Doc-patient "labels" trouble this physician, too

I sometimes think I'm the only one bothered by those who refer to physicians as providers, so it was great to see my opinion shared by the editor-in-chief of *The Journal of Family Practice* (Don't call me a provider. *J Fam Pract.* 2013;62:60). I plan on passing along Dr. Hickner's editorial to several colleagues and will now be more inclined to correct others who call the physicians in our group "providers."

I feel the same way when I hear patients referred to as "consumers," a label that still appears in the lay press. Economist and Nobel laureate Paul Krugman shared my sentiments in a column in *The New York Times*.[1]

"How did it become normal, or for that matter even acceptable, to refer to medical patients as 'consumers'?" Krugman wrote. "The relationship between patient and doctor used to be considered something special, almost sacred. … Now politicians and supposed reformers talk about the act of receiving care as if it were no different from a commercial transaction, like buying a car. …"

I could not agree more.

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1. Krugman P. Patients are not consumers. *New York Times.* April 21, 2011;Op-ed:A23.

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Newer study shows smoking cessation aid is safe

"Counseling is a must with this smoking cessation aid," stated a PURL published in March 2012 (*J Fam Pract.* 2012;61:156, 176). "Varenicline [Chantix] is associated with a small but significant harmful effect on CV outcomes." That statement, and the PURL itself, was based on a meta-analysis published in 2011 by Singh et al.[1] The meta-analysis included 14 randomized controlled trials (RCTs) that compared varenicline with placebo for the occurrence of serious cardiovascular disease (CVD) events, including myocardial infarction, coronary artery disease, arrhythmias, stroke, sudden death, and any related coronary death. RCTs that reported no CVD events were excluded.

Using a Peto odds ratio [OR] for analysis, Singh et al reported that varenicline use increased the risk of CVD events compared with placebo (OR=1.72; 95% CI, 1.09-2.71). A more recent meta-analysis by Prochaska et al,[2] however, challenges the validity of the Singh meta-analysis. As members of the Family Physicians Inquiries Network, which produces the PURLs, we would like to address the questions this newer study raises about varenicline's actual risk.

The Prochaska meta-analysis included all 14 RCTs analyzed by Singh, and used the same CVD event outcome measures. In addition, Prochaska included 8 trials in which no CVD events were reported, some of which were published after the Singh meta-analysis. And rather than use the Peto OR to estimate the risk, Prochaska calculated the absolute risk (AR). The result? The researchers found no difference in CVD events in the varenicline group compared with placebo (AR=0.27; 95% CI, -0.10 to 0.63; *P*=.15).

This is a good example of how inclusion criteria, subsequently published clinical trials, and the choice of statistical methods can lead to conflicting conclusions from meta-analyses on the same topic. Including studies that showed no adverse CVD events is more likely to capture the true risk than excluding them, and reporting AR is more meaningful than estimating relative risk based on the Peto OR.

Therefore, the Prochaska findings are more convincing. Given the effectiveness of varenicline and the known benefits of successful smoking cessation, it is important for clinicians to understand that the true risk of CVD adverse events attributable to varenicline is extremely low or even nonexistent.

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1. Singh S, Loke YK, Spangler JG, et al. Risk of serious adverse cardiovascular events associated with varenicline: a systematic review and meta-analysis. *CMAJ.* 2011;183:1359-1366.
2. Prochaska JJ, Hilton JF. Risk of cardiovascular serious adverse events associated with varenicline use for tobacco cessation: systematic review and meta-analysis. *BMJ.* 2012;344:e2856.