physicians of potential candidates identified by review of laboratory test results. Once registered, people with diabetes who choose to participate in the program are scheduled for testing according to the 2003 Canadian Diabetes Association Guidelines. Those who fail to attend as scheduled receive up to 2 reminder letters by mail. Those who do attend receive a personalized patient progress report by mail within 1 week of laboratory testing. The report includes the following:

- the 2 most recent $A_c$ results,
- the most recent systolic blood pressure measurement,
- the most recent lipid results (low-density lipoprotein, risk ratio),
- explanations of the different tests, including targets,
- a reminder of the next scheduled testing date, and
- a reminder of the importance of an annual eye examination.

Since inception, our program has achieved the following:

- 91% of the presumed number of people with diabetes in the Central Okanagan have been identified and registered,
- 69% of those registered participate actively in the program,
- 98% of family physicians practising in the area actively participate,
- 90% of participants had 2 or more $A_c$ tests in 2006 (compared with 35% of non-participants), and
- 65% of participants’ $A_c$ results were $\leq 7\%$ in 2006 (compared with 55% of non-participants’ results).

A laboratory-administered program that supports self-management by offering simple reminders and direct reporting of results to people with diabetes seems to enhance achievement of recognized metabolic targets and of testing frequency recommendations.

—Duncan Innes MB
—Andrew Farquhar MD
—David Cameron MD
Kelowna, BC
—Hugh Tildesley MD
Vancouver, BC
by e-mail

Reference


Culture-oriented health care

Policies on health care access and related issues have been undergoing many changes over the past several years in industrialized countries. Primary health care with specialist support as a baseline is now an accepted method in many places. This and other approaches are the result of and are subject to ongoing evolutionary processes based on the political, economic, and educational levels of each society.

As a physician who has had the opportunity to work in different health care systems, I have realized that cultural beliefs and societies’ perceptions of their medical systems are important aspects of health care access. Copying one relatively successful health care system and applying it in different countries with very different cultural backgrounds and beliefs is subject to many pitfalls and failures. A 2-m by 3-m carpet can be made by a machine in less than 5 minutes or handmade in more than 6 months. They can be used for the same purpose and cover the same surface area, but, no matter how many hours of lecture you deliver, you are unlikely to convince any Iranian-origin family to accept a carpet in their room that was not made by hand. It will not happen. This is something respected as a heritage and signature of that country.
Letters | Correspondance

The respect for and expectations of doctors follows similar lines. People expect the best results and approaches from their health care system at all encounters. This concept has been transferred to them with a proud history. In many parts of the world, doctors are more than teachers (as the origins of the word imply) or healers. They are artists and spiritual role models. Many people are not convinced by anything less than the finest specialized opinion right from the beginning. Most countries have adopted primary care methods partly because it is very expensive to train specialists. If a society is able to train and create access to specialists for its population as first-line access, then there would be nothing wrong with that—a luxurious model with its own difficulties but with high levels of satisfaction for those who are from cultures that believe in it.

—Ali Ahmadizadeh MD
Miramichi, NB
by e-mail

Thinking about errors

Thank you for the informative research article classifying errors in family medicine. ¹

I would like to draw attention to a related article in the New Yorker magazine in January 29, 2007: “What’s the Trouble? How doctors think,” by Jerome Groopman.²

This article outlines the work of Pat Croskerry, an emergency physician in Halifax, NS, with a background in psychology. He has published articles borrowing insights from cognitive psychology to explain how doctors make clinical decisions, especially how they make errors in diagnoses. To make diagnoses, most doctors rely on shortcuts known in psychology as “heuristics.” Croskerry has divided errors in diagnosis into 3 categories.

• Representativeness errors are made when thinking is overly influenced by what is typically true.
• Availability errors are made when judgments about patients are unconsciously influenced by the symptoms and illnesses of patients just seen.
• Affective errors arise from a tendency to make decisions based on what we wish were true.

Croskerry makes the important point that how doctors think can affect their success as much as how much they know or how much experience they have.

—Denise Bowes MD CCFP
Athens, Ont
by e-mail

References

Take stories to heart

I read with great interest Dr Miriam Divinsky’s editorial on narrative medicine. I also was saddened to hear of Dr Divinsky’s death, a profound loss for the family medicine community.

Although I was not familiar with narrative medicine, I am intrigued by its promise and intend to learn more about it.

My own experiences over the last 2 years have led me to believe that the medical professions, including family physicians, are badly in need of a boost in their abilities to offer compassion and empathy to patients and colleagues alike. During this time, I have had to cope with the illness and death of my wife from cancer (she died at about the same age as Dr Divinsky).

I have many stories to tell of this ordeal. Our experiences with the oncologists involved with my wife’s care were not pleasant, as her needs—especially her emotional needs—were never fully addressed. She was made to feel as if she were being “written off” (my wife’s words) without being offered some limited form of hope, even in the face of advanced disease.

Thankfully, during the late stages of her illness, she was cared for by a palliative care physician who treated...