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.

—Leah Seaman MD CCFP FCFP
Inuvik, NWT

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*.

—Carol P. Herbert MD CCFP FCFP
Vancouver, BC

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.

—Carol P. Herbert MD CCFP FCFP
Vancouver, BC

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

infection in which benefits are negligible and harms (including antibiotic resistance) are important. Even so, there is evidence that interventions that enhance SDM might reduce the inadequate use of antibiotics.[5] In these scenarios, could it be that eliciting preferences in the SDM conversation helps make a better decision?

Third, SDM intends to share the best evidence with the patient, including evidence about the consequences of doing nothing.[6] That option will always be valid if we respect the autonomy of well-informed patients and their right to refuse practices.[7] This is why we believe that more often than not there are at least 2 options (doing or not doing something) where SDM could be a suitable approach for involving patients in decisions.

Finally, the statement "some patients want a test or treatment where the recommendation is strongly against it or will refuse an intervention where the benefits clearly seem to outweigh the harms"[1] neglects the idea that well-informed patients might refuse an intervention because they make a different judgment about the net benefit than the judgment made by their physician or a clinical practice guideline. The example of the consideration of colon cancer screening in elderly but fit individuals paradoxically considers that patient preferences can reverse a recommendation against a potentially harmful practice. Why could this not happen conversely (ie, a 50-year-old healthy individual who does not want to undergo screening)?

This does not imply that practices that offer net harm should be validated, but considering the long tradition of paternalistic communication models in medical practice and the slow and scant uptake of SDM, we believe that SDM should be the rule, not the exception, especially considering the balance of benefits and harms. Shared decision making aims to combine the best medical evidence with patients' values and preferences. Deciding whether to use SDM only based on a biomedical component, such as the level of guideline recommendations, seems an incomplete approach to patient-centred care.

—Juan V.A. Franco MD MSc
—Paula Riganti MD
—María V. Ruiz Yanzi MD
—Karin Kopitowski MD
Buenos Aires, Argentina

Competing interests
None declared

References

1. Thériault G, Grad R, Dickinson JA, Breault P, Singh H, Bell NR, et al. To share or not to share. When is shared decision making the best option? *Can Fam Physician* 2020;66:327-31 (Eng), e149-54 (Fr).
2. Elwyn G, Durand MA, Song J, Aarts J, Barr PJ, Berger Z, et al. A three-talk model for shared decision making: multistage consultation process. *BMJ* 2017;359:j4891.
3. Zhang Y, Coello PA, Brożek J, Wiercioch W, Etxeandia-Ikobaltzeta I, Akl EA, et al. Using patient values and preferences to inform the importance of health outcomes in practice guideline development following the GRADE approach. *Health Qual Life Outcomes* 2017;15(1):52.
4. Alper BS, Oettgen P, Kunnamo I, Iorio A, Ansari MT, Murad MH, et al. Defining certainty of net benefit: a GRADE concept paper. *BMJ Open* 2019;9(6):e027445.

5. Coxeter P, Del Mar CB, McGregor L, Beller EM, Hoffmann TC. Interventions to facilitate shared decision making to address antibiotic use for acute respiratory infections in primary care. *Cochrane Database Syst Rev* 2015;(11):CD010907.
6. Légaré F, Shemilt M, Stacey D. Can shared decision making increase the uptake of evidence in clinical practice? *Frontline Gastroenterol* 2011;2(3):176-81. Epub 2011 Apr 21.
7. *Health Care Consent Act.* 1996. S.O. 1996, c. 2, Sched A.

Correction

In the article "Chlamydia test-of-cure in pregnancy," which appeared in the June issue of *Canadian Family Physician,*[1] the authors were listed in the incorrect order. The correct order is as follows:

Jessie Pettit MD Carol Howe MD MLS Joshua Freeman MD

The online version has been corrected.

Reference

1. Freeman J, Pettit J, Howe C. Chlamydia test-of-cure in pregnancy. *Can Fam Physician* 2020;66:427-8.

Correction

In the article "Prioritizing coordination of primary health care," which appeared in the June issue of *Canadian Family Physician,*[1] the affiliations of Ms Vaidehi Misra and Ms Kimia Sedig were incorrect, and they should have been acknowledged as co-first authors. The correct affiliations and acknowledgment are as follows:

Ms Misra and **Ms Sedig** are research assistants at Western University in London, Ont. **Dr Dixon** is a member of the clinical faculty in the Schulich School of Medicine and Dentistry at Western University. **Dr Sibbald** is Assistant Professor in the School of Health Studies at Western University.

Acknowledgment

Ms Misra and **Ms Sedig** are co–first authors and contributed to the article equally.

The online version has been corrected.

Reference

1. Misra V, Sedig K, Dixon DR, Sibbald SL. Prioritizing coordination of primary health care. *Can Fam Physician* 2020;66:399-403 (Eng), e165-70 (Fr).

Correction

Dans l'article intitulé « Donner la priorité à la coordination des soins de santé primaires », publié dans l'édition de juin du *Médecin de famille canadien*[1], les affiliations de M^me^ Vaidehi Misra et de M^me^ Kimia Sedig étaient inexactes, et elles auraient dû être reconnues comme coauteures principales. Les affiliations correctes et les remerciements se lisent comme suit :

M^me^ Misra et **M^me^ Sedig** sont assistantes de recherche à l'Université Western à London (Ontario). Le **D^r^ Dixon** est membre du corps professoral de clinique à la Faculté de médecine et de chirurgie dentaire Schulich de l'Université Western. **M^me^ Sibbald** est professeure adjointe à l'École des études de la santé de l'Université Western.

Remerciements

M^me^ Misra et **M^me^ Sedig** sont coauteures principales et ont contribué également à l'article.

La version en ligne a été corrigée.

Référence

1. Misra V, Sedig K, Dixon DR, Sibbald SL. Prioriser la coordination des soins primaires. *Can Fam Physician* 2020;66:399-403 (ang), e165-70 (fr).

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