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## Response

I appreciate the comments of Dr Anthony D'Urzo concerning the recent debate on the safety of β-agonist use in chronic obstructive lung disease (COPD).[1] I will respond to his comments here, but first I would like to point out that Dr D'Urzo has consultant arrangements with the pharmaceutical firms AstraZeneca and Novartis, has received grant support from AstraZeneca, and is on the speakers' bureau for Schering-Plough.[2] It is possible that Dr D'Urzo's comments are tempered by a serious bias toward promoting long-acting β-agonist use, especially that of formoterol, the long-acting β-agonist made by these companies.

As Dr D'Urzo pointed out, my recent analysis of β-agonist use in COPD[3] did not include the TORCH study,[4] but this is because it had not been published at that time. As I discussed in the debate rebuttal, this trial also showed an increase in respiratory deaths for β-agonist use compared with placebo, although it was not statistically significant. It is true that the TORCH trial found an 18% reduction in hospitalizations due to COPD,[4] while previous studies found no reduction in COPD hospitalizations with β-agonist use.[3] This is consistent with the evidence that β-agonists improve COPD symptoms but might increase respiratory mortality compared with placebo. It is important to compare these results with those of anticholinergic agents, which have been shown to reduce hospitalizations by 33% and respiratory mortality by 73%, compared with placebo.[3]

Another published analysis evaluated long-acting β-agonists in asthma and found a similar increase in respiratory mortality compared with placebo.[5] This adverse effect of β-agonists in obstructive lung disease is thought to be due, in part, to tolerance that develops to β-agonist use over time, although I agree with Dr D'Urzo that other factors might be involved.[6] As Dr D'Urzo points out, the FACET trial[7] was not included in my previous analysis, but that is because it was not a placebo-controlled trial. He also suggests that these safety concerns in asthma have centred on salmeterol and not formoterol, but pooled trial data have found a significant and equal increase in asthma hospitalizations for both formoterol and salmeterol, compared with placebo.[5]

Dr D'Urzo is worried that my arguments are not supported by the best available evidence because my literature review is not comprehensive and that this might introduce a serious bias. He suggests that my review might "serve only to confuse family physicians who are far too busy looking after patients to carry out comprehensive literature searches of their own." A full literature review was not possible in this short position statement, but I would like to assure the readers that my meta-analyses have included all of the randomized placebo-controlled trials that were available when the reviews were completed. The fact that *Canadian Family Physician* invited a debate on whether β-agonists should be avoided in COPD should alert readers that there might be some serious concerns about their safety. I myself am a practising general internist caring for patients with COPD, and I have no ties to the pharmaceutical industry. I personally use anticholinergic agents instead of β-agonists as the bronchodilator of choice in the treatment of these patients.

—*Shelley R. Salpeter MD FACP*
*San Jose, Calif*
*by e-mail*

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## Better generally?

I support Dr Hennen in opposing the move to call general practice a specialty.[1] In fact, I was one of a diminishing number of GPs present when Dr Irwin Bean of Saskatchewan argued against the change of name from *general practice* to *family medicine* in the early 60s—I tended to agree with him. However, I changed my letterhead, enthusiastically supported the renamed organization, became the first Certificant in Maple Ridge, BC, and was delighted to be honoured as a Fellow. But I think now that the term *family physician* is (sadly) too ambitious in the present context.

A primary care doctor has to be a generalist. She has to be ready to respond appropriately to any medical problem that presents to her on the street, in her office, or in the hospital. She is a generalist. She does not have the luxury of restricting her practice. The task is large and it is the first priority. Those physicians

who have the talent to add a special skill are to be admired, as long as it does not undermine the commitment to generalism.

Again, the task is large. Lawrence Weed, the founder of the problem-oriented approach to care, suggested many years ago that GPs should be paid more so that they could provide more time than specialists for their consultations. He pointed out, as Michael Balint and others have done, that adequate exploration of an unorganized illness requires adequate time. There is a danger in organizing illness prematurely and inappropriately, partly because the organization might determine later referral patterns.

The GP's tragedy in providing ongoing diagnosis and management is that she will always have an ethical imperative to refer patients to consultants whenever there is someone available who can do what is necessary better than she can. GPs are always having to let go. Of course, GPs do not and cannot know everything. The message is that the service must be determined by the needs of the patient, not by the FP's personal interests or preferences.

It is a tragedy and a disgrace that we have the current shortage of FPs/GPs. The decision, made by government approximately 15 years ago, to cut medical school enrolment was disastrously wrong. Ironically, the College of Family Physicians of Canada has probably inadvertently worsened the situation. I have personally been involved in some of the programs to foster improved quality of care, specifically improvements in medical record-keeping and patient-centred care. This, with the rapid advancement of knowledge and the emphasis on evidence-based medicine, has actually made the work of GPs/FPs more difficult. It has become more satisfying to care for fewer patients with greater depth.

Dr Bailey has suggested that practice by physicians in teams or networks can help to meet community needs, and this is true. The main benefit, however, will come from 24/7 access to FP/GP care for patients, better opportunities for collegiality, and better off-call time for doctors.

Multidisciplinary teams with allied health care providers can also be valuable. However, great care has to be taken in spelling out the scopes of practice and the formal relationships within the team. It is essential to ensure that the appropriate expertise and authority of the physician (in medical matters) is acknowledged and honoured. Also team functioning and decision making can be very time consuming. Finally, the dilution of personal responsibility can result in patient disempowerment when the team is perceived as "ganging up" on the patient.

I believe that organized medicine has been remiss in not recognizing sooner the dilemma of governments faced with escalating costs. It seems clear that primary care reform will require a change in the system of remuneration for physicians. I personally would support remuneration that fosters population as well as continuity of personal care by physicians, provides some predictability of income, and fosters teamwork. The UK system of payment by capitation (with appropriate enhancement incentives) seems to come closest to providing this.

*—Brian Dixon-Warren, MD, CCFP, FCFP*
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*by e-mail*

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## *Responses*

Dr Dixon-Warren has raised a number of important points related to current challenges in both family medicine education and practice. Many of these challenges are not unique to Canada and have been experienced by nations across the globe.

The recognition of family medicine as a specialty has been undertaken in many nations. Whether the term