this might not be a liability when it comes to participating in guidelines.

All that said, we believe this alone would have little effect on family physicians' ability to participate in developing their own guidelines. Family medicine–driven clinical research will undoubtedly improve the care of our patients. However, we think it is a mistake to assume that the ability to carry out solid clinical research alone will lead to inclusion of primary care clinicians in guidelines. Further, we would argue that researchers focused in specific areas might not be ideal guideline participants. The predisposition bias and overreliance on their own research would compound the known challenges experts seem to have when interpreting evidence.

For those of us who have participated in clinical practice guidelines led by non–family physician specialists, we have seen that the selection of those with specific areas of interest and research focus is a pervasive problem contributing to many of the common biases and issues seen in clinical practice guidelines. In addition, many of these same individuals have industry affiliations that can compound their biases. So, even as family physicians participate in more primary care research, we would argue that any researchers (primary care, specialty, doctoral, etc) should only play a minor role in any guideline team.

We would like to address 2 final issues raised by Dr D'Urzo.

First, critical appraisal skills alone cannot be considered the primary requisite for guideline inclusion. To clarify, critical appraisal often implies the ability to use simplified checklists of criteria to determine validity and reliability. We believe that the skills required for a thorough analysis of the medical literature and its application to primary care go far beyond that and those are the precise skills we require in guideline participants. Paradoxically, these skills are not consistently found in all researchers. So yes, critical analysis and application skills are necessary over research experience.

Finally, we do not believe it is unrealistic for our leadership, including the College of Family Physicians of Canada, to limit endorsement of guidelines targeting primary care that have not had adequate primary care involvement or governance. It is somewhat sad that any primary care clinician believes otherwise. It will take leadership from the highest levels to ensure this becomes the priority it so desperately needs to be—otherwise, this pervasive problem will never change.

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—Nicholas Pimlott MD CCFP
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Competing interests
None declared

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1. Pimlott N. For family physicians, by family physicians? *Can Fam Physician* 2016;62:699 (Eng), 700 (Fr).
2. Allan GM. Should primary care guidelines be written by family physicians? Yes [Debates]. *Can Fam Physician* 2016;62:705-6 (Eng), 708-10 (Fr).
3. Pimlott N. Golden age of family medicine research. *Can Fam Physician* 2015;61:489 (Eng), 490 (Fr).
4. Hogg W, Donskov M, Russell G, Pottie K, Liddy C, Johnston S, et al. Riding the wave of primary care research. Development of a primary health care research centre. *Can Fam Physician* 2009;55:e35-40. Available from: **www.cfp.ca/content/55/10/e35.full.pdf+html**. Accessed 2016 Oct 3.

Response

I appreciate the response by Drs Pimlott and Allan to my letter and I believe we share the same good intentions on the issues we are discussing.[1,2] There is no question that primary care has made great strides in research in recent years, but as I stated in my initial letter, the premise promoted by my colleagues is not consistent with the current realities that drive guideline development. Among the principles of family medicine[3] is included the notion that we are prudent stewards of scarce resources. Given the substantial economic implications of prescriptions generated in primary care, I would disagree that not participating in this type of research would not translate into a liability in terms of participation in guidelines. If family physicians were designing pharmacotherapeutic clinical trials with a better balance between internal and external validity with relevant primary care outcomes that translated into improved, cost-effective care, this would likely get the attention of policy makers and public payers and put us in a position where we might be more fiscally responsible for our clinical decisions. At a minimum, we would be more able to develop strategies to be more accountable for the health care costs we generate. The latter possibility would be an important foundational piece in moving toward the development of primary care guidelines by primary care physicians collaborating with colleagues in other specialties.

I also appreciate the suggestion that bias might come into play if researchers with focused interests (often non–family physician specialists) are driving the guideline agenda, but this is simply a symptom of the lack of primary care engagement. To suggest that the future might be different is fine, but it does not reconcile the current challenges we face and the trajectory we should launch to achieve our goals.

I have been and continue to be a strong supporter of the College of Family Physicians of Canada, but I am not able to let this loyalty stand in the way of providing constructive advice about how we might best position ourselves to be leaders in clinical care and research.

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Competing interests
Dr D'Urzo has received research, consulting, and lecturing fees from GlaxoSmithKline, Sepracor, Schering-Plough, Altana, Methapharm, AstraZeneca, ONO Pharmaceutical, Merck Canada, Forest Laboratories, Novartis, Boehringer Ingelheim (Canada) Ltd, Pfizer Canada, Skyepharma, KOS Pharmaceuticals, and Almirall.

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1. Pimlott N. For family physicians, by family physicians? *Can Fam Physician* 2016;62:699 (Eng), 700 (Fr).
2. Allan GM. Should primary care guidelines be written by family physicians? Yes [Debates]. *Can Fam Physician* 2016;62:705-6 (Eng), 708-10 (Fr).
3. College of Family Physicians of Canada. *Four principles of family medicine*. Mississauga, ON: College of Family Physicians of Canada; 2006. Available from: **www.cfpc.ca/principles**. Accessed 2016 Oct 3.

Correction

In the article "Euglycemic diabetic ketoacidosis in type 2 diabetes treated with a sodium-glucose cotransporter-2 inhibitor," which appeared in the September issue of *Canadian Family Physician,*[1] there was an error in the opening paragraph. The first 2 sentences should have read as follows:

More than 10 million Canadians are currently living with diabetes or prediabetes. Of those with diabetes, 90% have type 2 diabetes mellitus (T2DM).

We apologize for the error and any confusion it might have caused.

Reference

1. Jazi M, Porfiris G. Euglycemic diabetic ketoacidosis in type 2 diabetes treated with a sodium-glucose cotransporter-2 inhibitor. *Can Fam Physician* 2016;62:722-4 (Eng), e514-7 (Fr).

Correction

Une erreur s'est glissée dans le paragraphe d'introduction de l'article intitulé «L'acidocétose euglycémique dans le diabète de type 2 traité avec un inhibiteur du cotransporteur sodium-glucose de type 2» publié dans le numéro de septembre du *Médecin de famille canadien*[1]. Les 2 premières phrases auraient dû se lire comme suit:

Plus de 10 millions de Canadiens vivent actuellement avec le diabète ou un prédiabète. Parmi les personnes diabétiques, 90% ont un diabète de type 2 (T2DM).

Nous nous excusons de cette erreur et de toute confusion qu'elle aurait pu causer.

Référence

1. Jazi M, Porfiris G. L'acidocétose euglycémique dans le diabète de type 2 traité avec un inhibiteur du cotransporteur sodium-glucose de type 2. *Can Fam Physician* 2016;62:722-4 (ang), e514-7 (fr).