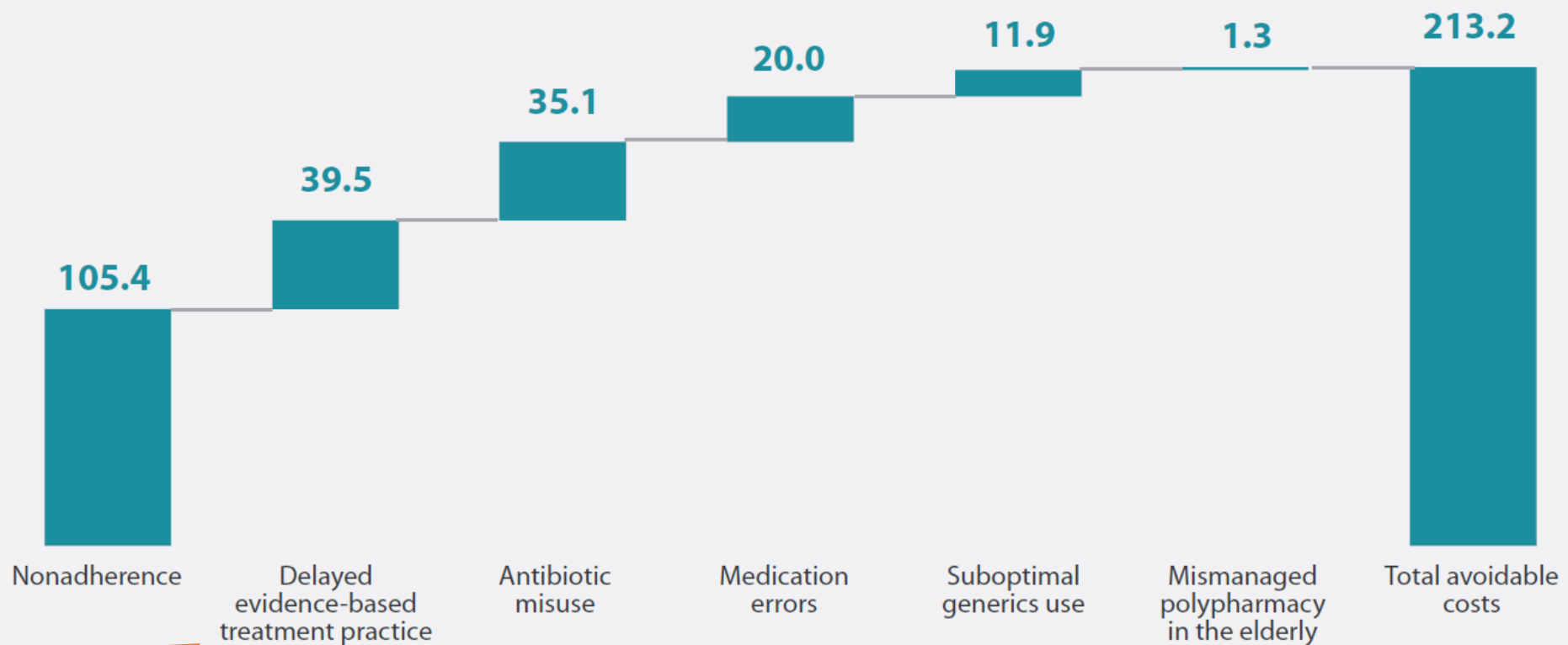
Strength of recommendation

consensus



Did quality of guidelines improve ?

Estimated Avoidable Costs by Lever (US\$Bn, 2012)



Source: Avoidable costs in healthcare study

GUIDELINES ARE A CONSTRUCTIVE RESPONSE TO THE reality that the practicing physician requires assistance to assimilate and apply the exponentially expanding, often contradictory, body of medical knowledge. Guidelines are widely perceived as evidence based, not authority based, and therefore as unbiased and valid. Because they are sponsored by organizations, staffed by experts, and conducted according to apparently formal processes, the products of the exercise—the guidelines—are generally assumed to have the same level of certainty and security as conclusions generated by the conventional scientific method. For many clinicians, guidelines have become the final arbiters of care.

the committee believes are defining characteristics. The new definition is as follows: **Clinical practice guidelines are statements that include recommendations intended to optimize patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options.**

To be *trustworthy*, guidelines should



scelta

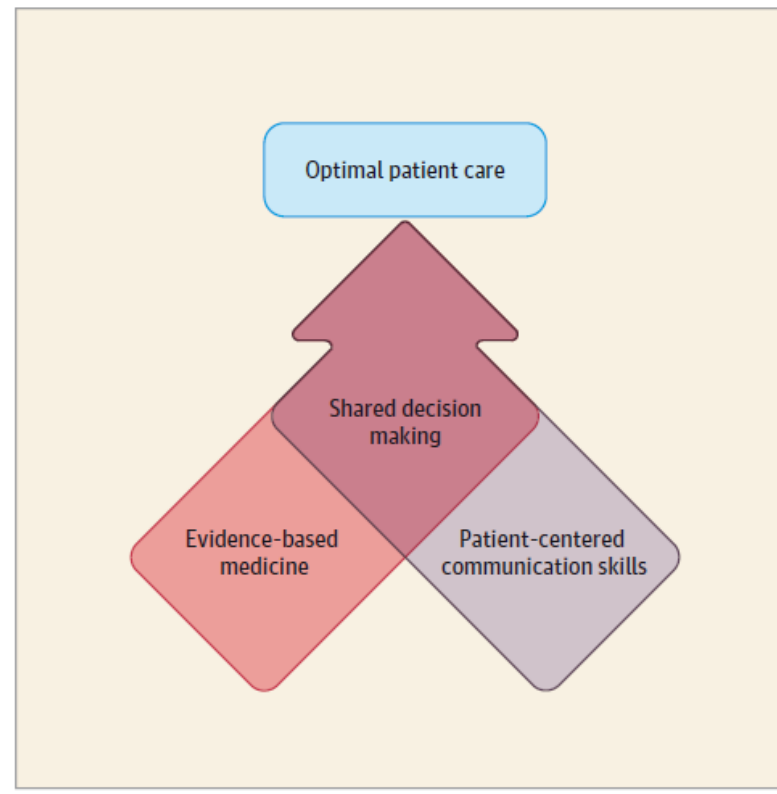
Guidelines, not tramlines

Institute of Medicine, 2011

The Connection Between Evidence-Based Medicine and Shared Decision Making

JAMA October 1, 2014 Volume 312, Number 13 1295

Figure. The Interdependence of Evidence-Based Medicine and Shared Decision Making and the Need for Both as Part of Optimal Care



Art. 5. Legge Gelli

(Buone pratiche clinico-assistenziali e raccomandazioni previste dalle linee guida)

1. Gli esercenti le professioni sanitarie, nell'esecuzione delle prestazioni sanitarie con finalità preventive, diagnostiche, terapeutiche, palliative, riabilitative e di medicina legale, si attengono, salve le specificità del caso concreto, alle raccomandazioni previste dalle linee guida pubblicate ai sensi del comma 3 ed elaborate da enti e istituzioni pubblici e privati **nonché dalle società scientifiche e dalle associazioni tecnico- scientifiche** delle professioni sanitarie iscritte in apposito elenco istituito e regolamentato con decreto del Ministro della salute.....

3. Le linee guida e gli aggiornamenti delle stesse elaborati dai soggetti di cui al comma 1 sono integrati nel **Sistema nazionale per le linee guida (SNLG)**,**L'Istituto superiore di sanità** pubblica nel proprio sito *internet* le linee guida e gli aggiornamenti delle stesse indicati dal SNLG, previa **verifica della conformità della metodologia adottata a standard definiti e resi pubblici** dallo stesso Istituto, nonché della **rilevanza delle evidenze scientifiche** dichiarate a supporto delle raccomandazioni. In mancanza delle suddette raccomandazioni, gli esercenti le professioni sanitarie si attengono alle **buone pratiche clinico assistenziali**.

Opportunità

- **Sistema nazionale** di linee guida di riferimento credibili, autorevoli, rilevanti per la pratica socio-clinico-assistenziale a livello individuale, di popolazione, sanità pubblica, health policy, decisioni di coverage
- Miglioramento della qualità delle cure e, possibilmente, degli esiti assistenziali (**high value care**)
- Maggiore diffusione della cultura EBM fra i professionisti della Sanità e nel Paese
- Miglioramento della **comunicazione efficace e professionale dell'incertezza** con i pazienti
- Riduzione contenziosi medico legali
- Contrasto alla deriva «difensivistica» della medicina

Criticità

- Qualità e quantità LG prodotte da società scientifiche italiane potenzialmente inseribili in SNLG rispetto al corpus di conoscenze/LG evidence based internazionali di alta/altissima qualità a disposizione
- Aspettative eccessive da parte dei medici e altri professionisti della sanità, policymaker, cittadini, pazienti (avvocati, giudici...)
- Predominanza del valore regolatorio/cogente della LG rispetto al suo uso critico e consapevole → uso indiscriminato e irriflessivo
- Aumento paradossoso della pratica della medicina difensiva

What is evidence?

A collection of facts that ground one's belief that something is true

Institute of Medicine, 2008

The elusive nature of «evidence»

Principio di causalità, INUS (Mackie)

di quale evidenza parliamo ?

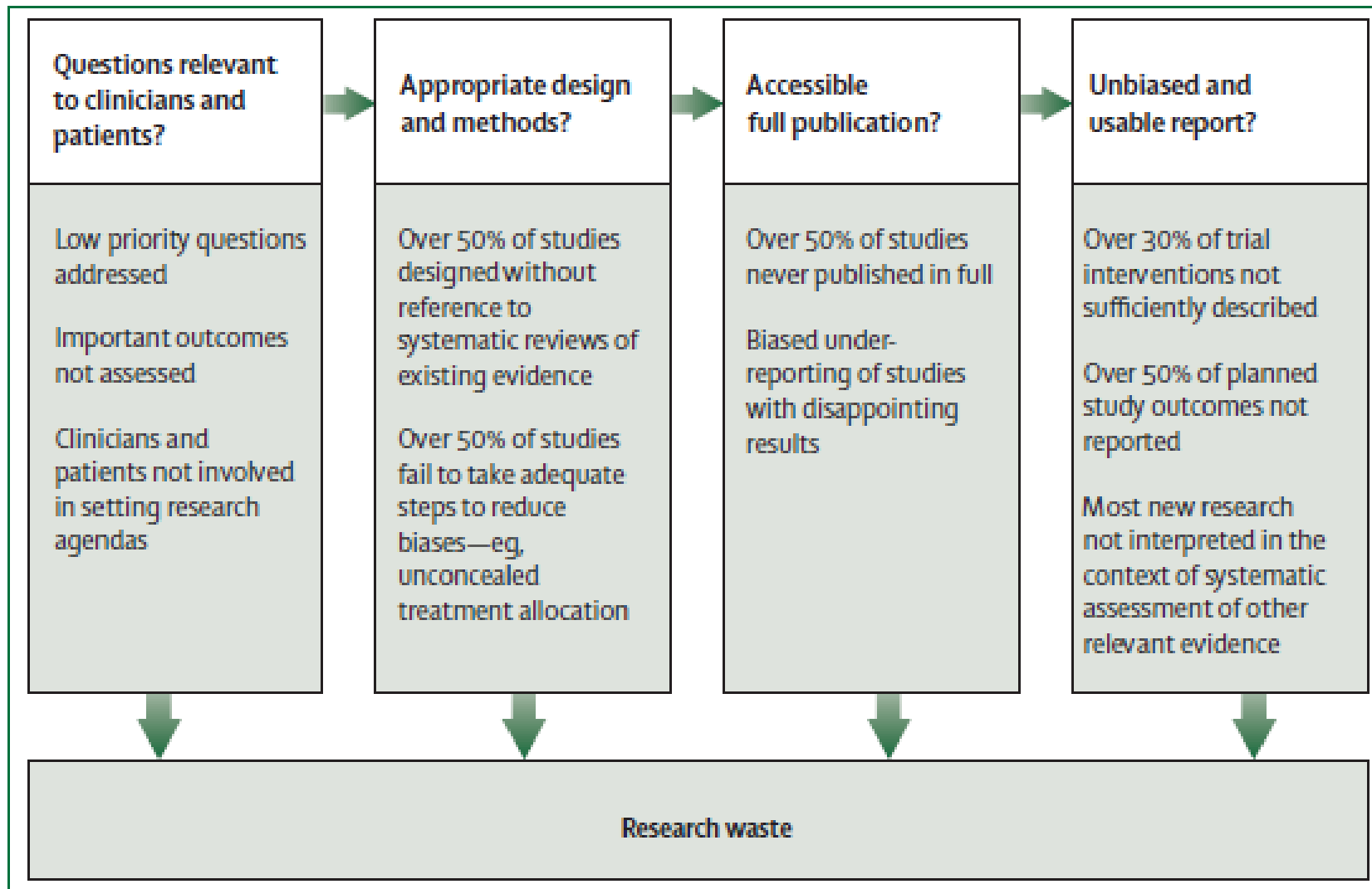


Figure: Stages of waste in the production and reporting of research evidence relevant to clinicians and patients

ONLINE FIRST | HEALTH CARE REFORM

Failure of Clinical Practice Guidelines to Meet Institute of Medicine Standards

Two More Decades of Little, If Any, Progress

Justin Kung, MD; Ram R. Miller, MD; Philip A. Mackowiak, MD

Table 1. Frequency of Adherence to Institute of Medicine Standards by Organization Type and Subspecialty Area

Organization Type (No. of Guidelines)	Standards Met, Median	Guidelines Meeting >50% of Standards, No. (%)
All (114)	8 (44.0)	56 (49.1)
United States (68)	8 (44.0)	34 (50.0)
Non-US (46)	9 (50.0)	22 (47.8)
US government agency (15)	9 (50.0)	10 (66.7)
Subspecialty societies (41)	8 (44.0) ^a	16 (39.0) ^b
Subspecialty area		
Infectious diseases (21)	9 (50.0)	11 (52.4)
Oncology (17)	9.5 (52.8)	9 (52.9)
OB/GYN (12)	8 (44.0)	3 (25.0)
All other (64)	8 (44.0)	36 (56.2) ^c

Abbreviation: OB/GYN, obstetrics/gynecology.

^a $P = .34$ by Mann-Whitney test compared with all other organization types.

^b $P = .11$ by Fisher exact test compared with all other organization types.

^c $P = .40$ by χ^2 test across all subspecialty areas.

Major stroke guidelines and recommendations for alteplase at 3-4.5 hours after stroke onset

*Guidelines presenting **strong recommendation for** (“is recommended” or highest recommendation rating)*

American Heart Association/American Stroke Association (Class I; Level of evidence B)⁵

Canadian Stroke Network and Heart and Stroke Foundation of Canada (Evidence level A)⁶

Chinese Stroke Therapy Expert Panel for Intravenous Recombinant Tissue Plasminogen Activator (Level 1 recommendation, Level A evidence)⁷

European Stroke Organisation (Class I, Level A)⁸

Haute Autorité de Santé (Professional agreement)⁹

Japan Stroke Society (level of evidence Ia; grade of recommendation A)¹⁰

National Institute for Health and Care Excellence (“is recommended”)¹¹

National Stroke Foundation (Australia) (Grade A)¹²

South African Stroke Society (Class I, Level A)¹³

*Guidelines presenting **weak recommendation for** (lower recommendation rating)*

American College of Chest Physicians (Grade 2C)¹⁴

American College of Emergency Physicians/American Academy of Neurology (Level B recommendation), currently being reconsidered

by American College of Emergency Physicians¹⁵

American College of Emergency Physicians (draft guideline in process) (Level B recommendation)¹⁶

*Guidelines presenting **weak recommendation against***

Canadian Association of Emergency Physicians (draft guideline in process) (Weak recommendation, moderate quality evidence)¹⁷

*Statements that t-PA is **controversial at all timeframes** and should not be considered standard of care*

American Academy of Emergency Medicine¹⁸

Australasian College for Emergency Medicine¹⁹

Canadian Association of Emergency Physicians (currently posted policy)²⁰

New Zealand Faculty of the Australasian College for Emergency Medicine²¹

BMJ 2015; 350 doi:

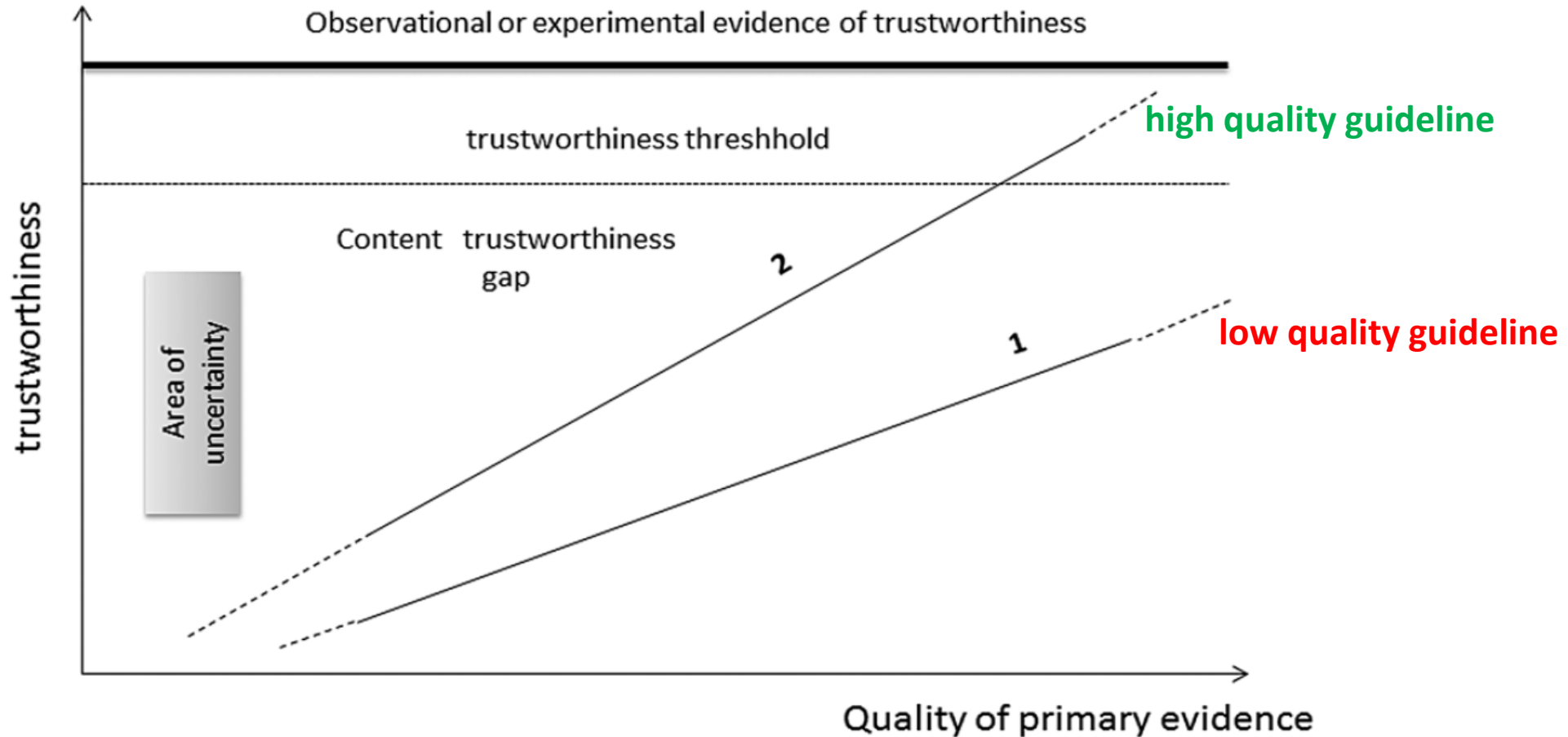
<https://doi.org/10.1136/bmj.h1075>

(Published 17 March 2015)

Wrong guidelines: why and how often they occur

Primiano Iannone,¹ Nicola Montano,² Monica Minardi,³ James Doyle,³ Paolo Cavagnaro,⁴ Antonino Cartabellotta⁵

Credibilità delle LG: cosa significa ?



Wrong guidelines: why and how often they occur

Primiano Iannone,¹ Nicola Montano,² Monica Minardi,³
James Doyle,³ Paolo Cavagnaro,⁴ Antonino Cartabellotta⁵

BMJ

Evid Based Med March 2017 | volume 22 | number 1 |

1

Overall, a conservative estimate is that 50% of current evidence-based guidelines suffer from either methodological flaws, have questionable content with respect to the primary evidence to which they refer to or documented outcomes diverging from those expected. On average, guidelines sponsored by medical specialty societies were and still continue to be of lower quality compared with those endorsed by national health agencies.

Situazione italiana

EvidenceLive



NUFFIELD DEPARTMENT OF
PRIMARY CARE
HEALTH SCIENCES



ABSTRACT SUBMISSION

Title: Quality and trustworthiness of clinical practice guidelines developed by Italian medical specialty societies: a cross sectional study

Affiliations

- (1) GIMBE Foundation, Bologna, Italy
- (2) National Institute of Health - Istituto Superiore di Sanità, Rome, Italy
- (3) University of Messina, Messina, Italy

Authors

Antonino	Cartabellotta	(1) Presenting
Antonio Simone	Laganà	(3)
Primiano	Iannone	(2)
Walter	Ricciardi	(2)

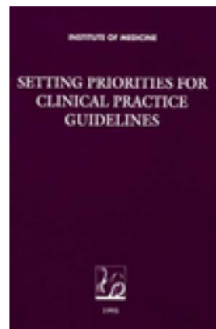
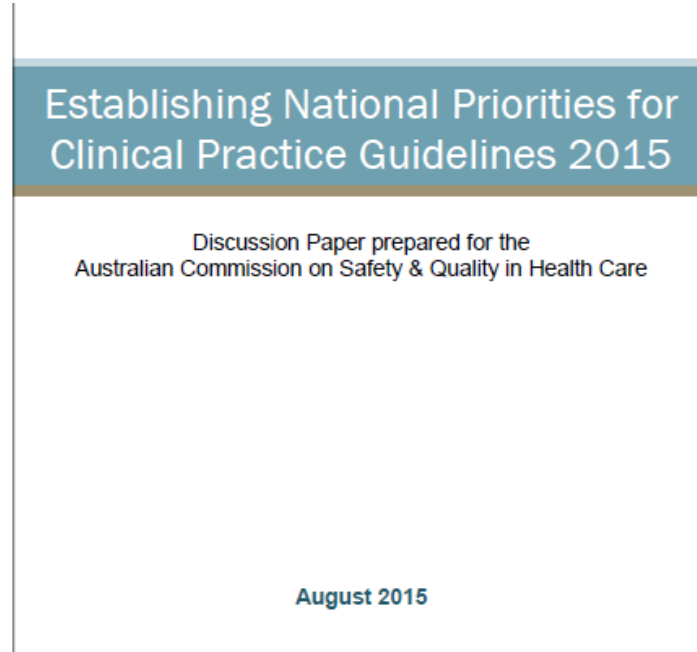
Risultati 4: aderenza standard G-I-N 1

Item	Sì
3. Conflitti di interesse	17%
1. Composizione del gruppo di sviluppo della linea guida	63%
11. Finanziamenti e sponsor	64%
2. Processo decisionale	65%
6. Revisione delle evidenze	67%
10. Validità e aggiornamento della linee guida	67%
5. Metodi	71%
9. Peer review e consultazione degli stakeholders	72%
8. Rating delle evidenze e delle raccomandazioni	81%
7. Raccomandazioni della linea guida	95%
4. Ambito della linea guida	100%

SNLG :

Alcuni punti fermi

1. Stabilire le priorità del SNLG



Setting Priorities for Clinical Practice Guidelines

Marilyn J. Field, Editor; Committee on Methods for Setting Priorities for Guidelines Development, Institute of Medicine

ISBN: 0-309-58797-2, 176 pages, 6 x 9, (1995)

This PDF is available from the National Academies Press at: <http://www.nap.edu/catalog/4959.html>



Journal of Clinical Epidemiology 67 (2014) 1335–1342

Journal of
Clinical
Epidemiology

ORIGINAL ARTICLES

Priority-based initiative for updating existing evidence-based clinical practice guidelines: the results of two iterations

Chika Agbassi^{a,c,d}, Hans Messersmith^{a,c,d}, Sheila McNair^{a,c,d}, Melissa Brouwers^{a,b,c,d,*}

^aDepartment of Oncology, McMaster University, 1280 Main Street West Hamilton, Ontario L8S4L8, Canada

^bDepartment of Clinical Epidemiology & Biostatistics, McMaster University, 1280 Main Street West Hamilton, Ontario L8S4L8, Canada

^cEscarpment Cancer Research Institute (ECRI), Juravinski Hospital Research Centre, 711 Concession Street, G Wing, Hamilton, Ontario, L8V 1C3, Canada

^dProgram in Evidence-based Care, Cancer Care Ontario/McMaster University, Juravinski Site, 60 (G) Wing, 711 Concession Street Hamilton, Ontario, Canada, L8V 1C3

Accepted 1 June 2014; Published online 10 September 2014

Health Research Policy and Systems



Review

Open Access

Improving the use of research evidence in guideline development: 2. Priority setting

Andrew D Oxman^{*1}, Holger J Schünemann² and Atle Fretheim³

Address: ¹Norwegian Knowledge Centre for the Health Services, P.O. Box 7004, St. Olavs plass, N-0130 Oslo, Norway, ²INFORMA, S.C. Epidemiologia, Istituto Regina Elena, Via Elio Chianesi 53, 00144 Rome, Italy and ³Norwegian Knowledge Centre for the Health Services, P.O. Box 7004, St. Olavs plass, N-0130 Oslo, Norway

Email: Andrew D Oxman^{*} - oxman@online.no; Holger J Schünemann - hjs@buffalo.edu; Atle Fretheim - atle.fretheim@nokc.no

^{*} Corresponding author

Published: 29 November 2006

Received: 07 April 2006

Health Research Policy and Systems 2006, 4:14 doi:10.1186/1478-4505-4-14

Accepted: 29 November 2006

This article is available from: <http://www.health-policy-systems.com/content/4/1/14>

2. Standard di riferimento metodologici

APPRAISAL OF GUIDELINES
FOR RESEARCH & EVALUATION



GRADE

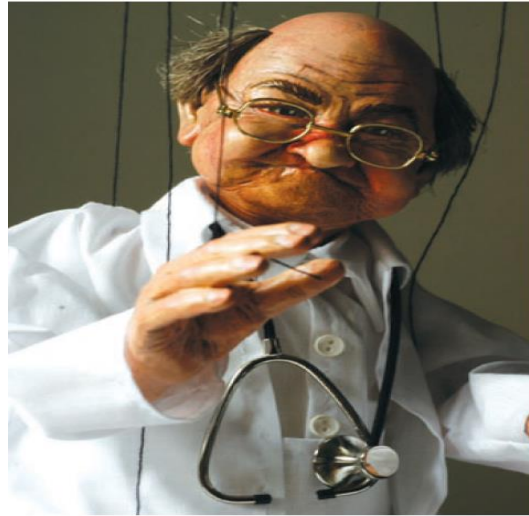
G-I-N Public Toolkit:
Patient and Public
Involvement in Guidelines.

**CLINICAL PRACTICE
GUIDELINES
WE CAN TRUST**

INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES

NICE National Institute for
Health and Care Excellence

3. Gestire efficacemente i conflitti di interesse



KEY OPINION LEADERS
Independent experts or
drug representatives in
disguise?

Ray Moynihan examines the role of the influential experts paid by industry to help “educate” the profession and the public

Key opinion leaders—what fees can they command?

Single lecture or scientific speech \$3000
(source: Marketwire)

Hourly rate for influential physicians offering advice—up to \$400
(source: Cutting Edge Information)

Work for drug companies on clinical trials—More than £200 an hour
(source: BMA)

BMJ | 21 JUNE 2008 | VOLUME 336

Many key opinion leaders participate of guideline panel groups (or chair them)

4. Considerare i tempi (e costi) di produzione di una LG

18-24 months (average time of a full GL de-novo production)

5. Adattamento di LG esistenti vs produzione ex novo

H.J. Schünemann et al. / Journal of Clinical Epidemiology ■ (2016) ■

ARTICLE IN PRESS

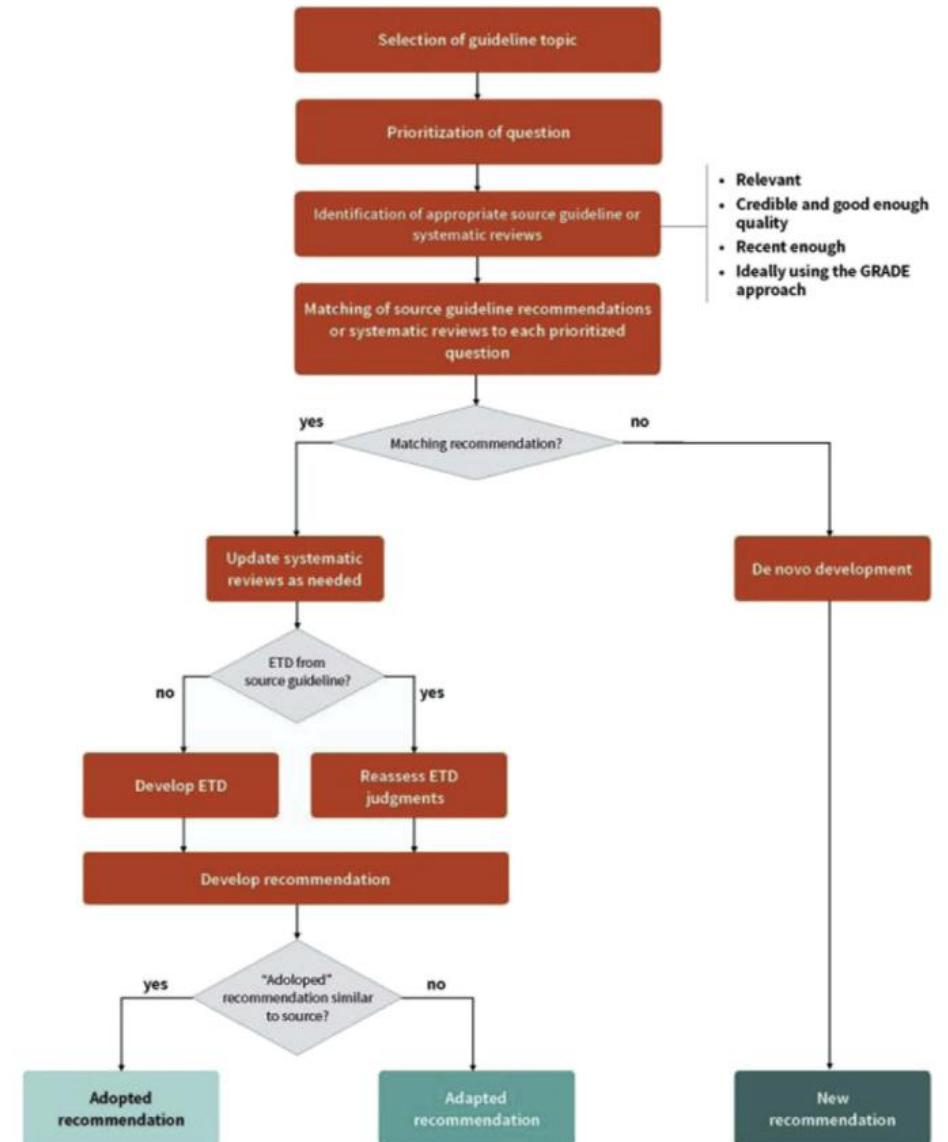


Journal of Clinical Epidemiology ■ (2016) ■

Journal of
Clinical
Epidemiology

ORIGINAL ARTICLE

GRADE Evidence to Decision (EtD) frameworks for adoption, adaptation, and de novo development of trustworthy recommendations: GRADE-ADOLOPMENT



5. Destinatari e finalità delle LG

GRADE Evidence to Decision (EtD) frameworks: a systematic and transparent approach to making well informed healthcare choices. 1: Introduction

Pablo Alonso-Coello,^{1,2} Holger J Schünemann,^{2,3} Jenny Moberg,⁴ Romina Brignardello-Petersen,^{2,5} Elie A Akl,^{2,6} Marina Davoli,⁷ Shaun Treweek,⁸ Reem A Mustafa,^{2,9} Gabriel Rada,^{10,11,12} Sarah Rosenbaum,⁴ Angela Morelli,⁴ Gordon H Guyatt,^{2,3} Andrew D Oxman⁴ the GRADE Working Group

Cite this as: *BMJ* 2016;353:i2016
<http://dx.doi.org/10.1136/bmj.i2016>

RESEARCH METHODS AND REPORTING

GRADE Evidence to Decision (EtD) frameworks: a systematic and transparent approach to making well informed healthcare choices. 2: Clinical practice guidelines

Pablo Alonso-Coello,^{1,2} Andrew D Oxman,³ Jenny Moberg,³ Romina Brignardello-Petersen,^{2,4} Elie A Akl,^{2,5} Marina Davoli,⁶ Shaun Treweek,⁷ Reem A Mustafa,^{2,8} Per O Vandvik,³ Joerg Meerpohl,⁹ Gordon H Guyatt,^{2,10} Holger J Schünemann,^{2,10} the GRADE Working Group

Cite this as: *BMJ* 2016;353:i2089
<http://dx.doi.org/10.1136/bmj.i2089>



LG patient oriented, not disease oriented

Multimorbidity: clinical assessment and management

NICE guideline

Published: 21 September 2016

[nice.org.uk/guidance/ng56](https://www.nice.org.uk/guidance/ng56)

BMJ

BMJ 2013;346:f2510 doi: 10.1136/bmj.f2510 (Published 2 May 2013)

Page 1 of 4

ANALYSIS

Better management of patients with multimorbidity

Martin Roland and **Charlotte Paddison** call for greater emphasis on continuity of care and clinical judgment to improve the experience of patients with multiple conditions

6. Buone pratiche cliniche

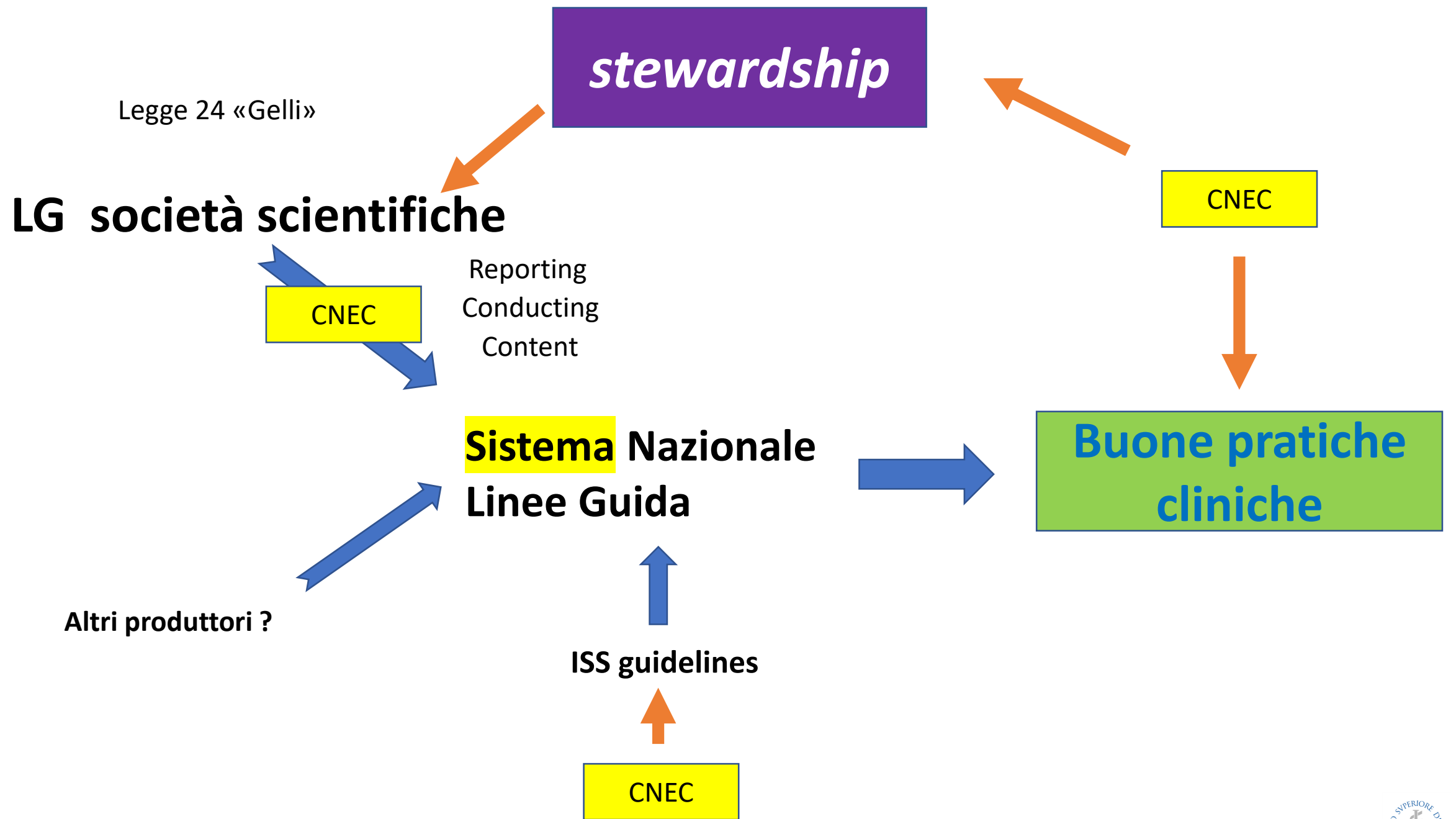
La Legge n.24/2017 afferma che quando le linee guida (in SNLG) non sono disponibili, gli operatori sanitari dovrebbero fare riferimento a "**buone pratiche cliniche**".

È ragionevole che tali buone pratiche cliniche debbano essere selezionate anche dall'ISS e raccolte nel sito web dell'SNLG.

È probabile che, almeno all'inizio, la maggior parte delle indicazioni per gli operatori sanitari derivino da esse.

In questo ambito potranno ricadere : **bad** e **low values practices** (*Choosing Wisely*, per esempio), **do not do list** del NICE, **LG di alta qualità metodologica non (ancora) adattate e/o tradotte in lingua italiana**, nonché **position statements** di organismi di salute pubblica internazionali, società scientifiche e raccomandazioni di Agenzie Internazionali.

Come per le LG pubblicate nell'SNLG, la non ridondanza e la coerenza interna saranno qualità essenziali di questo elenco.





[🏠](#) > Archivio per categoria "Linee guida"

Archivi categoria: *Linee guida*

Protetto: Pubblicazione nell'SNLG delle LG proposte da soggetti ex art.5 Legge 8 marzo 2017 n.24

N.B.: le modalità di pubblicazione sono suscettibili di modifiche sulla base dei decreti attuativi di prossima divulgazione della L. 24/2017.

Eventuali commenti e proposte di modifica possono essere inviati all'indirizzo e-mail: cneec-snlg@iss.it

In questa sezione sono riportate le modalità di invio e la procedura di valutazione delle Linee Guida (LG) per la pubblicazione nell'SNLG.

Gli enti e le istituzioni pubbliche e private, le società scientifiche e le associazioni tecnico-scientifiche delle professioni sanitarie iscritte in apposito elenco istituito e regolamentato con DM 2 agosto 2017 (GU n.186 del 10-8-2017) propongono al CNEC la LG da pubblicare nell'SNLG.

Il CNEC verifica in primo luogo l'eleggibilità della LG in base a pre-requisiti di priorità e non ridondanza e, successivamente, valuta la LG con criteri

Where are we headed ?

Corruption of the Evidence as Threat and Opportunity for Evidence-Based Medicine

*Victor M. Montori, MD, MSc
and Gordon H. Guyatt, MD, MSc*

146 Harvard Health Policy Review

Vol. 8, No. 1, Spring 2007 145



Health Affairs

At the Intersection of Health, Health Care and Policy

Cite this article as:

John M. Eisenberg

Globalize The Evidence, Localize The Decision: Evidence-Based Medicine
And International Diversity
Health Affairs, 21, no.3 (2002):166-168

doi: 10.1377/hlthaff.21.3.166

Globalize The Evidence, Localize The Decision: Evidence-Based Medicine And International Diversity

The use of evidence is most successful when local differences are factored into the decision-making process, whether at the clinical, system, or policy level.

by John M. Eisenberg

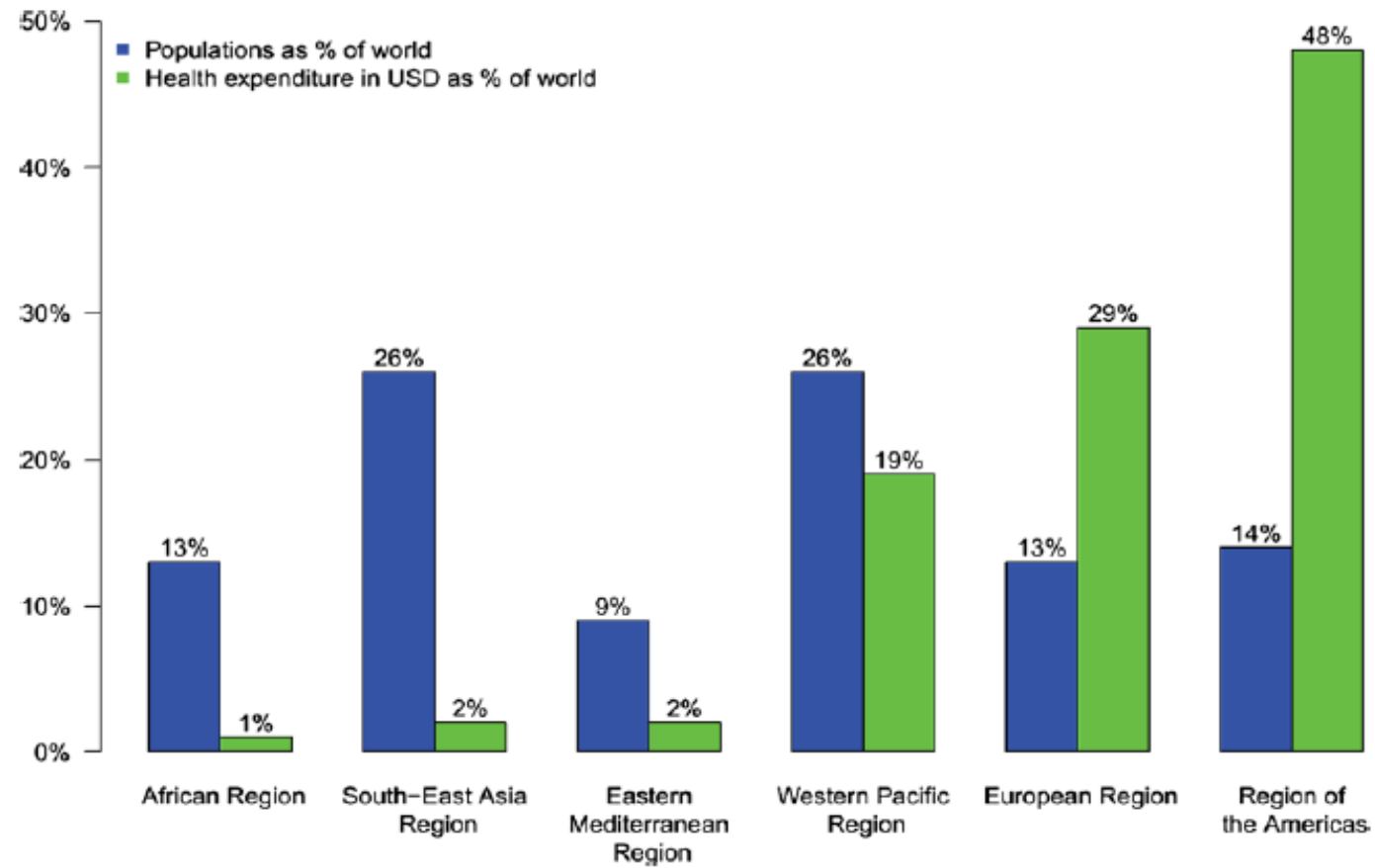


Fig. 1 Distributions of populations and global health expenditure according to WHO 2012

A survey of guideline developers found that only 29% always involve consumers and 39% involve consumers only if necessary

Evidence-informed health policy 2 - survey of organizations that support the use of research evidence.

Lavis JN, Implement Sci. 2008; 3:54

EDITOR'S CHOICE

What is health?

Fiona Godlee *editor, BMJ*

Why should we be interested in defining health? Because if health is the goal of healthcare and research, we need to know what it looks like and how to measure it. As these articles explain, the currently accepted definition, formulated by WHO in 1948, is no longer helpful and is even counterproductive. Its emphasis on “complete physical, mental and social wellbeing” was radical in its day for stepping away from defining health as the absence of disease. But it is absolute and therefore unachievable for most people in the world. As Richard Smith, one of the authors of this week’s article, pointed out in a *BMJ*

The WHO definition is also unworkable for other reasons, the authors say. In the face of an ageing global population with an increasing burden of chronic disease, it “minimises the role of the human capacity to cope autonomously with life’s ever changing physical, emotional, and social challenges and to

FEATURE

MEDICALISATION

Preventing overdiagnosis: how to stop harming the healthy

Evidence is mounting that medicine is harming healthy people through ever earlier detection and ever wider definition of disease. With the announcement of an international conference to improve understanding of the problem of overdiagnosis, **Ray Moynihan**, **Jenny Doust**, and **David Henry** examine its causes and explore solutions

Ray Moynihan *senior research fellow*¹, Jenny Doust *professor of clinical epidemiology*², David Henry *chief executive officer*³

OPINION

Open Access

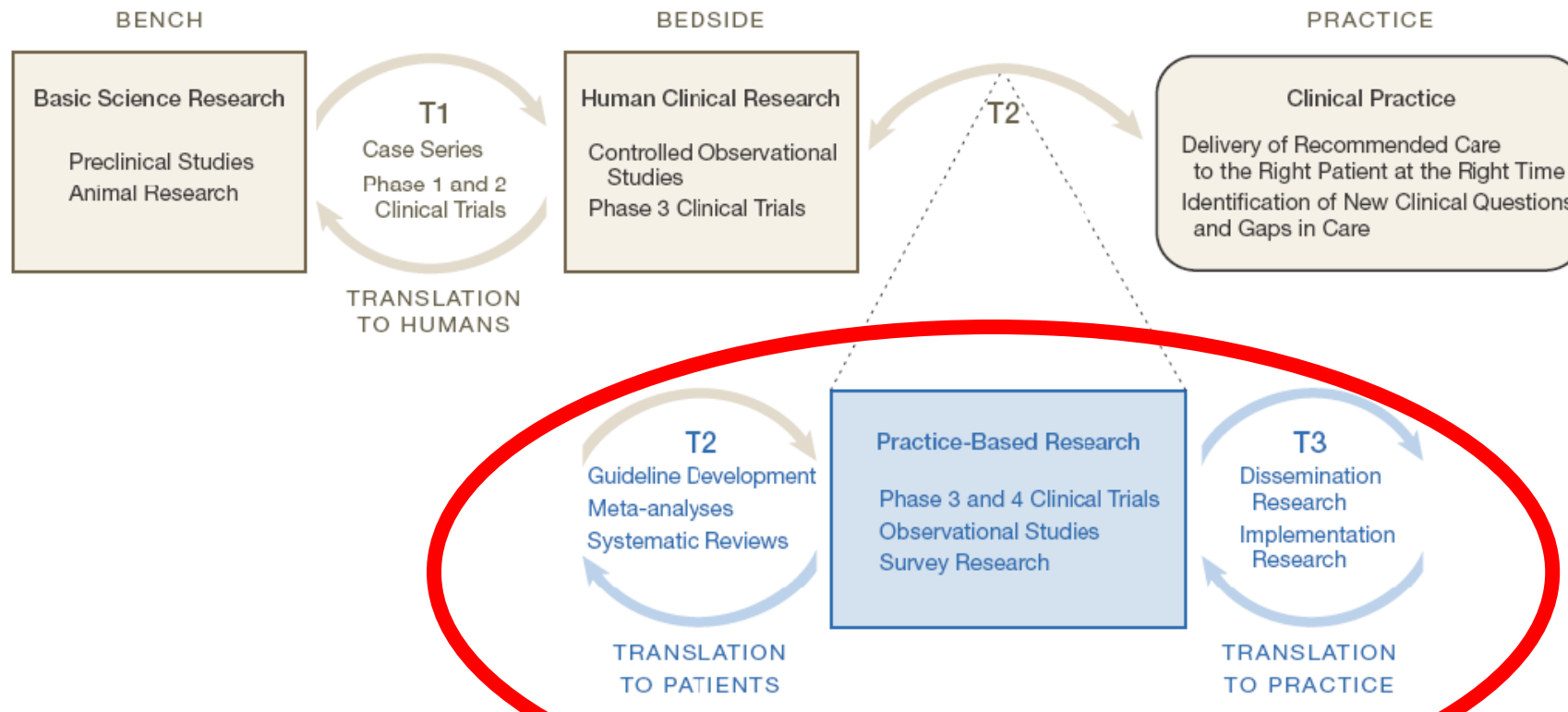
Reconciling evidence-based medicine and precision medicine in the era of big data: challenges and opportunities



Jacques S. Beckmann* and Daniel Lew

"Blue Highways" on the NIH Roadmap

Figure. "Blue Highways" on the NIH Roadmap



Why Don't Physicians Follow Clinical Practice Guidelines? A Framework for Improvement

Michael D. Cabana, MD, MPH

Cynthia S. Rand, PhD

Neil R. Powe, MD, MPH, MBA

Albert W. Wu, MD, MPH

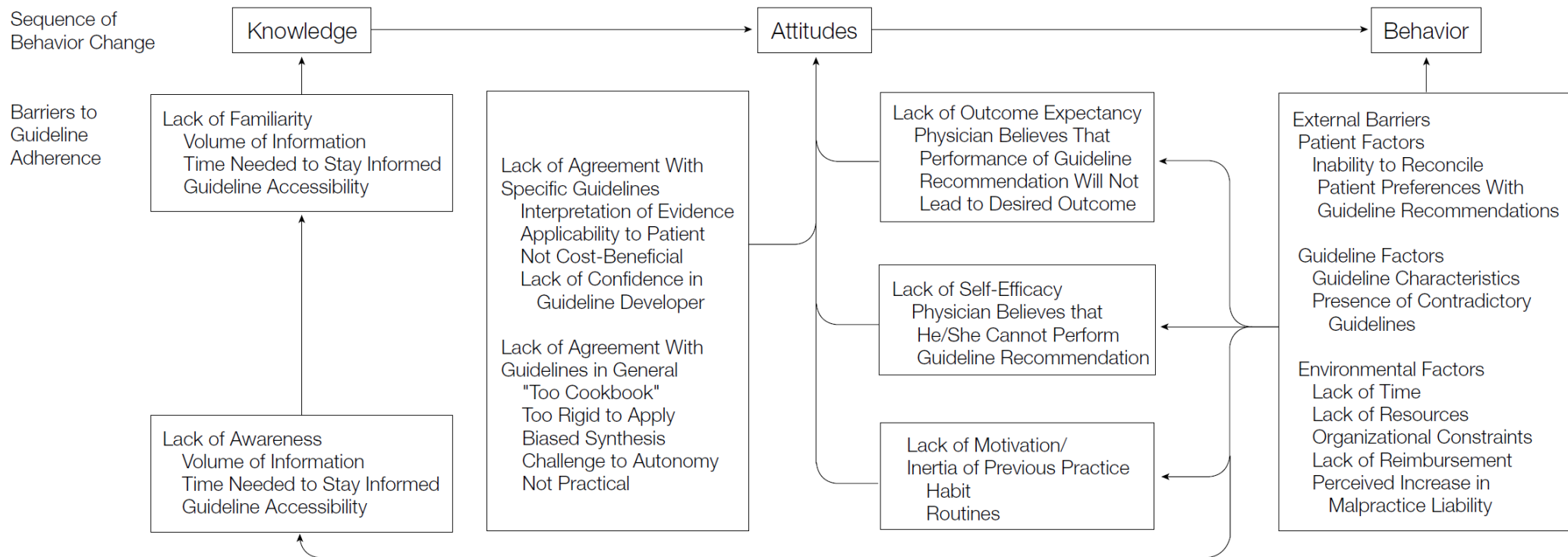
Modena H. Wilson, MD, MPH

Paul-André C. Abboud, MD

Haya R. Rubin, MD, PhD

Figure. Barriers to Physician Adherence to Practice Guidelines in Relation to Behavior Change

JAMA. 1999;282:1458-1465



Communication and Dissemination Strategies To Facilitate the Use of Health-Related Evidence



Results. The search identified 4,152 articles (after removing duplicates) for all three KQs. After dual review at the title/abstract stage and full-text review stage, we retained 61 articles that directly (i.e., head to head) compared strategies to communicate and disseminate evidence. Across the KQs, many of the comparisons yielded insufficient evidence to draw firm conclusions. For KQ 1, we found that investigators frequently blend more than one communication strategy in interventions. For KQ 2, we found that, compared with single dissemination strategies, **multicomponent dissemination strategies are more effective at enhancing clinician behavior,** particularly for guideline adherence. Key findings for KQ 3 indicate that evidence on communicating overall strength of recommendation and precision was insufficient, but certain ways of communicating directness and net benefit may be helpful in reducing uncertainty.

Linee Guida come scorciatoie euristiche?

***guidelines [should] force us to scrutiny
primary research literature in ways that
we don't normally do***

Richard Horton, Editor of *The Lancet*



ADDRESSING UNCERTAINTY IS PROFESSIONAL

‘One of the key attributes of professionalism . . . should be the ability to identify and address uncertainty in medicine. Every day professionals confront and cope with uncertainties about disease pathogenesis, about diagnosis, and about treatment. Yet the intrinsic uncertainties in all these spheres of medical activity are seldom acknowledged explicitly and some professionals remain uncomfortable about admissions of uncertainty – in their dealings with patients especially.

From: Medical Research Council response to Royal College of Physicians consultation on medical professionalism. 2005

Evidence Based Medicine is an
eminently creative methodology
which emphasizes critical reasoning
and not the robotic application of
rules and recommendations...

Bogathy & Brophy, Lancet 2003

