Aggregate values, not arithmetic

We thank Dr Bob Bernstein for his insightful comments[1] on our recent publication in *Canadian Family Physician*.[2] However, there has been a misunderstanding in the interpretation of our work detailing the predictive validity of several available tests for the investigation of chest pain.

The values presented in Table 1 of our article are aggregate data reported in the literature and not calculated figures from any one study. Dr Bernstein presented a series of 2×2 tables in his letter to demonstrate that the sensitivity and specificity reported for a variety of investigative tests were not concordant with positive and negative predictive values for the identification of coronary artery disease (CAD). In our article, we did not claim that either set of values can be used to mathematically derive the other—rather, we reported on the range of published diagnostic accuracy measures (including sensitivity, specificity, and likelihood ratios) based on the most robust published studies to date.

Dr Bernstein cited a pretest likelihood for CAD of 10% and 50% for low- and intermediate-risk groups, respectively.[1] However, these estimates depend on the specific patient population evaluated and the risk scoring systems used. We agree with Dr Bernstein that clinical judgment is critical and that patients with low pretest likelihood of CAD typically do not require any noninvasive testing.

—Connor T.A. Brenna
—Fahmeen J. Afgani MBBS
—Kate Hanneman MD MPH FRCPC
—Elsie T. Nguyen MD FRCPC
Toronto, Ont

Competing interests
None declared

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Time to celebrate, not condemn

I am writing as someone who cares about the College of Family Physicians of Canada (CFPC) and cares very much about family doctors broadly across the country who are working hard every day to support their communities, their colleagues, and their patients.

I want to express my concern about how tone-deaf Dr Ladouceur's editorial in the June issue of *Canadian Family Physician* is.[1] Because it appears in the "official journal of the CFPC," the editorial reflects poorly on the CFPC itself.

Dr Ladouceur makes numerous allegations about practice patterns with no supporting data and he is highly critical without any apparent understanding that many physicians have been struggling in a system that does not support them. Many physicians started this pandemic with no access to personal protective equipment, in offices too small to safely distance from one another, and with staff who needed to excuse themselves from the workplace, leaving some physicians without usual office supports. That reality has hugely influenced the ways in which physicians have been able to see people in their office settings, particularly in the initial months of the pandemic.

I acknowledge that there are stories of practices that have failed their patients during the pandemic, but to suggest that it is all simply unethical and greedy behaviour is to completely misunderstand the reality under which many family physicians have laboured, largely unsupported by the health care system.

As many family physicians come limping out of this pandemic, this is the time to celebrate the many, many ways in which family physicians have absorbed a huge amount of emerging information, contributed to care in their communities, strengthened the health care system, and supported long-term care, assessment centres, and vaccine clinics. Now is the time to celebrate the ways in which family physicians have demonstrated accountability to their communities through adapting to emerging needs—a skill that we are abundantly capable of as generalist clinicians.

Can we also ask questions about what we can do better? Of course we can, but when we do, we should be doing so in a way that is solution-focused—which Dr Ladouceur's editorial distinctly does not do. He slaps a metaphorical wrist and offers nothing by way of support.