Response

I appreciate that my March Vital Signs[1] inspired Dr Saiger's letter. Dr Saiger's commitment to palliative care and the patients she serves is to be commended. However, her recommendation that the College of Family Physicians of Canada recognize special interests for FPs as specialty or subspecialty areas does not take into consideration the constitutional mandate of our College and its responsibilities to the role it has been chartered to play. Our College is the voice of family medicine, and it is responsible for establishing and monitoring the standards of training and continuing education for 1 specialty in Canada: family medicine. Governments and the public of Canada support our discipline's programs in Canada's 17 medical schools with the goal of producing FPs, most of whom are then expected to provide personal comprehensive continuing care for the patients they serve in communities in all parts of our nation. The Royal College of Physicians and Surgeons of Canada carries a parallel responsibility for all other specialities. While our College also has the latitude to establish standards for educational programs aimed at enhancing the skills of FPs and to recognize FPs for the competencies they demonstrate as add-ons to their broad scope of core functions as FPs (which we will be doing through our Certificates of Added Competence), the priority is that this should be done as part of comprehensive care family medicine rather than as programs leading to practices concentrated in a single, more focused clinical area (with exceptions for those who might play more complex lead roles in clinical, teaching, or research programs). The bottom line is that we are not in the position constitutionally to offer training or other pathways leading to "specialty" standing in Canada in any area other than family medicine.

Dr Saiger rightfully recognizes that family medicine must change in keeping with the transformations taking place in the world around us. Our Board shares this perspective and has, in fact, spent the past several years studying the changes we need to make and meeting with other stakeholders to determine the directions we should take to ensure that Canadians receive the best possible care from their FPs. The overwhelming direction of the feedback we have received has been consistent—be it from most of our members, from medical students and residents, from our peers in other health professions, from governments who play considerable roles in supporting our family medicine training programs and our practices, or most important from the public, our patients. It has reinforced the following:

- Family medicine is a recognized specialty equal to all other medical disciplines within Canada's academic medicine world.
- Our College's new Triple C Competency-based Curriculum (focused on enshrining broad-scope comprehensive continuing care centred in family medicine) will play a leading role in the future of medical education in Canada.
- Increasing numbers of medical school graduates are now selecting family medicine as their preferred career choice (35% of graduates made it their first choice in 2012[2]).
- Canadians have repeatedly informed surveyors that having personal FPs who will provide and coordinate all of their health care needs is valued as one of their highest priorities.

The College's introduction of the Patient's Medical Home vision of patient-centred, team-based care in practices where every person has a family doctor is being welcomed and supported across the nation. Strengthening comprehensive continuing care provided by FPs—

shown by Starfield et al[3] to be the key to producing the best population health outcomes—is not a thing of the past. It will remain front and centre as one of the most important core and defining attributes of our discipline and a priority for our College.

As part of this commitment, FPs with special interests and skills in areas like palliative care can and should be well supported by our College. They should be part of our Triple C Competency-based approach to training and lifelong learning, and they should be contributing to team-based care in Patient's Medical Home practice models. Family doctors are being welcomed in large numbers to be part of our College's new Section of Family Physicians with Special Interests or Focused Practices so that they can network, as well as learn from and plan educational experiences with colleagues who have similar practice profiles.

Some of the programs in the section will focus on developing formal training or practice experiences that will serve as part of pathways toward Certificates of Added Competence, which are achieved by those who demonstrate competencies in areas like palliative care that they are adding on to their core scope of practice as FPs. While we will help support members who become or are already leaders in their fields and who practise solely in areas of focused interest, our main objective for the future is to train, recognize, and support FPs who incorporate their enhanced or added skills into broader-scope family practices. Our vision is a future in which comprehensive care FPs (ie, specialists in family medicine), including some with added skills in defined areas, will work together with our Royal College specialist colleagues to provide the full spectrum of medical care that Canadians need.

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Competing interests
None declared

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Hypertension revisited

Siu and colleagues' letter[1] in the January issue of *Canadian Family Physician* misrepresents original clinical trial data, our review on blood pressure (BP) treatment in people with diabetes,[2] and the Canadian Hypertension Education Program (CHEP) hypertension recommendations process. Our review,[2] as indicated in its title, "Hypertension in people with type 2 diabetes. Update on pharmacologic management," focused on the pharmacologic management of hypertension in diabetes, partnering with CHEP's recommendations for a comprehensive care approach that includes other modifiable risk factors for vascular disease (dyslipidemia, obesity, unhealthy eating, lack of activity, and lowering of glucose).[3] As such, we reject Siu and colleagues' insinuation that the latter have been ignored. However, in order to improve the cardiovascular outcomes of patients with diabetes, lowering BP is one of the most important interventions that can be done. Hypertension accounts for up to 40% of premature mortality and up to 75% of cardiovascular complications in people with diabetes.[4,5]

The ACCORD-BP (Action to Control Cardiovascular Risk in Diabetes—Blood Pressure) trial results are one of the sources of the differences in opinion.[6] In contrast to Siu and colleagues' statement that the ACCORD-BP trial has not been commented on by CHEP and the Canadian Diabetes Association (CDA) for the past 2 years,[1] a critical appraisal of the ACCORD trial can be obtained by reading the CHEP recommendations that summarize the CHEP and CDA deliberations.[7,8] The ACCORD trial had a complex 3 2 factorial design of intensive glucose lowering, lipid lowering, and BP lowering. In the appendix of the published trial, it is indicated that there was a 92% probability of an interaction between the glucose-lowering and BP-lowering aspects of the trial. In the setting of an interaction, it is recommended to not combine the glucose-lowering interventions. In the standard glucose-lowering intervention of ACCORD, the primary outcome (nonfatal myocardial infarction, nonfatal stroke, and cardiovascular death) was reduced by 24% with systolic BP lowering to less than 120 mm Hg compared with less than 140 mm Hg. Apart from disagreement over the presence of a treatment interaction, other methodologic issues also affect interpretation of the ACCORD trial. The ACCORD-BP results were discussed in depth by CHEP for both the 2011 and 2012 guidelines, and a collective decision was made that changes should not be made to our target BP of less than 130/80 mm Hg in persons with diabetes. Unfortunately many recent meta-analyses incorporate the main ACCORD results without consideration of the treatment interaction, making interpretation of new meta-analyses challenging.[9] Members of CHEP and the CDA await more detailed analyses of the ACCORD trial. The ACCORD-BP trial results were released after the acceptance of our review article and a late revision of our review was not undertaken because the results did not alter our conclusions.

Siu et al used the retrospective post hoc analysis of INVEST (International Verapamil SR–Trandolapril Study) trial data to argue against lowering systolic BP in people with diabetes.[10] Retrospective post hoc analyses of observational data from trials constitute very weak