When science translates badly

In the article "Statistical research: lost in translation?" Drs Hogg, Wong, and Burge[1] clearly describe an important issue. Language influences our perception of reality.

They describe *independent practice* as each doctor being in a full "stand-alone" operation with independent space, independent staff, independent records, and independent finances, and suggest the practitioner does not interact in his or her regular day-to-day work with others doing the same type of work. Using their criteria, no family medicine practice qualifies as an independent practice because all practitioners "influence each other, however minimally."[1] Solo general practitioners do not operate in isolation. They routinely collaborate with other health professionals. Every practitioner works and collaborates with medical and nonmedical experts who are also trying to help patients.

Solo practitioners might not share office space, but they do share overall resources and spaces for care, including access to laboratory tests, emergency departments, hospital beds, and common areas in medical buildings. Each day, staff in solo practice relate by e-mail, telephone, or fax with staff in the offices of other general practitioners or specialists. Patient information, including health records, is often shared with other doctors using common standards.

In all provinces, the incomes of all primary care practitioners are related. Government decides on the pool of money available for primary care. The payments per visit or salaries for each doctor relate to the total number of clinicians and the services they provide.

The authors use the term *independent practice,* but the term *solo practice* might be a better descriptor. Hardly anyone, including medical professionals, fulfils the criteria outlined by Donner and Klar[2] for independent practice. Solo practitioners have never been independent; they have always collaborated with and been influenced by the people around them and the government who pays them.

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Competing interests
None declared

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Call to action: frailty assessment in primary care

We thank Dr Lee and colleagues for their very interesting study in the January 2017 issue of *Canadian Family Physician.*[1] It is to be hoped that many medical organizations will follow this feasible "call to action" on dual-trait measurement of gait speed and hand-grip strength for frailty screening and implement it permanently in daily primary care practice.

The authors have included the study by Auyeung et al in their references, but unfortunately it was not mentioned that this study also examined the sensitivity and specificity of each of the 5 Fried criteria in the identification of frailty in 4000 Chinese older adults (mean age was 72.5 years).[2] Auyeung et al also concluded gait speed and grip strength were key indicators of frailty in the primary care setting. For gait speed, the sensitivity and specificity were 91.9% and 84.5% in women (area under the receiver operating curve [AUC] = 0.88) and 82.7% and 83.1% in men (AUC = 0.83), respectively. For grip strength, the sensitivity and specificity were 84.5% and 81.9% in women (AUC = 0.84) and 89.5% and 80.6% in men (AUC = 0.86), respectively.

General practitioners' clinical impression of frailty is important but alone it is not sufficient.[3] We agree with the authors that objective, simple, quick, and inexpensive screening tests such as gait speed and grip strength are necessary to improve the accuracy of frailty detection in elderly patients in primary care.[3,4] This is also supported by other current studies to identify the Fried frailty phenotype in the primary care setting.[5]

To Dr Lee and colleagues: Very well written, correct results, and appropriate references. Congratulations!

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Competing interests
None declared

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