Help patients navigate the system

In his editorial in the October issue,[1] Dr Pimlott quoted Dr Rebecca Rosen, who stated that "repeated face-to-face consultation with a doctor is seen as the wrong approach ... with technology-enabled consultations with a variety of health professions offering new options for assessment, review and treatment."[2] Computerized algorithms are used by companies, universities, and governments to decide who should have credit, get accepted to university, receive advertising, get a job interview, get insurance, and be offered a lenient decision by a court.[3]

People labeled untrustworthy by an algorithm have difficulty navigating the system. The family doctor is perhaps the most highly educated publicly funded person who can help the patient access knowledge and services, including health benefits.

Tests to detect cancer in asymptomatic people are promoted by the slogan "Screening saves lives." It does, but it also leads to a lot of testing and treatment, not all of which is beneficial.[4,5] My patients and I get reminders about the patient being overdue for a Papanicolaou test and for the fecal immunochemical test. Both reminders come from the BC Cancer Agency. One has a doctor's name at the bottom of the notice, and the other has no name on it. I asked the person whose department created the second notice why the notice had no name. The reply was, "[the notification] is generated out of the screening program database and is not sent by a person."

The patient needs help to decide what is best for him or her. The family doctor can review with a patient the risks and benefits of testing or treatment, including the goals of the proposed intervention, and the number needed to treat and the number needed to harm.

Canadian doctors move at the privileged end of the social spectrum. Even we can be excluded from decisions that affect us—the Canadian Medical Association did not consult its membership before selling MD Financial Management to a bank. The family practitioner marshals scientific evidence and deep knowledge of the patient to help the patient make the best decision for himself or herself. In the age of computerized decision making by big entities, our role is more important than ever.

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Competing interests
None declared

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Correction

Recommendations in 2 articles published in *Canadian Family Physician*, "Nausea and vomiting of pregnancy. Evidence-based treatment algorithm"[1] and "Treatment of nausea and vomiting in pregnancy. An updated algorithm,"[2] have subsequently come under critical scrutiny.[3,4] These articles were not subjected to standard peer review, and *Canadian Family Physician* acknowledges that upon closer inspection these articles did not provide satisfactory evidence that would have justified the recommendation of doxylamine-pyridoxine as a sole first-line treatment for nausea and vomiting in pregnancy (NVP). More recent Canadian NVP guidelines have been published[5]; however, a subsequent re-analysis[6] questions the conclusions of 1 of the studies[7] cited in these guidelines to justify doxylamine-pyridoxine as a recommended first-line treatment for NVP. Additionally, for the articles in *Canadian Family Physician*[1,2] there was an undisclosed conflict of interest with Duchesnay, the manufacturer of Diclectin, the combination of doxylamine-pyridoxine. *Canadian Family Physician* encourages readers to interpret previously published NVP recommendations with caution. Readers are also referred to the commentary "Motherisk and *Canadian Family Physician*" in the January 2017 issue of *Canadian Family Physician*.[8]

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