

Practical research to improve outcomes

Manville et al have presented an insightful account of their transitional care unit intervention to improve outcomes for elderly care patients.¹

The authors were right to point out the limitations of their study. The main limitation was that it was conducted as a retrospective chart audit. However, this limitation was outweighed by the fact that this was real-world research with tangible, useful, and usable results. Questions about this field should not be so much about research methods but rather about how the research findings can be disseminated and taken up by other units. Before this happens a number of barriers need to be overcome. Perhaps the most important obstacle is to move the leadership agenda from the office environment, where chart audits might be conducted, to the ward environment, where leadership will have the greatest effect. This will require distributed leadership. All staff, including nursing and interdisciplinary staff, will need to be motivated to take part. They will need to be trained in quality improvement methods to drive forward change. They will need to be empowered not simply to reproduce the intervention described by Manville et al but rather to contextualize it for their own setting. Ultimately they will need to learn the skills of continuous measurement and plan-do-study-act cycles. Moreover, the culture of medicine and health care will need to change.

For too long, academic medicine has been almost exclusively about biomedical research. This has often been at the expense of paying adequate attention to those who run practical, outcomes-based research. All forms of research have their places, but the culture now likely needs to be rebalanced toward those engaged in more practical research.

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Competing interests
None declared

Reference
1. Manville M, Klein MC, Bainbridge L. Improved outcomes for elderly patients who received care on a transitional care unit. *Can Fam Physician* 2014;60:e263-71.

Contradicting the evidence for bisphosphonate therapy

The article by Brown et al was entirely unexpected.¹ Not because the information provided was groundbreaking, but because it was utterly supportive of bisphosphonate therapy in primary prevention of fractures in women who do not have very low bone density. This is despite high-quality reviews performed

by the Cochrane Collaboration, the Therapeutics Initiative, and other specialized evidence-based medicine (EBM) groups. As far as I can tell from these highly regarded groups, the evidence points to not using bisphosphonates for primary prevention unless a patient has very low bone density. As for secondary prevention, the evidence clearly points to a marginal but statistically significant benefit when the benefits outweigh the harms.

The information and methods used to perform this review included many trials that had clear bias and inconsistent data; they also minimized harm while falsely inflating the suggestion of benefit. I believe this likely points to the underuse of properly trained researchers able to synthesize an accurate review of the available information (that is, statistical consultants or co-authors).

Furthermore, there is reason to suspect substantial author bias, given that nearly every author of this paper received funding or has been a speaker or presenter for either Merck or (but most often, “and”) Novartis.

This was a supremely disappointing article, as many family physicians might be led down the path of “pseudo” or sham EBM with the sincere desire to practise unadulterated or true EBM.

I implore *Canadian Family Physician* to set a higher standard to prevent publication of purported reviews such as this one.

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Competing interests
None declared

Reference
1. Brown JP, Morin S, Leslie W, Papaioannou A, Cheung AM, Davison KS, et al. Bisphosphonates for treatment of osteoporosis. Expected benefits, potential harms, and drug holidays. *Can Fam Physician* 2014;60:324-3 (Eng), e197-207 (Fr).

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