Prognosis not a lost competency

In the Yeung et al[1] commentary in the September issue of *Canadian Family Physician*, the authors outline their search strategy for material related to "prognosis" in the CanMEDS–Family Medicine material available from the College of Family Physicians of Canada (CFPC). Yeung et al[1] lament its apparent absence from our stated competency goals because, as they point out, these materials are a curriculum resource for training programs. They also underline the importance of "prognosis" in palliative care, and suggest that its absence might partially explain the lack of sufficient emphasis on palliative care training in family medicine programs.

I want to remind readers and future authors that the CFPC has more than 1 official document on competencies as guides for training. The report on evaluation objectives,[2] first published by the College's Working Group on the Certification Process and distributed to the programs in 2010, is readily available on the CFPC website.[2] The report includes discussions on the priority topics and key features for assessment of competence in family medicine, as well as detailed operational definitions of *communication skills, professionalism,* and *patient-centredness* that are useful for the assessment of competence in family medicine. A word search similar to that conducted by Yeung et al[1] for terms related to prognosis in the report[2] results in 6 citations: there is 1 in each of the 6 different priority topics. Also, palliative care is a separate priority topic, with its own specific key features.

The CFPC does therefore outline some specific directions regarding the importance of prognosis and palliative care in determining the competence of family physicians. Program members are aware of this and have already developed strategies to teach and assess competence in these 2 important concepts. Authors are encouraged to consult all relevant CFPC reports before reaching conclusions about the educational priorities of the College.

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Competing interests
Dr Crichton is Chair of the College of Family Physicians of Canada Working Group on the Certification Process.

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Different perspective on ASA use

We read with interest the article by Ms Truong in the November issue of *Canadian Family Physician* on low-dose acetylsalicylic acid (ASA) for primary prevention of cardiovascular disease.[1] While we agree with Ms Truong's first suggestion that ASA should not routinely be recommended for the primary prevention of cardiovascular disease, we have different perspectives on the other 2 questions that she addresses.

When should we offer ASA for primary prevention?

Ms Truong suggests that ASA should be offered when the benefits outweigh the risks, and suggests identifying "high risk" patients based upon the presence of various risk factors (eg, men older than 50 years of age). Our approach is to use cardiovascular risk calculators to estimate an individual's risk of a cardiovascular event to avoid arbitrarily categorizing individuals as high, moderate, or low risk. An excellent website that has 3 such calculators is **http://cvdcalculator.com**. The calculator that we use most often is the ASCVD (atherosclerotic cardiovascular disease) calculator, which calculates the 10-year risk of heart attack, stroke, and cardiovascular death. The 2009 Antiplatelet Trialists' Collaboration patient-level meta-analysis suggests that ASA reduces the risk of a first serious cardiovascular event by approximately 10%.[2] In the example of a 50-year-old man who is subjectively classified as high risk based upon sex and age alone, it is possible that his 10-year risk of heart attack, stroke, or cardiovascular death is only 1% when using the ASCVD calculator. The use of ASA every day for 10 years in this individual might lower that risk by about 0.1%, an amount likely considered unimportant by most clinicians and patients. By

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using risk calculators, and knowing the estimated risk reductions of various interventions, health care professionals can have discussions with patients about specific benefits and harms of various interventions in the spirit of shared decision making.

Should we stop ASA in patients who have been using it for primary prevention for many years?

Ms Truong highlights a theoretical concern of provoking a hypercoagulable state when discontinuing ASA. To support this, she cites 3 sources: 1) a review article, 2) a retrospective case-control study in patients taking ASA for the secondary prevention of cardiovascular events, and 3) a rapid-response opinion to the second citation that did not provide any new information. In our own search of the literature, we could not find any credible information that suggested an increased risk of cardiovascular events in patients stopping ASA when it was being used for primary prevention. We believe this is very important to note, as we do not believe that clinicians should hesitate to stop ASA when there is no clear indication for its use.

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Competing interests
None declared

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Further discussion on mandatory CPD for opiate prescribing

I want to further discuss the topic of mandatory continuing professional development (CPD) for opioid prescribing, which was addressed by Dr Lemire in the November issue of *Canadian Family Physician*.[1] If opiate-prescribing CPD became a requirement, then the content and bias of the course becomes extremely important.

California passed a mandate that all physicians who see patients required CPD on pain control. It was sold mainly as a compassionate measure for dying patients who were indeed being inadequately treated, but chronic pain treatment was included and was, in truth, the real target of the CPD. The mandate had been lobbied for by the makers of slow-release opiates and was part of the wider consensus they had purchased that physicians were grossly underusing opiates for chronic pain patients. The mandated CPD produced the desired effect: an explosion in opiate prescribing, with the unintended consequence of an epidemic of deaths from prescription opiates that is ongoing to this day.

Our profession needs to take responsibility for the fact that our prescription pads have been the source, directly or indirectly, of thousands of Canadian deaths in the past 20 years. Our prescribing is the start for many of an opiate addiction that eventually leads to a life of crime, homelessness, or death.

Mandated CPD is a powerful tool, given our profession's deference to authority. Dr Lemire is right to question if the message of mandated CPD could swing the pendulum the other way. However, given good evidence that chronic opiate use can exacerbate chronic pain, I think the real danger is in a watered-down message that allows physicians to justify their current prescribing habits.

In such a case, mandatory CPD would be less than useless.

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Competing interests
None declared

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