majorité des ressources : invalidités musculosquelettiques, problèmes de santé mentale et symptômes inexpliqués. À l'aide de cas fictifs mais réalistes, la série se penchera sur le parcours de vie des clients militaires et des clients de la GRC du Ministère, des plus jeunes aux plus âgés. La série vise également à expliquer la collaboration des médecins de famille avec les équipes multidisciplinaires de services aux clients et les médecins des bureaux de district du Ministère partout au pays pour aider leurs patients et clients communs à avoir accès à la réadaptation, à l'indemnisation et aux avantages médicaux.

*—James M. Thompson MD CCMF(MU) FCFP*
*Conseiller médical, Direction de la recherche, Anciens Combattants Canada*
*—Roland Chiasson MD*
*Agent médical national, Anciens Combattants Canada*
*—David Pedlar PhD*
*Directeur, Direction de la recherche, Anciens Combattants Canada*
*Ottawa, Ont*

## Adherence to osteoporosis guidelines

A research paper published in the August issue of *Canadian Family Physician* correctly states that many family physicians are not following the 2002 Clinical Practice Guidelines for the Diagnosis and Management of Osteoporosis in Canada.[1] The abstract concludes, "Higher rates of bone mineral density screening and more widespread treatment of osteoporosis could prevent many fractures among these patients."[1]

Family physicians in Canada are well aware of the Canadian osteoporosis guidelines and of risk factors for and management of osteoporosis. However, most of us in clinical practice are also aware that bone mineral density studies are not accurate predictors of who will and who will not get fragility fractures.[2] The results of bone mineral density studies, therefore, often make little difference to our recommendations to our patients.

The Canadian Osteoporosis Society suggests everyone 65 years of age and older should have bone mineral density testing. This recommendation is clearly a waste of scarce medical resources. As the 2002 consensus document published in the *Canadian Medical Association Journal* readily discloses, the Canadian Consensus Guidelines were sponsored by funding from the Canadian Dairy Foundation and major drug companies.[3]

I suggest the reason that most family physicians do not comply with the 2002 Osteoporosis Society of Canada Guidelines is not because of physician ignorance but because of wisdom and a need to adhere to evidence-based, sensible, and sound clinical practice. More recent evidence, for example, suggests that excess calcium increases morbidity in our elderly patients.[4]

Family physicians need to do what is best for their patients and not what is best for special-interest groups.

*—John Sehmer MD*
*Vancouver, BC*

**References**

1. Cheng N, Green ME. Osteoporosis screening for men. Are family physicians following the guidelines? *Can Fam Physician* 2008;54:1140-1.e1-5.
2. Stone KL, Seeley DG, Lui LY, Cauley JA, Ensrud K, Browner WS, et al. BMD at multiple sites and risk of fracture of multiple types: long-term results from the Study of Osteoporotic Fractures. *J Bone Miner Res* 2003;18(11):1947-54. Erratum in: *CMAJ* 2003;168(4):400. *CMAJ* 2003;168(6):676. *CMAJ* 2003;168(5):544.
3. Brown JP, Josse RG. Scientific Advisory Council of the Osteoporosis Society of Canada. 2002 clinical practice guidelines for the diagnosis and management of osteoporosis in Canada. *CMAJ* 2002;167(10 Suppl):S1–34.
4. Bolland MJ, Barber PA, Doughty RN, Mason B, Horne A, Ames R, et al. Vascular events in healthy older women receiving calcium supplementation: randomised controlled trial. *BMJ* 2008;336(7638):262-6. Epub 2008 Jan 15.

## Response

Adequacy of the guidelines is not the only issue.

Dr Sehmer correctly states that the 2002 Clinical Practice Guidelines for the Diagnosis and Management of Osteoporosis in Canada likely need updating to reflect our current understanding of the evidence for and against screening and treatment, particularly in men. Recently meta-analyses have concluded that treatment of osteoporosis does reduce the risk of nonvertebral fractures, which has been demonstrated in a small number of trials for men, but the very low numbers of men studied limit the power to draw definitive conclusions about the efficacy of treatment—more research is therefore needed in this population.[1,2] As a result, several recent publications have concluded that screening high-risk men is probably both clinically effective and cost effective, but suggest that screening be initiated based on either an estimation of absolute 10-year fracture risk as determined by a risk calculator such as FRAX (an on-line tool developed at the University of Sheffield in the United Kingdom) or a combination of other high-risk indicators, such as weight loss, low physical activity, or more advanced age (somewhere in the range of 70 to 80 years).[3-6]

As discussed in our article, there are many reasons that screening might not be carried out, with physician dissatisfaction with the quality of guidelines being an important factor. This study was a first step in describing the degree of application of this particular set of guidelines. Further studies on the reasons behind the results would be required to determine with certainty why so few men are screened, but informal feedback from colleagues suggests the guidelines themselves are not the only limiting factor. We also noted that screening rates were not substantially better for men older than 80 years of age, the group for which there is stronger evidence to support screening and treatment. We stand by our conclusion that improved screening strategies have the potential to reduce the rate of osteoporotic fractures in Canadian men.

*—Michael E. Green MD MPH CCFP*
*Kingston, Ont*

**References**

1. MacLean C, Newberry S, Maglione M, McMahon M, Ranganath V, Suttorp M, et al. Systematic review: comparative effectiveness of treatments to prevent fractures in men and women with low bone density or osteoporosis. *Ann Intern Med* 2008;148(3):197-213. Epub 2007 Dec 17.
2. Sawka AM, Papaioannou A, Adachi JD, Gafni A, Hanley DA, Thabane L. Does alendronate reduce the risk of fracture in men? A meta-analysis incorporating prior knowledge of anti-fracture efficacy in women. *BMC Musculoskelet Disord* 2005;6:39.
3. Qaseem A, Snow V, Shekelle P, Hopkins R Jr, Forciea MA, Owens DK, et al. Screening for osteoporosis in men: a clinical practice guideline from the American College of Physicians. *Ann Intern Med* 2008;148(9):680-4. Erratum in: *Ann Intern Med* 2008;148(11):888.
4. Liu H, Paige NM, Goldzweig CL, Wong E, Zhou A, Suttorp MJ, et al. Screening for osteoporosis in men: a systematic review for an American College of Physicians guideline. *Ann Intern Med* 2008;148(9):685-701.
5. Schousboe JT, Taylor BC, Fink HA, Kane RL, Cummings SR, Orwoll ES, et al. Cost-effectiveness of bone densitometry followed by treatment of osteoporosis in older men. *JAMA* 2007;298(6):629-37.
6. Kanis JA, McCloskey EV, Johansson H, Strom O, Borgstrom F, Oden A, et al. Case finding for the management of osteoporosis with FRAX—assessment and intervention thresholds for the UK. *Osteoporos Int* 2008;19(10):1395-1408. Epub 2008 Aug 28.

## Hospitalists

I agree with Dr Samoil that hospitalists improve hospital care.[1] In Cambridge, Ont (population 125 000), in 2000, we had 55 FPs overseeing 60 patients in the medical ward. This was inefficient. Eighty percent of those FPs resigned and we got hospitalists, who have done a wonderful job. Our FPs still take calls for the hospitalists and are encouraged to see their own patients if they want, and 20% still do.

It's important to note that, in 2000, Ontario FPs were being paid $17 per hospital visit. When you think that half goes to overhead and half of what's left goes to taxes, we were getting $5 for the sickest patients in our practice and had to pay $500 per year to park! Also, we were being forced to take on orphan patients whom we had looked after in-hospital at our practices, in spite of being way over our comfort level.

So you can see why busy FPs get out of hospital work. As one older FP said to me, "the hospital gives me 2% of my pay and 98% of my problems."

*—John W. Crosby, MD CCFP(EM) FRCPC*
*Cambridge, Ont*

**Reference**

1. Samoil D. Are inpatients' needs better served by hospitalists than by their family doctors? Yes [Debates]. *Can Fam Physician* 2008;54:1100,1102 (Eng); 1104,1106 (Fr).

## Open dialogue

I found the debate on hospitalists[1,2] interesting. Unfortunately, it is a rather irrelevant issue for those of us practising in urban areas. Family physicians have not been looking after inpatients at my community hospital for years and I do not see that changing in the future.

A more relevant issue for me and others in my community is the lack of communication between physicians with respect to our hospitalized patients. I was hoping that having hospitalists who were also family physicians would improve this situation. Unfortunately, at my hospital,