Letters
Correspondance

Vexed

I need to express my abject disdain for *Canadian Family Physician's* February cover image. Please tell me how a woman's naked body, her genitalia obscured by only a bouquet of wheat, is in any way related to celiac disease? I understand the inclusion of wheat in the photograph but I am completely mystified as to the meaning or purpose of the naked women holding it. The only answer that I am able to reasonably construe is that the people who are responsible for the cover page simply gave virtually no thought to the graphic that would represent the featured article of February's issue; in other words, plain old laziness. Any other reason would be inane and perhaps even offensive. This sort of indiscretion is forgivable, but the intellectual rigour and effort poured into producing this periodical is undercut by a silly, superfluous picture of a nearly naked women. The journal's prestige no doubt suffers greatly from such a lack of thoughtfulness.

—Robert Simpson MD CCFP
Fort Macleod, Alta

I am concerned about the image used for the February 2009 issue of your medical journal. I am the wife of a doctor and I wonder why it is appropriate to put the nearly naked body of a woman on your front cover. I hope in the future you will think twice before choosing degrading or naked pictures for your cover pages. Children and patients do not need to see this.

—Lize Burger
Whiterock, BC

A perfect fit

We wish to congratulate Drs Lussier and Richard for their cogent Commentary in the August 2008 issue of *Canadian Family Physician*.[1] We agree with the important premise—one shoe does *not* fit all patients. It is wonderful to hear this from other primary care providers.

We are, however, concerned that the notion of patient-centredness suggests a single style of practice. It does not. The very term *patient-centred* implies different conversations with different patients for all sorts of reasons, which the authors outlined very well. We are also concerned by the authors' statement that a patient-centred approach "most closely corresponds"[1] to care of chronic conditions in which the psychosocial aspects of management might be important. A fundamental principle of our approach to patient-centred care is that it applies to every encounter between patients and physicians—in hospital or in the office—no matter how serious the circumstances. For example, if a patient with a sore throat wants a quick visit with minimum intervention, a patient-centred family doctor will ascertain this quickly. He or she will still provide all the required care for respiratory disease, but will not (because the patient has cued them) make inquiries about other problems or about feelings. On the other hand, if a hospitalized patient becomes uncomfortable and teary with panic after cardiac surgery and needs to express physical and emotional feelings, a patient-centred family doctor will be sure to explore these issues in depth to both avoid possibly serious physical consequences and relieve emotional stress. There are clearly exceptions to every rule; in fact, it can be said that every patient is the exception because each requires a unique response.

As well as finding a communication pattern that fits the patient and the context, the patient-centred approach seeks to integrate the world of the patient and that of the physician—it is not just about communication, it is a clinical method.

The College of Family Physicians of Canada's certification examination makes it clear that patient-centred practice varies from patient to patient while, at the same time, providing a consistent structure from which a resident can learn. The dynamic interplay between simplicity and reality occurs when teaching and researching patient-doctor communication.

This paper is a great addition to the literature. Patient-centred care requires flexible physicians who are willing to modify their approaches to suit patients' wishes, context, and urgency of problems. Being sensitive to suffering and personal circumstance is always relevant, no matter how serious the medical condition.

—Moira Stewart PhD
—Judith Belle Brown PhD
—Tom Freeman MD MClSc
—Wayne Weston MD CCFP FCFP
—Carol McWilliam MScN
London, Ont

Reference
1. Lussier MT, Richard C. Because one shoe doesn't fit all. *Can Fam Physician* 2008;54:1089-92 (Eng), 1096-9 (Fr).

Building emotional intelligence

I recently read the Commentary "Because one shoe doesn't fit all."[1] It is important to continually improve physician-patient relationships to best suit the needs of primary care and provide medical and emotional support to our patients. I was intrigued by the graphic representation of possible transformations in the doctor-patient relationship, which will certainly prove useful in medical training. I have seen physicians treat patients differently based on the difficulty of the cases. It would only be prudent to treat each patient in the same way on an emotional level, whether the problem is acute or chronic.

In cases that are purely medical, it seems likely that physicians might forget to incorporate patients' emotions into assessment and treatment, and might not acknowledge their own emotional reactions to

situations. I recently came across a study that examined emotional intelligence in physicians and how it affected patients' trust in the patient-physician relationship.[2] I hope that the awareness your article suggests[1] will include emotional intelligence training for physicians so they might understand how patients' personal and emotional contexts affect physicians' treatment capabilities.

Last, I wanted to bring to your attention a study from the Walter Reed Army Institute of Research in which the authors demonstrated that sleep deprivation had minimal effect on the ability to incorporate emotion and cognition to guide moral judgment in individuals with higher emotional intelligence.[3] Increasing the emotional intelligence of our physicians might help to avoid the negative effects of stress.

—Shaheen E. Lakhan MEd PhD AFACB MD
Executive Director and Medical Scientist
Global Neuroscience Initiative Foundation

References
1. Lussier MT, Richard C. Because one shoe doesn't fit all. *Can Fam Physician* 2008;54:1089-92 (Eng), 1096-9 (Fr).
2. Weng HC. Does the physician's emotional intelligence matter? Impacts of the physician's emotional intelligence on the trust, patient-physician relationship, and satisfaction. *Health Care Manage Rev* 2008;33(4):280-8.
3. Killgore WD, Killgore DB, Day LM, Li C, Kamimori GH, Balkin TJ. The effects of 53 hours of sleep deprivation on moral judgment. *Sleep* 2007;30(3):345-52.

Rural scope of practice

I read the article by Dr Kolber and colleagues[1] with great interest, and applaud them for providing patients with an important screening alternative. I too am a rural physician who performs endoscopies and I have also gone through training to provide safe and high-quality service.

Current North American recommendations support population screening with fecal occult blood testing (FOBT)—a less expensive, less sensitive alternative to colonoscopy. American patients, however, are being screened more often with colonoscopy than Canadian patients are.

Although colonoscopy has been available for a long time, no large randomized controlled trials have compared colonoscopy with FOBT. However, multiple small studies have demonstrated its benefits for detecting adenomas and cancer. Current evidence shows that the sensitivity for detection of cancer by FOBT is about 50%; by colonoscopy it is more than 90%.[2] Knowing this, it is difficult to deny patients colonoscopy as an alternative.

Recently, I was pleased to see a Cancer Care Ontario publication for patients that listed colonoscopy as an option for screening. This provides patients with a more educated understanding of their options.

In Canada, concerns include cost and provider availability. While constantly improving patient care, we should look forward and assess our resources, especially in rural areas.

We have to broaden the training of rural physicians to provide comprehensive care, including endoscopy, to improve care in rural areas. This will provide better screening for patients and will shorten wait times for diagnosis of colorectal cancer, which is the second and third most common cause of mortality from malignancies among men and women in Canada, respectively.

—Val E. Ginzburg MSc MD CCFP
Alliston, Ont

References
1. Kolber M, Szafran O, Suwal J, Diaz M. Outcomes of 1949 endoscopic procedures. Performed by a rural family physician. *Can Fam Physician* 2009;55:170-5.
2. Pignone M. Screening for colorectal cancer in adults at average risk: summary of the evidence for the US Preventive Services Task Force. *Ann Intern Med* 2002;137(2):132-41.

The top 5 articles read on-line at cfp.ca last month

1. **Clinical Review:** Complementary and alternative medicine for treatment of irritable bowel syndrome (February 2009)
2. **Clinical Review:** Home blood testing for celiac disease. Recommendations for management (February 2009)
3. **Commentary:** Irritable bowel syndrome. Are complementary and alternative medicine treatments useful? (February 2009)
4. **Dermacase** (February 2009)
5. **Editorial:** Screening and the family physician (February 2009)

Correction

In the article "Home blood testing for celiac disease. Recommendations for management,"[1] published in the February issue, an error appeared in the byline. Ms Case should have been listed as Shelley Case, RD. The error has been corrected on-line ahead of print.

Reference
1. Rashid M, Butzner JD, Warren R, Molloy M, Case S, Zarkadas M, et al. Home blood testing for celiac disease. Recommendations for management. *Can Fam Physician* 2009;55:151-3.

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