Time for leadership and conversations

I very much appreciate Dr Shane Neilson's article in the June issue of *Canadian Family Physician* and the points he raises.[1]

I think most of us physicians accepted that in a time when our system is direly overwhelmed, as in northern Italy, we would make decisions that would limit access to care, ventilators, etc, for the elderly and possibly for those with disabilities. We have not had much public discussion of this issue, not even within small rural and remote hospitals and health centres.

This relative "lull" in coronavirus disease 2019 (COVID-19) activity is a good time for in-depth conversations, leadership from top ethicists, etc, at local, regional, and national levels. Is the College up for leading this?

At the least, I would be very interested to hear more from Dr Neilson and to engage in further discussion with him on this vital issue that lies at the base of our collective and individual values for life itself.

Thank you—Mahssi cho.

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Competing interests
None declared

Reference

1. Neilson S. Why I won't see you on the barricades. Disability and COVID-19. *Can Fam Physician* 2020;66:449-50.

Question strategies that disadvantage

Thanks to Dr Shane Neilson for so eloquently describing the ethical problem in a triage strategy that discriminates against disabled or elderly individuals and people with chronic conditions.[1] There are no easy approaches to allocation when resources are limited, but we must closely question strategies that systematically disadvantage the already disadvantaged. Structural inequity is a reality in Canada, as it is elsewhere, and it becomes more obvious when choices are made by those who have traditionally held positions of power and authority. I think Third Rail is a great addition to *Canadian Family Physician*.

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Competing interests
None declared

Reference

1. Neilson S. Why I won't see you on the barricades. Disability and COVID-19. *Can Fam Physician* 2020;66:449-50.

New beneficial practices should be retained

I thank Dr Nicholas Pimlott for such a meaningful editorial in these difficult times.[1] It is instructive that change in practice has occurred at blinding speed when so often it seems to take forever to integrate practice improvements. We can hope that new practices that have proven good for patients will be retained after the crisis resolves. We can also hope that better payment methods than fee-for-service will be adopted universally to enable family physicians to serve their communities optimally and be appropriately compensated.

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Competing interests
None declared

Reference

1. Pimlott N. Hope in a global pandemic. *Can Fam Physician* 2020;66:312 (Eng), 313 (Fr).

Equipoise is preference sensitive

We generally agree with issues raised by Thériault et al[1] in their article in the May issue of *Canadian Family Physician* in terms of the importance of thinking about when shared decision making (SDM) is of greatest value. As a matter of fact, the first step of SDM involves talking about the decision to be made.[2] However, we disagree with the concept that equipoise is a prerequisite to establishing an SDM conversation, or at least as how equipoise was defined in this article for the following reasons.

First, clinicians might consider that a strong recommendation or grade A recommendation (this might vary, as there are many systems for grading recommendations) to do something (eg, starting a medication) might impede an SDM conversation, as there is no equipoise. Nevertheless, methods for incorporating patient preferences in recommendations were recently developed[3] and they are not widely implemented. Considering that patients might value outcomes differently, the net balance of interventions is highly preference sensitive.[4] And even if a strong recommendation includes the preferences of the general population, what happens if the preferences of our individual patients diverge from these?

Second, we understand that SDM might be inadequate when there is a strong suggestion that harms outweigh the benefits, which is highlighted in the article example of the use of antibiotics for an upper respiratory tract