cent of what does, or should, occur daily in the offices of Canada's family physicians.

Family doctors see patients with various values, resources, education levels, motivations, fears, preferences, degrees of risk aversion and levels of understanding. Their task is to define treatment goals consistent with all these patient attributes and then base management decisions on those goals. Guidelines, where available, should contribute to the discussion but should rarely be the sole determinant of a patient's treatment goals. Just as from a population health perspective we must weigh benefit with cost and lost opportunity, so must we do with each individual. Guidelines must inform us but should not necessarily compel us.

Unfortunately, as our primary care system comes under more and more stress, the family physician's ability to discuss individual treatment goals, as opposed to simply applying guidelines, is diminished. It is easier to titrate a drug to a guideline or laboratory end point. Furthermore, achievement of such end points is often easily measured and therefore this goal is attractive to administrators. This may not, however, be best for patients when evaluated in the context of treatment goals, population outcomes and system costs.

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Eddie Vos and Colin Rose are concerned that we overestimated the benefit of statins in women and older people in our analysis[1] of the Canadian recommendations for dyslipidemia management.[2] On the other hand, Jacques Genest and colleagues accused us of underestimating the benefit of statins.[3] Others suggest that statins have a small or no relative benefit in people at low risk of developing cardiovascular disease.[4]

Debates about the relative benefit of statins are welcomed but do not change the main findings of our analysis, because a patient's underlying risk of cardiovascular disease is in many cases more important than the precise relative risk reduction.[5] Statins have a very small absolute benefit in people at low risk and a very high absolute benefit in people at high risk. The 2003 Canadian dyslipidemia guidelines[2] inappropriately fail to recommend treatment of many Canadians at the highest risk of developing cardiovascular disease while recommending treatment of markedly more individuals at low risk.

If we assumed a higher relative benefit of statins in our analysis, as Genest and colleagues suggested, it would be even more apparent that the guidelines should recommend treatment to people at high risk who are not currently offered statins. However, because the baseline risk of death is very small in groups at low risk of developing cardiovascular disease, even with a higher relative benefit of statins very few deaths would be avoided in these people. If we assumed a lower relative benefit of statins, as Vos and Rose suggest, the absolute benefit in populations at low risk would no longer be extremely small (as we found in our original analysis) but would be virtually undetectable, or statin therapy would possibly even have to be considered harmful. In the end, the take-home message remains the same: statins are beneficial in people at high risk of cardiovascular disease and not clinically important in those at low risk.

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Correction

In a recent Review article,[1] the amount for saline, as indicated in the caption for Fig. 1, should have read 0.45% (not 45%).

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