Dangerous ideas

Top 4 proposals presented at Family Medicine Forum

The Dangerous Ideas Soapbox is a session presented annually at Family Medicine Forum by the College of Family Physicians of Canada's Section of Researchers. Originating with the Society for Academic Primary Care in the United Kingdom, this forum invites innovative ideas as a demonstration of the first step toward advancing our profession through family medicine research. A Dangerous Idea presents a cutting-edge or out-of-the box proposal for how to improve family medicine care, why it is dangerous (ie, what is the challenge?), and why it matters. Sessions give the audience the opportunity to challenge the presenters, culminating in a vote to decide the most dangerous idea. Submissions for each year's Dangerous Ideas competition open in January. Do you have a "dangerous" idea that could improve your practice or the health of Canadians?

Here are the top 4 abstracts that were selected for the Dangerous Ideas Soapbox session held at Family Medicine Forum in November 2015 in Toronto, Ont. Following the finalists' presentations, audience members voted for which proposal they believed was the most compelling idea.

Fourth place: Caveat EMR vendors—toward an evidence-informed approach to health information technology

Electronic medical records (EMRs) do not improve care. Systematic reviews have found that there is still limited and conflicting evidence of substantial improvement in important patient outcomes with EMRs. There is also, despite various claims, very little solid evidence of superiority for any particular EMR product. We need to move toward an evidence-informed approach to information technology. Vendors must back their assertions with data and evidence. Their claims must come with solid and complete documentation. In an ideal world, we prescribe new medications based on randomized controlled trial evidence of important improvements in patient outcomes; health information technology should be no different. A critical requirement for the generation of evidence is measurement. We need data for measurement. The vendors must have

- a product that is able to provide an extract of all data from the EMR database for export into a format suitable for analysis, independent of vendor actions or control and free of vendor costs;
- timely provision and updates of a data dictionary about their product; and
- timely provision and updates of an entity relationship diagram for their EMR database.

Similar to past pharmaceutical sales and claims, the EMR landscape across Canada includes unsupported assertions of effectiveness and efficiency rather than evidence of improvement in outcomes. Vendors must release the data locked in their product to enable us to measure our care; data hostaging should become a relic of the past. Let us challenge the vendors and have them provide proof and data that their products and activities support effective and efficient care for our patients through intelligent use of the information we enter in our EMRs. In God We Trust; everyone else must have data. Caveat EMR vendors.

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These abstracts have been peer reviewed.
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THE COLLEGE OF FAMILY PHYSICIANS OF CANADA | LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA
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?

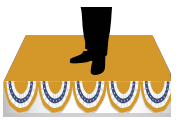
The Dangerous Ideas Soapbox offers a platform for you as an innovator to share an important idea that is not being heard, but needs to be heard in the family medicine community. A dangerous idea could be very controversial, completely novel, blue-sky thinking, or something that challenges current thinking.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

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 Jamie Jensen at **jj@cfpc.ca.**
Ideas will be accepted until **June 1, 2016**.

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?

Third place: Canada does not need more physicians who specialize in geriatric medicine

The population of Canada is aging. The population older than 65 years of age is expected to double in the next 25 years; in 2055 approximately a quarter of Canadians will be older than 65. However, we argue that Canada does not need more physicians who specialize in geriatric medicine. What we need is for all physicians—surgeons, gynecologists, and especially family physicians—to have enhanced competence in caring for older patients. The American Geriatrics Society has developed lists of "minimum" or "core" geriatric competencies for residents in emergency medicine, internal and family medicine, psychiatry, and surgery, de-emphasizing reliance on geriatric specialists for common medical problems experienced by older patients. Family physicians in Canada should follow that lead as we face the privilege and challenge of caring for more elderly patients on a daily basis. Moreover, as family medicine is a community-based discipline, family physicians must adapt to the changing needs of our aging communities. One way to encourage family physicians to embrace their role as care providers to Canada's aging population is to prioritize education in geriatric care during family medicine residency. Family physicians should feel as comfortable on the first day of practice with the complex, homebound, frail older person as they do with pregnant women or healthy newborns. Increasing geriatric medicine curriculum requirements in family medicine residency programs would ensure that new family physicians are prepared to care for the elderly right from the start of their careers. For family physicians already in practice, a priority should be increasing easily accessible, high-level continuing medical education opportunities focused on core geriatric topics. Fundamentally, we argue that not all family physicians have to become geriatric specialists, but all family physicians must be "geriatric friendly."

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Second place: No more unfilled prescriptions—bringing national pharmacare to Canada

Imagine a world in which every single prescription you wrote actually got filled. Today, chronic diseases are the main medical cause of morbidity and mortality, and medications are often the main intervention we have at our disposal. However, in our publicly funded health care system, medications that are covered while in hospital are no longer covered when patients go home. Doctors' visits are covered, but the medications they recommend are not. For this reason, 1 in 10 people in Canada have gone without filling a prescription owing to cost. This is unacceptable but there is a way to do things better. We know that instituting a national pharmacare program in Canada in which medications are covered under our public plan would be fairer, improve health outcomes, and actually save us money. This is because the power of bulk buying, price negotiations, and centralization of processes increases efficiency. This alone can save Canadians more than an estimated 11 billion dollars, which does not even take into account potential savings in prevented emergency department visits and hospitalizations. Every other industrialized nation in the world with universal health care is doing it but us. National pharmacare would revolutionize our ability to treat our patients and substantially improve health outcomes. As family physicians on the front lines of health care, getting involved in the fight for national pharmacare is a dangerous idea whose time has come. The right thing to do is also the smart thing to do, so let's do it.

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First place: Making family physicians primary in primary care guidelines

Family medicine is at a crossroads. Family physicians provide by far most of the care delivered in Canada (*Can Fam Physician* 2015;61:449-53), but are we part of the teaching and leadership? Research indicates that only a small minority (17%) of family physician continuing professional development is delivered by family physicians. Even more concerning is that family physicians make up the minority (17%) of contributors to primary care guidelines. In contrast, non–family physician specialists account for 54% of the contributors to primary care guidelines—a number that increases in national guidelines and those funded by the pharmaceutical industry. Non–family physician specialists also have almost double the chance of having a conflict of interest compared with family physicians (*Can Fam Physician* 2015;61:52-8). Other research shows that non–family physician specialists are more likely to write biased reviews, and the more focused their practice the higher risk of bias. Further, other research shows that the proportion of other specialists to family physicians alters the recommendations in guidelines. These findings should be viewed in light of the Institute of Medicine's document "Clinical practice guidelines we can trust." These recommendations include finding a better balance in contributors to reflect end users and minimizing potential for conflict of interest. I believe that many of the challenges in applying primary care guidelines might stem from many of these limitations. My dangerous idea is that primary care should take control of its own guidelines. We should be chairs of the guideline committees, make up at least 50% of the contributors, and generate the relevant clinical questions for the guidelines (for which we will lead the evidence review). This will ensure relevance to primary care, minimize potential for conflict of interest, minimize bias, and improve evidence application. No one understands primary care like family physicians, and only family physicians can improve it.

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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.