art" of deprescribing, he touched on an important expectation around professionalism, as described in CanMEDS–Family Medicine: to "demonstrate a commitment to reflective practice."[2] There is true humility required to stop ordering tests, treatments, or procedures that offer more harm than good.

Implementing Choosing Wisely Canada recommendations can be challenging, as in the case of the recommendation to avoid using benzodiazepines and other sedative-hypnotic medications in the elderly.[3-5] When we endeavour to tackle these kinds of recommendations, we draw on 5 CanMEDS–Family Medicine areas: scholar, family medicine expert, communicator, manager, and professional. The support we give each other around this work is therefore essential. Choosing Wisely Canada can connect family physicians and teams who are working on similar implementation projects—e-mail **info@choosingwiselycanada.org**.

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Competing interests
Dr Wintemute is Primary Care Co-Lead of Choosing Wisely Canada.

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No evidence for benefit of medication for obesity

The goals of the College of Family Physicians of Canada include patient-centred care and social equity. In the debate published in the February issue,[1] Drs Bourns and Shiau quote 2 randomized controlled trials.[2,3] The rest of their references were to guidelines. Bourns and Shiau state that orlistat can cause oily stool, fecal urgency, and fecal leakage.[1] The liraglutide product monograph says that it has been associated with tachycardia, first-degree atrioventricular block, nausea, vomiting, diarrhea, dehydration, renal failure, and pancreatitis (including 1 fatality).[4]

Wadden et al found that enhanced weight loss counseling helps about one-third of obese patients achieve clinically meaningful weight loss.[2] They did not show that the treatment prolonged life or decreased hospitalization. Pi-Sunyer et al found that 3.0 mg of liraglutide as an adjunct to diet and exercise counseling was associated with reduced body weight and improved metabolic control.[3] They did not show that the treatment was associated with prolonged life or decreased hospitalization. A secondary end point included health-related quality of life: "Liraglutide treatment was associated with higher scores on the SF-36 [36-Item Short Form Health Survey] for overall physical and mental health."[3] Substantially more patients taking liraglutide had nausea, diarrhea, and vomiting compared with those taking placebo.[3] The cost of 3.0 mg of liraglutide a day is $200 a month.[5]

Bourns and Shiau have not shown that medication for obesity prolongs life or improves patient quality of life. Nonetheless, they recommend that we prescribe orlistat or liraglutide. Liraglutide is expensive and causes nausea, vomiting, and diarrhea, while the use of orlistat forces the patient to use diapers and to know the location of all the bathrooms in the neighbourhood in an attempt to limit the consequences of urgent leakage of oily fecal matter.

The evidence suggests that we should not prescribe medications for obesity.

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Fallacy of yes or no choices

The debate "Should family physicians prescribe medication for obesity?"[1,2] misses the mark completely in both points of view. As is too often the case, the question is too simple and does not address the reality of actual patient care. There is no good evidence at all, so we are left with making sense of a clinical picture and acting in the best interest of an individual patient with no good scientific reference point.

The correct answer to the debate is "sometimes." I have patients who are obese by body mass index standards, but who are fit, exercise regularly, have

no family history of diabetes or vascular disease, no lipid disorder, good renal function, and normal blood pressure. These patients need diet counseling and follow-up but nothing more. I have others who have the precise opposite problem—family histories of diabetes or vascular disease, with evidence of a lipid disorder and hypertension. The answer here is yes ... I prescribe metformin because of its proven ability to delay or prevent frank diabetes.[3,4]

There are other patients with a less clear risk pattern, but if I see obesity with low high-density lipoprotein and high triglyceride levels it takes very little to tip me into the "treat" column. In my opinion, true metabolic syndrome needs early intervention, even in the absence of good evidence. It is pretty clear what road these patients are walking down, and to do nothing to avert a catastrophe is unethical too.

Without evidence one way or another we need to make the best decisions we can respecting the known pathophysiology of disease and intervene where these mechanisms can be modified. By all means let's do a randomized controlled trial, but let us also be practical and scientific and patient-centred while we wait.

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