Dangerous ideas

Top 3 proposals presented at Family Medicine Forum

The Dangerous Ideas Soapbox is a session presented annually at Family Medicine Forum (FMF) by the College of Family Physicians of Canada's Section of Researchers. This session invites innovative ideas that might advance our profession through family medicine research. There were 122 Dangerous Ideas submitted for the 2017 FMF in Montreal, Que. All submissions were reviewed and scored by 3 reviewers. Dangerous Ideas are judged by the reviewers, and later by the audience at FMF, on 3 criteria: 1) Is the idea novel? 2) Does the idea offer a challenge? and 3) Could the idea make a difference? Dangerous Ideas are selected for presentation at FMF based on reviewers' scores, and the innovators are required to attend the Dangerous Ideas Soapbox session to present and defend their idea in person. Each innovator gets 3 minutes to convince the audience of the importance and robustness of his or her idea. Presentations are followed by an 8-minute question-and-answer period.

At the 2017 Dangerous Ideas Soapbox session at FMF, we had 3 presenters in attendance. At the end of the session the audience was asked to applaud for the best and most robust Dangerous Idea. To measure audience members' applause, an "official" applause meter app was downloaded. Audience members had a lot of fun voting for their favourite idea. All 3 ideas received "fantastic" applause based on the applause meter; however, 1 idea reached the level of "amazing" and was declared the winner.

Fantastic idea: *Stop telling people to lose weight*

Weight loss does not work. Although many studies, even meta-analyses, suggest that it does, careful reading of these studies reveals that weight loss rarely lasts longer than 1 to 2 years, and study authors, in that time frame, can only measure surrogate outcomes like body mass index, reduced lipid levels, waist circumference, and blood sugar levels. Longer-term studies confirm what we already know from experience: most people will regain the lost weight and more. There is no proof that telling people to lose weight causes them to be healthier, happier, or live longer. On the contrary, repeated weight cycling appears to cause metabolic changes that make it even more difficult to lose weight. The frustration and negative self-image resulting from repeated "failure" to maintain the weight loss can have important consequences for patients' mental health and for the physician-patient relationship. For most people, the tendency to gain weight was established before they were born, and although the environment and individual behaviour play an important role, once the weight is established, it is next to impossible for most people to lose it permanently. There are exceptions but they are rare. Family physicians should stop telling patients that they need to do what almost none of them will succeed in doing. Instead, we should encourage all of our patients, regardless of their weight, to focus on making the changes that have been shown to alter important end outcomes of death and disease: increasing physical activity and choosing healthier foods. By doing this, some will lose weight and many will not, but they will all be healthier and, more important, they will leave our office with their dignity intact and our relationship with them will be preserved, allowing us to continue to work with them over the long term.

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SECTION OF RESEARCHERS • SECTION DES CHERCHEURS

Dangerous Ideas Soapbox

An idea that is not dangerous is unworthy of being called an idea at all.
Oscar Wilde

Do you have a dangerous idea about clinical practice that you think could make a difference to family practice? To health care delivery? Or to patient health?

The Dangerous Ideas Soapbox offers a platform for you as an innovator to share an important idea that is not being heard, but needs to be heard in the family medicine community. A dangerous idea could be very controversial, completely novel, blue-sky thinking, or something that challenges current thinking. But it must also demonstrate a commitment to moving the idea forward—to making a difference.

Dangerous Ideas cannot have been implemented or published yet and must be new. The author of the Dangerous Idea that is selected for presentation MUST be present during the session.

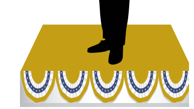
Each speaker will be given 3 minutes to present his or her idea. Audience members then have the opportunity to challenge the speakers, critique the ideas, and cast their vote to choose the most potent dangerous idea. Presented ideas will be published in *Canadian Family Physician.*

Submit your Dangerous Idea to **ideasubmission@cfpc.ca.**

Ideas will be accepted until **June 1, 2018**.

Submissions will be selected based on the following:
- creativity (is the idea new?),
- the challenge it offers (is the idea dangerous?), and
- suitability for dissemination (can the idea make a difference?).

Submissions must meet the following criteria:
- be in the form of a single paragraph,
- be a maximum of 300 words, and
- describe an idea and how it will make a difference to family practice, health care delivery, or to patient health.



What is your Dangerous Idea?

Fantastic idea: *Admit patients to hospital administratively so they can access medications*

The 3 million Canadians who cannot afford medicines could be administratively admitted to hospital—without ever actually setting foot in hospital—so that they can access lifesaving treatments. Family physicians could fulfil their duty to patients by facilitating access to treatments for diabetes, hypertension, HIV or AIDS, and other medicines that promote health for our vulnerable patients. The Canada Health Act requires governments to publicly fund medications for inpatients, and any patient can be administratively admitted (and put on leave) for the sole purpose of accessing publicly funded medicines. This approach is legal, ethical, and evidence-based. Why aren't we doing this right now?

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Amazing idea: *Blind medical school and CaRMS applications of all applicant names until interview selections are complete*

Compared with the general population, Canadian physicians have a skewed demographic profile, with less economic diversity; underrepresentation of black Canadians, First Nations people, and Hispanic Canadians; and an overrepresentation of Chinese and South-Asian Canadians. Because a person's name can reveal ethnicity, religion, sex, and perhaps even socioeconomic strata, it serves as a potential source of unconscious or unacknowledged bias in the minds of those who review the files. This bias can further exacerbate the asymmetry in medical schools and residencies. There is good evidence to show patient health and satisfaction improve with increasing similarity to their physicians; for this reason we should aim to produce a physician pool that more closely matches the general population. By eliminating applicants' names until after interview invitations are sent we would be following the example of numerous postsecondary institutions globally in an attempt to reduce the risk of discrimination for applicants and hopefully increase our medical communities' diversity so as to better serve our patients.

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The opinions expressed in commentaries are those of the authors. Publication does not imply endorsement by the College of Family Physicians of Canada.

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