

## Caution urged in interpreting study findings

I read with interest “Association between family physician gender and patient service times. Evidence from Ontario”<sup>1</sup> by Kralj et al in the January 2026 issue of *Canadian Family Physician*. The article examined associations between family physician gender, patient encounter duration, and income implications under fee-for-service remuneration. The topic is timely and relevant; however, several methodological and interpretive considerations merit further discussion.

The primary outcome measure, time spent per patient, was derived from self-reported survey data rather than objective sources such as electronic medical records or direct observation. Self-reported estimates are susceptible to recall and reporting biases, which may be non-differential or systematic. Given that relatively small differences in encounter duration were extrapolated to substantial annual income estimates, the absence of objective validation is a notable limitation.

Additionally, the analysis does not adequately account for patient case mix or visit complexity. Encounter length in family medicine is strongly influenced by multimorbidity, psychosocial burden, and visit purpose. Without adjustment for these factors, it is difficult to attribute observed differences primarily to physician gender, rather than to characteristics of patient panels or practice styles.

The interpretation of findings using terminology such as “gender pay gap,” together with suggested policy implications,<sup>1</sup> implies a causal relationship that cannot be established within a cross-sectional study design. While associations are clearly demonstrated, causality remains uncertain, and alternative explanations related to practice preferences, remuneration models, or scheduling patterns have not been fully explored.

Furthermore, extrapolations estimating an annual income difference of approximately \$45,500 assume uniformity in practice volume, billing patterns, and working hours, which may not reflect the heterogeneity of contemporary family medicine practice.

Finally, the study does not assess patient-level outcomes. Without examining whether longer encounters translate into improved care quality, continuity, or downstream health system utilization, conclusions regarding efficiency or disadvantage remain incomplete.

In conclusion, while the study raises important questions about how physician time is valued, methodological limitations and unmeasured confounders suggest that caution is warranted in interpreting the findings as evidence of gender-based income inequity. Future research incorporating objective encounter data, case-mix adjustment, and patient outcomes would strengthen the evidence base for policy reform.

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### Competing interests

None declared

### Reference

1. Kralj B, Sibley L, Kantarevic J, Clements K, et al. Association between family physician gender and patient service times: Evidence from Ontario. *Can Fam Physician*. 2026 Jan;72(1):e17-25. doi: 10.46747/cfp.7201e17.

Can Fam Physician. 2026 Mar;72(3):154. doi: 10.46747/cfp.7203154

## Response to letters about Hypertension Canada guideline

We thank Drs René Wittmer, Guylène Thériault, Samuel Boudreault, and Marc-Antoine Turgeon, as well as Dr Rémy Bousageon, and Dr David M. Allen, for their thoughtful engagement<sup>1-3</sup> with our article, “Hypertension Canada guideline for the diagnosis and treatment of hypertension in adults in primary care,”<sup>4</sup> published in the July/August 2025 issue of *Canadian Family Physician*. Their letters raised important questions about diagnosis, evidence interpretation, and guideline development. We welcome this opportunity to clarify several key points.

**Response to Wittmer et al.** Wittmer and colleagues highlighted enduring tensions in hypertension care: Where is the balance between early identification and unnecessary labelling? How should clinicians weigh subtle psychological harms against long-term cardiovascular benefit?<sup>1</sup> These are complex and legitimate concerns. Because the term *overdiagnosis* carries substantial implications, precision in terminology matters. *Overdiagnosis* refers to identifying a condition that would never cause symptoms or harm. This concept applies well in some screening contexts, such as certain cancers or incidental imaging findings. Hypertension, however, differs.

Blood pressure (BP) is a well-established, continuous, causal, and graded cardiovascular risk factor. Decades of evidence show that long-term risk increases at levels well below the traditional 140/90 mm Hg threshold.<sup>5</sup> Individuals with BP in the 130-139/80-89 mm Hg range consistently demonstrate a real and measurable increase in cardiovascular risk. This is not a harmless physiologic state. Large contemporary randomized trials show that identifying and managing elevated BP (>120 mm Hg systolic BP) in a risk-guided manner reduces cardiovascular events and mortality.<sup>6-9</sup> Benefits are greatest in those with higher absolute risk. Our guideline is built to capture these benefits without promoting unnecessary or premature drug therapy.

The key question, therefore, is not whether elevated BP carries risk—the evidence is clear that it does—but how to respond proportionately. The guideline distinguishes diagnosis from treatment.<sup>4</sup> A diagnosis of hypertension in the 130-139/80-89 mm Hg range does not trigger automatic pharmacotherapy. Rather, it initiates structured lifestyle counselling, home BP monitoring, and cardiovascular risk assessment. For low-risk individuals, lifestyle modification alone is recommended; for higher-risk individuals, early pharmacotherapy is evidence based.