Palliative care courses

Thank you to Dr Langlois for the very relevant article in the August issue of *Canadian Family Physician*.[1] As a semiretired family physician now doing part-time counseling in advance care planning and end-of-life issues, I share many of the emotions you expressed about palliative sedation and the privilege we have in bearing witness to the journey our patients are on. I will pass on very valuable advice I received from a palliative care mentor before I undertook this counseling role: if possible, take the "Being With Dying" and the recently added "Being With Suffering" courses at Upaya Zen Center in Santa Fe, NM. My experience with Upaya, its founder Roshi Joan Halifax, and the other teachers, including Frank Ostaseski, have been life altering. They use a mindfulness approach and stress self-care as much as patient care. Attending in person when it reopens would be ideal, but there are webinars and sessions that can be mind expanding and incredibly useful in the meantime.[2]

I hope you are able to reap the benefits as I have.

—Julie J. McIntyre MD
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Competing interests
None declared

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Continuity of care suggestions

Dr Lemire's column[1] in the June issue of *Canadian Family Physician* is important and we offer some comments from the United Kingdom.

The beneficial outcomes associated with continuity of family physician care are even stronger than those listed, and now include reduced mortality,[2] which has been shown to be linked specifically with primary care.[3]

Continuity is certainly falling in the United Kingdom as well, but encouragingly it is still being provided in some practices at a good level.

We offer 2 suggestions: it is important to measure the continuity provided, and simple organizational systems within practices linking patients with family physicians who feel responsible for them still work.

—Sir Denis Pereira Gray OBE FRCP FRCGP FMedSci
—Kate Sidaway-Lee PhD
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Competing interests
None declared

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Transparent criteria expose potential bias in clinical guidelines

With the explicit criteria provided by the College of Family Physicians of Canada in the July issue,[1] family medicine continues to lead the way in improving the quality, relevance, and usefulness of clinical practice guidelines for practitioners and their patients.[2] The emphasis on transparency and full disclosure of funding sources will help expose potential bias. The American Academy of Family Physicians pioneered these principles in 1994 by publishing the first international call for explicit declaration of conflicts of interest in the development of clinical practice guidelines.[3]

—William R. Phillips MD MPH FAAFP
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Competing interests
None declared

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Industry involvement in clinical practice guidelines

The College of Family Physicians of Canada (CFPC) is to be commended for developing criteria for the endorsement of clinical practice guidelines (CPGs),[1] but it is too bad that those criteria are not bolder when it comes to financial conflicts of interest (FCOIs).

Top 5 recent articles read online at cfp.ca

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3. **Praxis:** PEER simplified decision aid. *Neuropathic pain treatment options in primary care* (May 2021)
4. **Outils pour la pratique:** Posologie du fer (June 2021)
5. **RxFiles:** Pharmacotherapy management of schizophrenia for family physicians (May 2021)

There is good evidence linking FCOIs to biases in guidelines. One study that looked at industry involvement in the production of CPGs for opioid prescribing concluded that

> the clinical practice guidelines for opioid prescribing for CNCP [chronic noncancer pain] from 2007 to 2013 were at risk of bias because of pervasive conflicts of interest with the pharmaceutical industry, and with a paucity of mechanisms to mitigate bias.[2]

Industry-sponsored guidelines about the diagnosis and treatment of infants with allergies to cow's milk protein led to an increase in prescriptions of specialist formula milks in the United Kingdom for infants with cow's milk protein allergy of nearly 500%, despite lack of any data showing a significant change in the prevalence of the condition.[3]

The CFPC's criteria rightly require that the sources of funding for guidelines be stated, but are silent on the public disclosure of industry funding from organizations that commission guidelines. Among 18 Canadian disease or condition interest groups and medical professional societies that sponsored guidelines, 14 of 15 disclosed organizational funding from industry on their websites (3 did not disclose funding), but none disclosed this information in the CPGs themselves.[4]

The 2011 report from the Institute of Medicine (now the National Academy of Medicine) recommended that the chairs and co-chairs of CPG committees have no FCOIs and that committee members with FCOIs should represent no more than a minority of the committee.[5] The CFPC's criteria ignore those recommendations and even allow industry employees to be members of guideline committees provided there is an explanation about how FCOIs are managed.

Clinicians rely on CPGs for guidance when making treatment decisions for patients. In 2016, 8 of the 15 most cited articles across all science were medical guidelines, disease definitions, or disease statistics.[6] Well-done, evidence-based CPGs enhance the clinical care that physicians deliver,[7,8] but the CFPC needs to recognize the corrosive effect of industry involvement in the generation of guidelines and take decisive action.

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Competing interests

In 2017 to 2020, **Dr Joel R. Lexchin** received payments for being on a panel at the American Diabetes Association; for talks at the Toronto Reference Library; for writing a brief on an action for side effects of a drug for Michael F. Smith, Lawyer, and a second brief on the role of promotion in generating prescriptions for Goodmans LLP; and from the Canadian Institutes of Health Research for presenting at a workshop on conflicts of interest in clinical practice guidelines. He is currently a member of research groups that are receiving money from the Canadian Institutes of Health Research and the Australian National Health and Medical Research Council. He is a member of the Foundation Board of Health Action International and the Board of Canadian Doctors for Medicare. He receives royalties from University of Toronto Press and James Lorimer & Co, Ltd, for books he has written.

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