Misleading communication aid

The systematic review comparing various osteoarthritis treatment options is a valuable summary of the evidence and I thank the authors for their work.[1]

Unfortunately the simplified decision aid with the page of 100-face diagrams is misleading and does not accurately and clearly summarize the evidence collected.[2] *Meaningfully improved pain* is not defined in the article so it is not clear exactly what is being measured in the diagrams. It looks as though 94% of the patients to whom I prescribe exercise will have improvement (54% of them owing to the exercise and 40% related to natural variation in disease severity). This leaves only 6% who will get worse or stay the same. One has to read the text in detail to discover the statistical compromises that resulted in this implausible finding.

The accompanying table lists opioids as being likely harmful, but the 100-face diagram makes them look modestly beneficial. Only the text makes it clear that this is because the diagram represents short-term outcomes and the table focuses on long-term outcomes (which is appropriate for a chronic disease).

Glucosamine, chondroitin, and viscosupplementation appear twice on the page of 100-face diagrams, but only the text explains that the benefits are unclear because industry-funded trials with positive results could not be replicated.

I am glad that I read the whole article and it will help me with quantifying benefits when sharing decision making with my patients, but I will definitely not be using the 100-face diagram as a communication aid. It is not a good summary of the evidence so carefully collected in the systematic review.

—*Roger Suss* MD CCFP(EM) FCFP
Winnipeg, Man

Competing interests
None declared

References

1. Ton J, Perry D, Thomas B, Allan GM, Lindblad AJ, McCormack J, et al. PEER umbrella systematic review of systematic reviews. Management of osteoarthritis in primary care. *Can Fam Physician* 2020;66:e89-98. Available from: **https://www.cfp.ca/content/66/3/e89**. Accessed 2020 May 11.
2. Lindblad AJ, McCormack J, Korownyk CS, Kolber MR, Ton J, Perry D, et al. PEER simplified decision aid: osteoarthritis treatment options in primary care. *Can Fam Physician* 2020;66:191-3 (Eng), e86-8 (Fr).

Response

We thank Dr Suss for his letter regarding our osteoarthritis decision aid[1] that accompanies the systematic review[2] and are pleased he finds the systematic review a valuable summary.

Dr Suss states we did not define *meaningfully improved pain* but in the third sentence of the decision aid article we state meaningful reductions in pain are "generally defined as a 30% or more reduction in pain, but specific definitions of *clinically meaningful* vary widely across studies."[1] The decision aid itself does include this estimate (about 30%) in the title to assist clinicians when discussing treatment options with their patients.

Dr Suss raises some other specific concerns and states a number of times that he had to read the whole article to understand the tools. While the PEER (Patients, Experience, Evidence, Research) Group is always seeking to simplify evidence and make it as accessible as possible, we believe that a quick review of the instructions for any tool or resource is not unreasonable. The article is 368 words (about 100 more than Dr Suss' letter) before the graphics. That is substantially shorter than most available guidelines and evidence synopses.

We address the specific concerns raised:

The exercise benefit is implausible. Yes, it likely is. How to apply the meta-analyses response rate results is much debated. Pulling numbers directly from the metagraph is easiest, uses the raw absolute numbers, and offers a good approximation in most cases. However, many evidence experts believe we should apply the relative risk (or rate ratio) to standardized numbers (drawn from a population). In decision aids, this allows the relative benefits of interventions to be more easily compared but still presents absolute numbers. For our standardized control (placebo) event rate, we used the average of control rates across all studies. It is not without other limitations, however. The foremost is that interventions with good relative benefit but a comparatively low control rate (like exercise) will appear more effective. On the other hand, studies of topical nonsteroidal anti-inflammatory drugs had a higher placebo response rate, so conversion in those cases leads to a slight reduction of the absolute effect.

While we recognize the positive effect of activity on osteoarthritis is likely inflated by this methodology, we believe that the downside is more people might attempt increased activity. If the overestimation encouraged even a few more people to increase their activity, the

Top 5 recent articles read online at cfp.ca

1. Clinical Review: Pharyngitis. *Approach to diagnosis and treatment* (April 2020)
2. Clinical Inquiries: Efficacy of a low-carbohydrate or ketogenic diet in preventing patient morbidity and mortality (April 2020)
3. Research: PEER umbrella systematic review of systematic reviews. *Management of osteoarthritis in primary care* (March 2020)
4. Praxis: Update to the Preventive Care Checklist Form© (April 2020)
5. Tools for Practice: Antidepressants for irritable bowel syndrome (April 2020)

net gains would only be positive across multiple health outcomes. Additionally, we wanted to apply the methodology equally across all interventions and selectively applying the results would add further bias.

Opioids are potentially harmful. From the sensitivity analysis of our systematic review, trials shorter than 4 weeks found benefit in opioid therapy. There was no benefit at 4 to 12 weeks or beyond 12 weeks. When all the data were pooled, the short-term trials drove the results to a (marginally) positive benefit. As the evidence team, we believed it was not appropriate to select only certain results for some therapies and not for others. However, we wanted to provide clinicians and their patients with information to recognize that while opioids might have small benefit in the short term, they likely do not have benefit as a long-term pain medicine but do have potential for harm with long-term use.

Glucosamine, chondroitin, and viscosupplementation appear twice. As above, we believed it would be important for users of the tool to understand the challenges in interpreting the results of studies of these interventions. Many readers will know the evidence is, at best, conflicting. By showing clinicians the lack of effect in publicly funded trials, we gave them and their patients an opportunity to reflect on what that might mean for them. Some will not care and will choose to value the results of all trials while some will place more value on the results of publicly funded studies. We wanted to give clinicians and patients the option to see both and determine for themselves.

We are currently completing a series of large systematic reviews of common chronic pain conditions in primary care (osteoarthritis, back pain, and neuropathic pain). Once these are done, we will create a simplified guideline on chronic pain management in primary care. After the guideline committee is formed, we hope to provide more clarity. As the evidence team, we try to minimize the influence of our potential biases by avoiding overinterpretation of the systematic review results, preferring instead to simply present the results found with the caveats identified. We will select guideline committee members who (like us) do not have financial conflicts of interest. They will be encouraged to make recommendations considering the complexities of all the evidence—particularly regarding opioids, chondroitin, glucosamine, and viscosupplementation. The PEER Group prefers that a guideline committee of family physicians and other clinicians assist in the final application of the evidence. For now, we provide the best available evidence and try to minimize our potential influence or bias on interpretations.

In many ways, we are asking clinicians (and patients) to be their own guideline committee with all the available evidence to make good choices.

Even when we start with pooled randomized controlled trials, there is no perfect solution for taking data and translating them to easy-to-understand numbers, particularly when we try to present all the information and minimize any biases (those in the studies and those we might possess). Many other society and groups prefer instead to provide no actual numbers or comparisons, instead using vague terms, advocating some therapies over others, or just listing options. In these cases, with limited or nonexistent information, we cannot come close to an informed choice. The approach we used is a compromise, derived from the best available research on how to present numbers and data to patients,[3] allowing them to make the best possible decisions.

—G. Michael Allan MD CCFP
—James McCormack PharmD
—Michael R. Kolber MD CCFP MSc
—Joey Ton PharmD
—Adrienne J. Lindblad ACPR PharmD
—Christina S. Korownyk MD CCFP
Edmonton, Alta

Competing interests
None declared

References

1. Lindblad AJ, McCormack J, Korownyk CS, Kolber MR, Ton J, Perry D, et al. PEER simplified decision aid: osteoarthritis treatment options in primary care. *Can Fam Physician* 2020;66:191-3 (Eng), e86-8 (Fr).
2. Ton J, Perry D, Thomas B, Allan GM, Lindblad AJ, McCormack J, et al. PEER umbrella systematic review of systematic reviews. Management of osteoarthritis in primary care. *Can Fam Physician* 2020;66:e89-98. Available from: **https://www.cfp.ca/content/66/3/e89**. Accessed 2020 May 11.
3. Zipkin DA, Umscheid CA, Keating NL, Allen E, Aung K, Beyth R, et al. Evidence-based risk communication: a systematic review. *Ann Intern Med* 2014;161(4):270-80.

We must support comprehensive generalism

It was with both surprise and dismay that we read the editorial "The exhausted physician" by Dr Ladouceur in the April 2020 issue of *Canadian Family Physician*.[1]

First, to start with a quote that speaks only to men is completely inappropriate at this time. This quote stands in stark contrast to the article by Dr Lemire at the end of the journal, which discusses the importance of improving the culture of medicine, and in which she highlights that a part of the dissonance experienced currently is related to the "traditional male-dominated culture of medicine at a time when more women than men have entered the profession."[2] The College of Family Physicians of Canada and *Canadian Family Physician* need to lead the way in minimizing the dissonance, and the quote chosen for this editorial is not helpful, neither in minimizing the dissonance nor in reflecting the content of the article that follows it.

Dr Ladouceur's assertions about the role of family physicians are completely inaccurate and are unreferenced. It is not accurate to say that there is an expectation that "in each area and skill set, family physicians are expected to be on par with their other specialist colleagues."[1] To assert that "basically, family physicians are expected to know everything, do everything, and behave in an exemplary manner at all times and in all situations … they must be perfect at all times and in all things!"[1] is to completely misunderstand the role of comprehensive generalists who must indeed be comprehensive in their practice, but must be comfortable with uncertainty. I urge Dr Ladouceur to read the Family Medicine Professional Profile,[3] which speaks to the need for comprehensiveness and the relational continuity that creates high-value care. The professional profile says nothing about an expectation of being "on par with … other specialist colleagues who work in much more specific fields."[1] Comprehensiveness itself has, however, been shown to be an antidote to the burnout to which Dr Ladouceur is alluding by discussing "exhaustion."

This is not the time, in our opinion, to minimize what we are capable of. This is the time to call for the best and brightest to support family medicine. We work in complex environments, lead teams, manage uncertainty, strive to meet the needs of patients at a population level sometimes across multiple settings, and support whole communities. None of this is easy, and indeed it can be cognitively fatiguing. But, in our opinion, it is also deeply satisfying, rewarding, and meaningful work.

We need to understand family medicine as foundational to high-functioning health care systems, and we must reinforce that message at all levels of the health care system. We need to ensure that we understand what it means to focus on the fourth arm of the Quadruple Aim. To do this—to ensure improved clinician experience—we need to ensure that all family physicians have access to the infrastructure supports they need to do this work, access to the committed specialist support they need to manage and coordinate the care of patients with complicated illnesses, and access to the training they need to effectively lead teams. We also must acknowledge and push for support of the value of teams of family physicians working together to meet the needs of the community through a collective generalism, while they maintain the relational continuity that matters to patients and contributes to the cost effectiveness of the health care system.

The College of Family Physicians of Canada, at every level of the organization, including the editorial pages, must stand up for the future of family physicians and advocate for what we need to do the work that we are well positioned to do.

—Sarah-Lynn Newbery MD FCFP FRRMS
Marathon, Ont
—Jennifer Young MD CCFP(EM) FCFP
Collingwood, Ont

Competing interests
None declared