Keep evidence in sight when exploring complex algorithms

It was highly instructive for me to read the detailed article "Medication management for heart failure with reduced ejection fraction" in the December 2021 issue of *Canadian Family Physician*.[1] If I may be permitted to add some comments, I am familiar with the case of a fit 71-year-old woman with no previous cardiac history who was admitted to hospital in late 2016 with community-acquired pneumonia. Quite apart from the pneumonia, she was found to be in atrial fibrillation, was cardioverted, and was placed on rivaroxaban along with other treatments for the pneumonia and cardiac arrhythmia. Her echocardiogram at the time showed a left ventricular ejection fraction of 45%.

In subsequent follow-up with an internist, she was told she had heart failure and that it had predated the pneumonia. No evidence for this was offered. She was recommended to continue the rivaroxaban, along with digoxin, ramipril, and metoprolol.

Negotiations with the internist were prolonged, but over the course of several months she persuaded him with some difficulty to discontinue the digoxin, ramipril, and metoprolol. The rivaroxaban was maintained, as it has been to this day. Several echocardiograms followed, both on and off medication, and at no point did the left ventricular ejection fraction fall below 50%.

This patient, my wife, is now 76 years old, and she is busy shoveling snow on our driveway as I have recently injured my back. She remains in New York Heart Association class I, as she was before the episode of pneumonia. We both ride our bicycles regularly through the rugged country around our home on Vancouver Island, and she is totally asymptomatic, even after 80-km rides. She has transferred her care to her family physician and, if it ever becomes necessary, to a different internist.

I share this story because despite there being a mass of data and algorithms in the article, what is missing is any sense of productive negotiation between the patient and the physician. By taking a proactive and educated stand (we are both physicians), we have avoided more than 5 years' worth of medications that all have substantial side effects and in the long run are expensive; we have also avoided multiple laboratory and imaging tests and follow-up with medical specialists, all of which are costly to the publicly funded medical system.

My wife is, for all intents and purposes, a healthy, mostly medication-free 76 year old, and I hope she can continue to escape the pharmaceutical maelstrom espoused by many physicians on the basis of complex algorithms. There is no evidence that she has, or ever had, cardiac failure.

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Competing interests
None declared

Reference
1. Barry AR, Kosar L, Koshman SL, Turgeon RD. Medication management for heart failure with reduced ejection fraction. Clinical pearls for optimizing evidence-informed therapy. *Can Fam Physician* 2021;67:915-22 (Eng), e329-36 (Fr).

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Correction

In the article "Involvement of palliative care in patients requesting medical assistance in dying,"[1] which appeared in the November 2020 issue of *Canadian Family Physician*, an author was included in error. Michael Kekewich contributed data and feedback to the article but did not endorse the final version as published and does not agree with all the conclusions or commentary. The correct byline and affiliations are below:

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Peter Tanuseputro MD MHSc CCFP FRCPC

Dr Munro is a palliative medicine physician in the Division of Palliative Medicine and **Dr Romanova** is a general internal medicine physician in the Division of Internal Medicine, both in the Department of Medicine, all at the University of Ottawa and the Ottawa Hospital in Ontario. **Dr Webber** is Clinical Research Associate at the Ottawa Hospital Research Institute. **Ms Richard** is a nurse consultant with the Supportive and Palliative Care Team at the Ottawa Hospital. **Dr Tanuseputro** is a scientist in the Clinical Epidemiology Program at the Ottawa Hospital Research Institute and Assistant Professor in the Division of Palliative Care in the Department of Medicine at the University of Ottawa.

The online version has been corrected.

Reference
1. Munro C, Romanova A, Webber C, Kekewich M, Richard R, Tanuseputro P. Involvement of palliative care in patients requesting medical assistance in dying. *Can Fam Physician* 2020;66:833-42.

Can Fam Physician 2022;68:89. DOI: 10.46747/cfp.680289_1