Are the Evidence Based Medical Guidelines® fit for family medicine?

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Abstract

The author is a family physician and terminologist. He shares his experience of proofreading translations from English to French of the Evidence Based Medical Guidelines (EBMG) published by DUODECIM Ltd and Finnish general practitioners. These EBMGs are available to healthcare personnel in several countries. In Belgium they are disseminated by CEBAM, the Belgian Centre for Evidence Based Medicine, through the ebmpractice.net website on behalf of the national insurer, INAMI.

After having corrected a few hundred texts, the author shares his experience. Terminological issues are first addressed. System of corrections, specific difficulties or questions of acronyms are reviewed. Then the author gives a partial presentation of his own critical readings of about a hundred recommendations that he has more particularly studied. The main pitfalls encountered in the field of prevention, clinical pharmacology or mental health which are discussed here in light of the author's experience and vision of family medicine. The exchange of these criticisms with the Finnish authors of the guidelines proved to be particularly interactive and fruitful. Although the concept of evidence is not clear to anyone, the EBMGs are an indispensable tool for understanding and supporting the complexity of family medicine.

Introduction

As a practicing general practitioner and terminologist, I was given the opportunity to take on part of the work of revising the translations from English to French of the EBM Guidelines[1] published by DUODECIM Ltd (https://www.duodecim.fi/) and made available to Belgian healthcare personnel in French and Dutch by the Belgian national insurer INAMI through the website of the non-profit association ebmpractice net (https://www.ebpnet.be/). The EBMGs are available in English, Finnish, Dutch, French, German, Turkish and Ukrainian.

In the three years that I have been carrying out this work, for which Health Care Information Services (https://www.iscientia.com/) in Belgium is responsible for managing the translations, I have had to reread a few hundred of the more than 1000 guidelines in the available collection and to check the translations of the annual updates.

The texts, available online, are first translated into Dutch and English by professional translators. It is up to me and a small team of colleagues to check that the texts fit the vocabulary and style generally used in the profession of family doctor in French speaking Belgium.

This activity is reasonably financed and also allows me, after more than four decades in the profession, to review the medical subject matter.

Checking translations

The texts are presented online in English and French and corrected online using the Word® system. The work consists of checking translations, hunting for unusual sentence turns (*Table 1)* , false friends, mistranslated terms (*Table 2)* or acronyms (*Table 3)*.

Traces of the corrections are kept online until the final edition is made available to family doctors on the EBMpractice.net website. EBMpractice.net is one of the many achievements of CEBAM (Cebam Digital Library for Health)(https://www.cebam.be/), a Belgian non-profit organization dedicated to the publication of high quality medical information for healthcare providers.

Table 1 Example of English / French sentence-by-sentence translation verification. System Word™. As one can see in the second sentence, the English wording is sometimes unclear too.

Table	*1*
If these investigations are not done until, for example, after the sick leave period, the results may have returned back to normal.	Si ces enquêtes ne sont effectuées, par exemple, qu'après la période de congé de maladie, les résultats peuvent être revenus à la normale.~~Si ces examens ne sont pas réalisés à temps par exemple, après la période d'incapacité de travail, , leurs résultats peuvent être normaux.~~
Any patient with mild or moderate incontinence that is not caused by a tumour and who has been sufficiently investigated as regards neurological or other systemic disease, is eligible for a therapeutic trial.	~~Tout~~ Un patient souffrant d'incontinence légère ou modérée dont l'origine n'est pas tumorale, et qui a été ~~suffisamment examiné~~correctement investigué sur le plan neurologique ~~en ce qui concerne les maladies neurologiques~~ ou d'autres maladies systémiques, est admissible à un essai thérapeutique.

In general, the translations are already of good quality and the changes made are often minor. This work is all the more important because our French colleagues also benefit from it. Indeed, the French national insurer CNAM, following the example of the INAMI, makes these same guidelines available to French healthcare personnel. A team of French auditors is also at work, with whom the Belgian team of translators has fruitful contacts.

Table 2 Table 2 Medical specification of some English terms.

The translator's proposals are replaced by terms used in medicine.

English	Find in the French translation	Preferred French translation
scaling	mise à l'échelle	desquamation
condition	condition	pathologie / affection
burrows	terriers	galeries
weeping and crusty	pleureuses et croustillantes	suintante et crouteuse

Table 3 Some examples of acronyms, usually replaced by text for better readability. Some English acronyms have become commonplace in French.

Original	Proposed translation	Preferred translation
DIC	DIC	Coagulation intravasculaire disséminée (CIVD)
ENMG	ENMG	Electromyogramme (EMG)
ESR	VSG	Vitesse de sédimentation (VS)
FV Leiden	facteur V Leiden	facteur V de Leiden
GFR	DFG	débit de filtration glomérulaire
GFRe	DFGe	débit de filtration glomérulaire estimée
GFRe ou eGFR	DFGe	débit de filtration glomérulaire estimée
GGT	GGT	gammaGT
HBC	VHC	hépatite C
HBV	VHB	hépatite B
MPR	ROR	Vaccin Rougeole - Rubéole - Oreillon (RRO)
PET-CT	TEP-scan	PET-scan
PID	IGH	Maladie inflammatoire pelvienne
RAST	test de radioallergosorbent	RAST [Radioallergosorbent test]
skin (conversion)	TCT	TCT (test cutané à la tuberculine)
TTP	TTP	PTT (Prothrombin time)

The issue of acronyms (table3) is difficult to deal with when translating. Acronyms are like tattoos that make professionals feel like they belong to an insider caste. Under the false pretext of typographic economy, they establish a hierarchy between those who understand them at first glance and the others, vile manants, who dare to take an interest in knowledge. The notion of hierarchy is typical of hospital culture, and it is especially in hospital relationships that we find them. General practitioners make little use of acronyms, at least those who want patients to understand them. Thus it seemed appropriate to me to propose the removal of acronyms from the French text, unless they have become part of the everyday language of doctors, such as NSAIDs (Non Steroidal Anti-Inflammatory Drugs), ECG (Electrocardiogram) or MS (Multiple Sclerosis).

The question of variants of meaning is very interesting to discuss. I know that EBMGs are referenced externally in a very professional way but the use of synonyms and lay terms should be even more frequent in the texts than it is already. In addition to making it easier to find a guideline, it may also facilitate doctor-patient communication. An excellent example of the use of synonyms is the guideline on photokeratitis, whose entry is reproduced in the Table Y.

Table 4 Excellent example of the use of multiple synonyms including lay terms in the introduction of a guideline.

Ebm 00811 Photokeratitis Line 3f1415625-f531-49f5-83c2-f4e50606d7ee	<Ultraviolet radiation may cause an acute keratitis (UV keratitis, photokeratitis, welder's eye, arc eye, snow blindness, photophthalmia).

From a terminological point of view, it is the translation of the term "evidence" that has provoked the most debate between Belgian and French translators and doctors. As we know, there is no consensus on the transposition into French of the EBM (Evidence Based Medicine) concept itself. The translation of the English term "evidence" is therefore subject to numerous interpretations. A common error is the equivalence between English "evidence" and French *preuve* (proof). The French term *preuve* can be used in law but not in medicine. If it were, it would imply the absence of uncertainty in medicine, which would de facto take away its scientific character. We have therefore kept a more flexible translation by rendering "evidence" in English as *évidence* in French, a use consecrated by the online Google translation system.

It is not necessary to describe all the terminology difficulties here. Let's just take the example of the English terms "Transsexualism" and "transsexual". Based on the work of Motmans et al[2], the terms *transidentité* instead of *transsexualisme* and *transgenre* instead of *transsexuel* have been used.

Considerations on the content of the EBMGs

As a clinician, on a personal and voluntary basis and at the same time as the verification of translations, some texts and proposals have attracted attention. Here we review some examples of discussions initiated by the reading of statements or proposals from Finnish colleagues.

Very rapid update driven by the need in the context of the Corona virus pandemic.

The EBMGs are, as noted above, updated annually. The recent Coronavirus outbreak has caused a substantial change in the pace of work. A new Covid-19 guideline appeared very soon after the outbreak began and its content evolved very rapidly as the little knowledge we had at the beginning was supported by the countless publications that our Finnish colleagues have been continually collecting. The pace of updates increased to the point where we had one update per week, which made it possible to make available a good practice recommendation that was fully consistent with the available clinical, pharmacological and epidemiological data, in a quality target language.

About the concept of prevention

The issue of prevention is very present in EBMGs. The authors of EBMGs do not use other meanings than primary and secondary prevention (Table 4). These terms were proposed in the 1950s, including the concept Tertiary prevention, based on the study of the stages of syphilis[3] and transposing them into public health[4]. This view, based on the chronology of the disease, introduced a confusion between primary and secondary fields that is well noted in EBMG.

Under the influence of patient-centered medicine, and even more so on the doctor-patient relationship, the World Organization of Family Doctors (WONCA) proposed, in the Dictionary of General Practice[5] published in 2003, the subdivision of prevention into four fields based on the patient's feelings and the doctor's knowledge.

This helps to clarify concepts. In primary and secondary prevention, the patient does not experience illness and the physician believes that there is no illness (primary prevention) or that there could be illness (secondary). This delimits health education and vaccinations (primary) and screening or early diagnosis (secondary). If the patient feels ill and the doctor has been able to objectify or name the illness, it is not only the place of care but also the prevention of complications and rehabilitation (tertiary). Thus, for a family doctor, prescribing acetylsalicylic acid after a heart attack or planning an annual eye fundus for a diabetic is tertiary prevention.

From this point of view, what remains is quaternary prevention[6], where the disagreement explodes between the patient who is ill and the doctor who cannot find a disease. This tension and disagreement between the two protagonists of the relationship, doctor and patient, introduces chaos, well described by Stacey's diagram[7] and which contributes to the deepening of the social security deficit.

Table 5 Comments on the concept of prevention. Two guidelines address the concept of prevention et the statements are discussed

Ebm #	EBMG statement	Comments
ebm468 Prescription /elderly	Line 31 & 32: Secondary prevention has high importance in elderly persons. There is also research evidence on the benefits of primary prevention concerning at least nutrition, vitamin D, and pharmacotherapy for hypertension, vaccinations and physical activity.	There seems to be a mismatch between what is Primary, Secondary and tertiary prevention in the texts. I suggest to consider https://www.ncbi.nlm.nih.gov/pubmed/25674569 In such a way to reach an agreement on the definition of the field of prevention
ebm00469 elderly check up	"There is also proof of the efficacy of preventive measures in the elderly for the following interventions: breast cancer screening, "	The issue of mammography screening and early diagnosis is much more complicated than suggested by the authors

Note that this concept applies to the individual clinic as well as to public health. It is also clear from the current epidemic how much uncertainty on the part of the population and political leaders is

introducing social tensions. Controlling doubt, anxiety and uncertainty, of doctor and patient, of health officials and of society, is applying quaternary prevention[8]. It is a rapidly expanding field that covers over-information, over-medicalization, over-diagnosis or over-prescription and misinformation etc... The use, promotion and training of EBM and guidelines is intrinsic to quaternary prevention since EBM helps the physician to self-control his or her activity[9].

The Finnish authors were very sensitive to these observations. They consider this question to be highly relevant, but transforming the guidelines in this way would be a long-term task that cannot be envisaged in the immediate future, as the concepts of prevention are present in all the guidelines.

What is the place of the general practitioner in the management of care?

Several EBMGs guidelines discuss the relationship between hospital care and general practitioners. Although one can sense some discrepancies between the authors of different guidelines, it seems that the trend for hospitals to invade the field of primary care work has become international. The concept of rheumatology nurse (Table x) is directly in line with managed care. So you'll have a diabetic nurse, an oncologist nurse, a dermatologist nurse and the family doctor is watching the scene with a twiddle of the thumbs. Managed care and care pathway are the antithesis of taking into account multimorbidity and anthropological complexity. The rule should be that the general practitioner takes the advice of specialists and remains the treating physician. Then, if the patient is treated in hospital, the general practitioner remains the patient's representative, advises, guides and becomes the patient's advocate if necessary, bearing in mind that medicine can be dangerous to health and that it itself is a major contributor to mortality[10].

Table 6 Two example of referral in the EBMGs. The first (red eye) gives the general practitioner his place, the next one (eye pain) proposes a collaboration, the third one (PR) obliges him to pass the hand without delay and introduces the concept of a specialist based care.

Ebm 00808 red eye line 82	If symptoms of a disease treated by a GP are prolonged, the patient should be referred to an ophthalmologist.
Ebm 00810 Pain in and around the eye line78	Primary treatment of recurrent iritis or iritis with milder symptoms can often be done by a GP (an ophthalmologist should preferably be consulted by phone on how to start the treatment).
ebm00456 Rheumatoid Polyarthritis line 1	If rheumatoid arthritis (RA) is suspected, the patient should be referred without delay to a rheumatology outpatient clinic.
line 150	Visit to a rheumatology nurse or, if necessary, a physician
line 260	Patients on biological agents or JAK inhibitors should continue being monitored by a rheumatology unit.

About mental health

The texts on depression and dysthymia and, in general, the mental health texts in these guidelines seem to me to have been written by psychiatrists, not family physicians (Table 5). The concept of co-morbidity is used in the texts in a very narrow and often criticized sense[11]. Historically, psychiatrists

began to use the term co-morbidity when dealing with patients who were as depressed as they were anxious. Co-morbidity in family medicine[12] is much more complex than the simple association of problems in the mental sphere.

The WONCA Dictionary describes comorbidity as "other diseases or health problems in addition to those being studied or treated". Depression and mental health impairments are presented here in a linear fashion, as if one led to the other. The reality of everyday life is that patients are often beset by multiple concurrent or successive problems, sometimes over several generations, which interact with each other and close the doors to possible solutions. Emotional problems, money problems, image problems, family position problems, legal problems, work problems, mental health and addiction form a network of factors[13] that are not resolved by administering an antidepressant for "depression" or by dialectical cognitive psychotherapy.

Table 7 Comments about some mental health concepts statements in 3 guidelines

Ebm #	EBMG statement	Comments
ebm 0718 dysthymia line 36	Short-term medication usually only leads to recurrence of symptoms after the treatment period.	Antidepressant withdrawal can be perfectly confused with a recurrence of primary depression. Patients easily think that they are condemned to live their whole life with SSRIs. It is therefore not uncommon to meet patients who have been taking the same products for 5 or 10 years and who are encouraged to continue taking them despite poor knowledge of the outcome. See - Lejoyeux, M., Adès, J., Mourad, S., Solomon, J., & Dilsaver, S. (1996). Antidepressant withdrawal syndrome. CNS drugs, 5(4), 278-292 - Hughes, S., & Cohen, D. (2009). A systematic review of long-term studies of drug treated and non-drug treated depression. Journal of affective disorders, 118(1-3), 9-18.
ebm 0472 Depression line 4	It is often an underdiagnosed and undermanaged illness.	This kind of sentence is dangerous. The population identified under the label depression and the length of treatments have continued to grow over the past 40 years at the rate of new definitions published by experts whose conflicts of interest were only identified too late. It is an open door to over-medicalization or more simply to the medicalization of life. See ; - Lundh, A., Lexchin, J., Mintzes, B., Schroll, J. B., & Bero, L. (2017). Industry sponsorship and research outcome. Cochrane Database of Systematic Reviews, (2). (https://www.ncbi.nlm.nih.gov/pubmed/23235689)
ebm 0714 Psychotherapy	Comorbidity occurring with personality disorders is very common in most psychiatric diagnoses:	The terms 'comorbid state' and 'comorbidity' are used here in a narrow psychiatric sense which does not correspond to the use of the concept of comorbidity in general practice. Refer to ; https://www.hetop.eu/hetop/3CGP#rr=CGP_QC_QD322

Frozen knowledge

Since the scientific promotion of the Attention deficit/hyperactivity disorder by the experts of the American Psychiatric Association (APA) and its publication in the Diagnostic and Statistical Manual of Mental Disorders, widely sponsored by the industry[14], the market for Rilatin has exploded [15]. The Finnish authors distance themselves well from this endemic over-prescription (Table 5).

Table 8 About the guideline ebm 0677 on ADHD clinical practice recommendation

Ebm #	Comment	Additional comment
ebm 0677 on ADHD	The revision of Guideline 0677 on ADHD is well done with sufficient relativity about the pharmacological treatment.	However, It does not mention the diagnostic epidemic since the 2000s. The interaction of the ADHD and the Central Auditory Processing Disorder (CAPD) has been known for more than 20 years. There is significant progress in understanding TADH or some of these forms in neuroscience and auditory sciences. It would be consistent to keep GPs informed of these promising advances in both diagnosis and treatment. See; [i] Blech, J. (2006). Inventing disease and pushing pills: Pharmaceutical companies and the medicalisation of normal life. Egully. com. [ii] Cacace, A. T., & McFarland, D. J. (1998). Central auditory processing disorder in school-aged children: A critical review. Journal of Speech, Language, and Hearing Research, 41(2), 355-373. [iii] Riccig, C. A., & Hynd, G. W. (1996). Relationship between ADHD and Central Auditory Processing Disorder: a review of the literature. School Psychology International, 17(3), 235-252. [iv] Medici, D., & Morales Suárez Varela, M. (2017). Language and school performance in children with diagnosis of attention deficit/hyperactivity disorder. Revista Mexicana de Neurociencia, 18(1), 89-99. [v] Serrallach, B., Groß, C., Bernhofs, V., Engelmann, D., Benner, J., Gündert, N., ... & Seither, S. (2016). Neural biomarkers for dyslexia, ADHD, and ADD in the auditory cortex of children. Frontiers in neuroscience, 10, 324. [vi] Gerritsen, J. (2009). A review of research done on Tomatis auditory stimulation. Mozart center.

However, alternative hypotheses to Learning Disability are not discussed. To the observation reported in the table about the potential importance of Central auditory management disorders, it was replied by the Finnish colleagues that such a statement is considered by them to be too specific and not yet certain enough to be introduced in the EBMG. Nevertheless, the role of the family doctor in screening for school and learning problems, often hidden behind certificates and sick leaves, is essential. It should be kept in mind that neuroscience research can provide new insights into some of the problems frequently encountered in family medicine.

Clinical pharmacoepidemiology

Prescribing is probably the most difficult issue to deal with in evidence-based medicine (Table 7). The techniques for corrupting knowledge that the pharmaceutical industry has put in place over the last thirty years are beyond comprehension,[16, 17, 18]. False data, deceived poor patients, false articles, purchased articles, purchased special issues in major journals, purchased known signatures, ghost writers, manipulated statistics, pressure of all kinds are all part of what is called institutional corruption[19]. Profit and care are here in complete contradiction. Whether it is the Mediator affair[20], the actions of the Sacler family and the opium addiction epidemic[21] or the deadly vaccine such as the Dengue fever vaccine[22], corruption has no limits.

The general practitioner must also be a very active agent in the follow-up of special therapies. He must set up a rapid communication network, based on mutual trust, with the specialists concerned. For Instance, biological agents and JAK inhibitors (Table X) are dangerous and unpredictable products. They sometimes give wonderful and spectacular results. It is important to emphasize the pharmacovigilance role of the general practitioner. It is important to emphasize the pharmacovigilance role of the general practitioner. As soon as a new product is prescribed, the use of side effect databases (such as Uptodate™) is indispensable. For instance, any unusual symptoms in a patient taking a biological agent may be a side effect that the general practitioner must learn to identify. It is necessary to get out of the culture of positivity and nonchalance that characterizes the drugs. Drugs are in principle dangerous and must be the object of constant suspicion. Doctors have been put to sleep by thousands of contacts with medical sales representatives whose mission has always been to glorify the advantages and mask the disadvantages of their blockbusters.

The role of physicians dedicated to clinical epidemiology has thus become totally essential in separating the wheat from the chaff, the true from the false, the mirage from the reality. Fortunately, scientists of integrity, gathered in the International Society of Drug Bulletins (https://www.isdbweb.org/) or in the Cochrane Centres (https://www.cochrane.org/), devote their energy to analyze and discuss clinical pharmacology issues with great determination. This knowledge is disseminated in journals such as the Revue Prescrire, Therapeutics letter, or the journal Minerva and dozens of others as well as on generally free access Internet sites such as those of CEBAM in Belgium.

But the pitfalls of clinical pharmacology are not always identified and sometimes biased opinions are then published[23]. As stated by Umberto Eco both authors and readers are involved in the management of knowledge disseminated through texts[24]. Today's technology allows rapid and factual exchanges between authors and readers. Therefore, it seems to me that the guidelines should be proposed as dynamic elements of evolving knowledge, always open to question. This is the meaning of the notes transmitted to the authors of these guidelines through Excel files from which some demonstrative examples have been extracted.

Very positive interactivity of our Finnish colleagues

The Finnish colleagues who are authors of EBMGs are very sensitive to the critical feedback received (Table 7). Interaction with the reader is an intrinsic part of their publishing philosophy. The EBMGs are updated annually. The files that I sent were all taken extremely seriously and a detailed response was provided in each case.

Table 9 Some examples of discussions in clinical pharmacology

Ebm #	EBMG Statement	Comments
ebm883 NSAIDs line 99 and 129	With the use of coxibs the incidence of symptomatic and complicated ulcers is approximately halved as compared with non-selective NSAIDs. Use protective medication or choose a COX-2 selective drug for patients at high risk for gastrointestinal adverse effects.	Difficult to understand the insistence of the authors of the guideline to promote the coxib as alternative in the case of gastric sensitivity. The benefit-risk balance of anti-inflammatory drugs in the coxib family is unfavourable (http://www.prescrire.org/en/3/31/46727/0/NewsDetails.aspx). Three Coxib are marketed in France Celecoxib, Etoricoxib and Parecoxib. The coxib are present in 142 texts of Prescrire, they are part of the drugs to be excluded (Rev Prescrire 2018; 38 (412): 140-141). (Rev Prescrire 2017; 37 (409): 825) (Rev Prescrire 2014; 34 (374): 902)
ebm 0897 Tobaco line 96	Varenicline and bupropion are effective in supporting smoking cessation.	Varenicline and Bupropion are associated to suicide risk (Rev Prescrire 2012 ; 32 (342) : 271) The risk-benefit ratio of these two products is unfavourable. Varenicline is a risky drug (Rev Prescrire 2018 ; 38 (415) : 373-376). Bupropion is not specific to smoking cessation. It is a marketing maneuver by the firm to revamp an old antidepressant

		otherwise sold under the name of Wellbutrin and previously known as amphebutanone (kind of amphetamin)
line 165	Nortriptyline is effective	In this guideline bupropion and nortriptyline are not graphically put together on equal terms. Nortryptiline is relegated to the end in the treatments rubrics others. Yet bupropion, re-commercialized under this name, has been known for a long time and still is under the name of Welbutrin. Welbutrin and Nortryptiline are both old and well known antidepressants. They are not very effective to help the patient in the nicotine withdrawal. It is not mentioned in the article that nicotine is a natural antidepressant and anxiolytic. It is therefore not surprising that in case of withdrawal antidepressants may in some cases help the patient. see Masco, H. L., Kiev, A., Holloman, L. C., Batey, S. R., Johnston, J. A., & Lineberry, C. G. (1994). Safety and efficacy of bupropion and nortriptyline in outpatients with depression. Current therapeutic research, 55(7), 851-863.

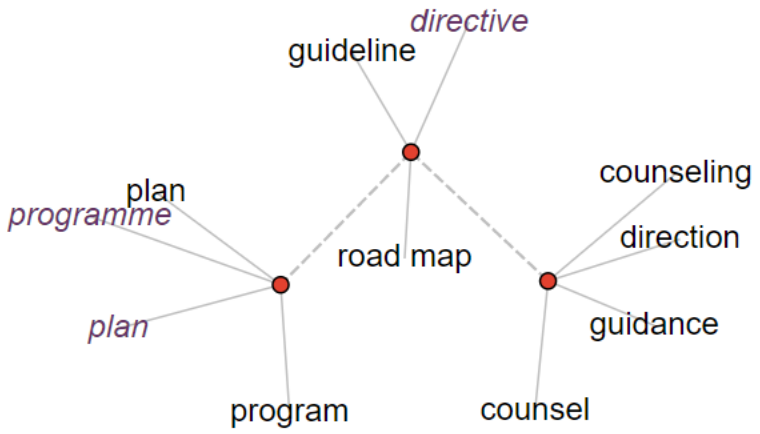
It was not my intention to carry out a systematic evaluation of the EBMGs. Therefore, I have no quantitative data to share. However, out of the few hundred guidelines verified, it seems to me that I must have sent a good hundred observations. The fact that the Finnish authors took these observations very seriously gives the active reader the feeling that he is part of the team that is trying every day to reduce the uncertainty of our profession. The 3 examples below show the reaction (right column)

Table 10 Some answers of the editors; Comments and answers in 3 guidelines

Ebm #	EBMG statement	Comments	Answer of the editors
Ebm702 Ado referal mental health	About 20–30% of adolescents have psychiatric problems.	Those numbers are usually quoted for the USA. The recent WHO report (2018) speaks about 29% of girls and 13% of boy "reported feeling low" more than once a week in the last week but this could be hardly presented as a mental health problem	The translation is a bit unfortunate, as the original speaks about "psychological disturbances", not "psychiatric problems". We'll revise the translation.
ebm719 Depression & other psych	The term 'dual diagnosis's often used to denote the combination of a substance abuse disorder and a mental disorder in the same patient <2>#</2>.	This terminology "dual diagnosis" is typical of psychiatric litterature and is not relevant for general practice / family medicine in which comibidity is the rule and not an exception. I suggest to write: The term 'dual diagnosis' <u>is often used in psychiatry</u> to denote the.... Consider ; Willadsen, T. G., Bebe, A., Køster-Rasmussen, R., Jarbøl, D. E., Guassora, A. D., Waldorff, F. B., ... & Olivarius, N. D. F. (2016). The role of diseases, risk factors and symptoms in the definition of multimorbidity–a systematic review. Scandinavian journal of primary health care, 34(2), 112-121.	OK, we agree and will amend the text.

894 Drug addi- ctions	If the craving for opioids seems to be reactivated after the withdrawal symptoms have been suppressed, naltrexone may be used to prevent a relapse	Naltrexone is no more active than placebo. See Minozzi, S., Amato, L., Vecchi, S., Davoli, M., Kirchmayer, U., & Verster, A. (2011). Oral naltrexone maintenance treatment for opioid dependence. Cochrane Database of Systematic Reviews,	The article is in need of updating. We will discuss with the author. There are some evidence summaries missing from this article, we will add them in between while waiting for the update.

Figure1 Concepts related to the term Guideline (*French in purple*). Visual Thesaurus ®
https://**www**.visualthesaurus.com/app/view



Discussion

In the course of a translation verification work from English to French, a few hundred EBMGs were reviewed and some were critically evaluated by the author. These criticisms were shared with the editors, who positively appreciated the feedback and introduced the necessary corrections in the EBMG updates.

As stated by Varonen and all[1]. "*There is evidence that guidelines are effective in changing the process and outcome of care*". Nevertheless, as family medicine is at the intersection of pathophysiological

knowledge and anthropology on the one hand, and multimorbidity is the rule in practice on the other hand, truly operative guidelines at the point of care are difficult to prepare and use.

The sources of guidelines are legion. Each organization tends to make its own, and in the end, they manage more or less the same knowledge. The strength of EBMGs lies not so much in their number (over 1000), but in their terminological management system, their availability in many languages, their use in Europe and beyond including Turkey and Ukraine, their rapid and frequent updating, their management by general practitioners in agreement with their organization, and from our experience by their ability to respond to their readers' suggestions and criticisms.

EBM is the integration of clinical expertise, patient values and the best evidence. The clinical epidemiology that is the basis of all best evidence proposals cannot replace expert opinion, experience, personal judgment and patient's advice when dealing with multimorbidity[25] in the biopsychosocial context that is central to family medicine. Therefore, the guidelines must be prepared by field practitioners, which is the characteristic of EBMGs, capable of searching for the most refined meta-analyses and tempering them with their clinical experience. Obviously, this type of guidelines cannot be evaluated by a system as precise and sophisticated as the AGREE II grid. The results of such an evaluation will inevitably be negative. It is understandable indeed that a very rigorous, formal and static analysis, as recently communicated by CEBAM experts[26], based on the AGREE system, does not give very favorable results. However, it must be emphasized, as stated by C. Smith, that "*so far, the AGREE II instrument has not provided a clear distinction between high-quality and low-quality clinical practice guidelines*"[27]. Of course, EBMGs can be denied the status of guideline as proposed in the CEBAM report, but the very term of guideline in English is subject to wide variations (Fig 1). We know that EBM training has "*some positive effects on knowledge and skills of healthcare professionals*"28 but in medicine there are no truths, there are only doubts, even in the evidence and EBM approach has to be taken cautiously and with humility[29].

Conclusion

Overall, the work done by the Finnish team of colleagues is very impressive. The EBMGs show the considerable extension of the field of family medicine and the difficulty of finding "evidence" in a field that brings together biomathematical science and anthropological knowledge. Our profession, family medicine, is also subject to enormous variation in practices and whatever their incompleteness, in our critical, dynamic and interactive vision, EBMGs, an European product, based on real GPs experience, are very welcome on a daily basis to support and delimit our uncertainties. One might wish that an interactive commentary mechanism would be available

online and allow readers to share their question with the authors, thus enhancing the interactivity of the experience.

References

[1] Varonen H, Jousimaa J, Helin-Salmivaara A, Kunnamo I. Electronic primary care guidelines with links to Cochrane reviews—EBM Guidelines. Family Practice. 2005;22(4):465-9.

[2] Joz Motmans, Inès de Biolley, Sandrine Debunne. Être transgenre en Belgique. Un aperçu de la situation sociale et juridique des personnes transgenres. Institut pour l'égalité des femmes et des hommes. (avec glossaire bilingue fr/nl) 2009 https://igvm-iefh.belgium.be/sites/default/files/downloads/34%20-%20Transgender_FR.pdf

[3] Clark EG. Natural history of syphilis and levels of prevention. British Journal of Venereal Diseases. 1954;30(4):191.

[4] Leavell HR, Clark EG. Textbook of preventive medicine. New York: McGraw-Hill; 1953.

[5] Wonca International Classification Committe. Wonca Dictionary of general/family practice. Maanedsskr ed. Bentzen N, editor. Copenhagen 2003.

[6] Jamoulle M. Quaternary prevention, an answer of family doctors to overmedicalization. International journal of health policy and management. 2015;4(2):61-4.

[7] Stacey RD, Strategic management and organisational dynamics: the challenge of complexity. 3rd ed. Harlow: Prentice Hall, 2002. Cited after Innes AD et al. Complex consultations and the 'edge of chaos' British Journal of general Practice 2005;55: 47-52

[8] Jamoulle M, Roland M, Bae J-M, Heleno B, Visentin G, Gusso G, et al. Ethical, pedagogical, socio-political and anthropological implications of quaternary prevention. Rev Bras Med Fam Comunidade. https://orbi.uliege.be/bitstream/2268/226522/15/RBMFC_en_mj.pdf

[9] Gomes, L. F., Gusso, G., & Jamoulle, M. (2015). Teaching and learning quaternary prevention. Revista Brasileira de Medicina de Família e Comunidade, 10(35), 1-1. doi:10.5712/rbmfc10(35)1050

[10] Donaldson, Molla S., Janet M. Corrigan, and Linda T. Kohn, eds. To err is human: building a safer health system. Vol. 6. National Academies Press, 2000. https://www.ncbi.nlm.nih.gov/books/NBK225182/

[11] Lilienfeld, Scott O., Irwin D. Waldman, and Allen C. Israel. "A critical examination of the use of the term and concept of comorbidity in psychopathology research." Clinical Psychology: Science and Practice 1.1 (1994): 71-83.

[12] Violan C, Foguet-Boreu Q, Flores-Mateo G, Salisbury C, Blom J, Freitag M, et al. Prevalence, determinants and patterns of multimorbidity in primary care: a systematic review of observational studies. PloS one. 2014;9(7):e102149

[13] Borsboom D. A network theory of mental disorders. World psychiatry. 2017;16(1):5-13.

[14] Lane C. Shyness: How normal behavior became a sickness: Yale University Press; 2008.

[15] Blech J. Inventing disease and pushing pills: Pharmaceutical companies and the medicalisation of normal life: Egully. com; 2006

[16] Healy D, Le Noury J, Wood J. Children of the Cure : Missing Data, Lost Lives and Antidepressants Samizdat Health Writers' Cooperative; 2020. 280 p.

[17] Light DW, Lexchin J, Darrow JJ. Institutional corruption of pharmaceuticals and the myth of safe and effective drugs. The Journal of Law, Medicine & Ethics. 2013;41(3):590-600.

[18] Rodwin, Marc A., Institutional Corruption and the Pharmaceutical Policy (December 6, 2013). Journal of Law, Medicine and Ethics, Vol. 41, p, 544, 2013, Suffolk University Law School Research Paper No. 13-25, Available at SSRN: https://ssrn.com/abstract=2298140

[19] Lessig L. "Institutional corruption" defined. The Journal of Law, Medicine & Ethics. 2013;41(3):553-5.

[20] Frachon I, Etienne Y, Jobic Y, Le Gal G, Humbert M, Leroyer C. Benfluorex and unexplained valvular heart disease: a case-control study. PloS one. 2010;5(4):e10128

[21] Keefe PR. "The family that built an empire of pain." The New Yorker. 2017

[22] Dans AL, Dans LF, Lansang MAD, Silvestre MAA, Guyatt GH. Controversy and debate on dengue vaccine series—paper 1: review of a licensed dengue vaccine: inappropriate subgroup analyses and selective reporting may cause harm in mass vaccination programs. Journal of Clinical Epidemiology. 2018;95:137-9.

[23] Turner EH, Matthews AM, Linardatos E, Tell RA, Rosenthal R. Selective publication of antidepressant trials and its influence on apparent efficacy. New England Journal of Medicine. 2008;358(3):252-60.

[24] Umberto Eco. Experiences in Translation. University of Toronto Press (2000)

[25] Campbell-Scherer, Denise. "Multimorbidity: a challenge for evidence-based medicine." Evid Based Med. 2010 Dec;15(6):165-6. doi: 10.1136/ebm1154.

[26] Vankrunkelsven P, Bekkering T, Goossens M, Lenaerts G, Schalley M, van Leeuwen E. Cebam Accreditation procedure Duodecim. Leuven, Belgium: Cebam Report; August 2020.

[27] Smith CA, Toupin-April K, Jutai JW, Duffy CM, Rahman P, Cavallo S, et al. A systematic critical appraisal of clinical practice guidelines in juvenile idiopathic arthritis using the appraisal of guidelines for research and evaluation II (AGREE II) instrument. PloS one. 2015;10(9):e0137180.

[28] Hecht L, Buhse S, Meyer G. Effectiveness of training in evidence-based medicine skills for healthcare professionals: a systematic review. BMC medical education. 2016;16(1):103.

[29] Perino, Luc. EBM et maladies chroniques. Humeur du 26/02/2019 https://lucperino.com/621/ebm-et-maladies-chroniques.html