I go to my minister to pray

When I saw the article title "Religion in primary care. Let's talk about it" in the March 2012 issue,[1] my secular mind started to review all the events, disasters, and atrocities that human history owes to bringing religion to all the aspects of our lives. Please, not here, not in medicine. You have the churches and mosques, synagogues and temples, politics and governments. We came a long way from religious healers to medical doctors, from astrology to astronomy, from alchemy to chemistry, millennia and centuries long. It would be a disastrous regress for us to give our precious time to going on our knees, taking our patients' hands, and praying for their recovery instead of using critical thinking, applying our medical knowledge, and spending time on what we really should be concerned about.

—Roya Firouzabadi MD CCFP
Whitby, Ont

Competing interests
None declared

Reference
1. Guilfoyle J, St Pierre-Hansen N. Religion in primary care. Let's talk about it. *Can Fam Physician* 2012;58:249-51 (Eng), e125-7 (Fr).

Religiosity in primary care

I really enjoyed that the article "Religion in primary care. Let's talk about it"[1] brought up the issue of religiosity in primary care, an area I am particularly interested in. I agree this is an area that remains neglected owing to the many reasons the article discussed,[1] especially the negative connotations that quickly come into the conversation with patients if there is any element of proselytizing. I myself remain committed to exploring the realm of spirituality in my personal life such that when I do have the occasion to bring up "spirituality" and related inquiry, there is really a neutral ground one can readily achieve if such discussions are approached with reverent curiosity in this very important realm of existence for any person so inclined. I even use a spirituality score (out of 10) to ask how a patient might be coping, which allows me to discuss spiritual strategies for those trials one inevitably needs to meet. With the proper accepted connection with a patient, there is then a much easier sense of comfort possible when meeting challenges that seem insurmountable by conventional, modern medical means. One does not expect to spend lengthy periods on this aspect, but leaves open to the patient further discussion and possible support from this angle. Interesting that in doing this, one really gains comfort oneself, as well as the ability to extend such comfort to the patient, a truly 2-way street.

—John de Couto MD
Burnaby, BC

Competing interests
None declared

Reference
1. Guilfoyle J, St Pierre-Hansen N. Religion in primary care. Let's talk about it. *Can Fam Physician* 2012;58:249-51 (Eng), e125-7 (Fr).

Response

I thank Dr de Couto for his kind comments. He has grasped the essence of what I was hoping to communicate in the article.[1] Hopefully, religion can continue to contribute to our well-being and that of our patients.

—John Guilfoyle MBBCh BAO FCFP
Garibaldi Highlands, BC

Competing interests
None declared

Reference
1. Guilfoyle J, St Pierre-Hansen N. Religion in primary care. Let's talk about it. *Can Fam Physician* 2012;58:249-51 (Eng), e125-7 (Fr).

On-target article

The article by Shaw et al,[1] which is one in a series that explains the Triple C initiative, in the March 2012 issue was excellent. It was beautifully written, concise, and right on target for readers who might be new to these terminologies—not an easy task, given the large number of authors! One of the final paragraphs hinted at an interesting challenge that lies ahead. While the rationale for changing to family medicine–centred residency education is clearly presented and easy to understand, it might legitimately still be viewed as largely theoretical. Some theories, in hindsight, made a lot of good sense at the time, yet fell to practical challenges and rigorous testing. As a discipline, and as a specialty, it will be important to question these new changes, even as we proceed. At every step we will need to ask ourselves not only whether our specialty is better served, but also whether our patients are truly seen to benefit. As much as it will be exciting for our future family medicine researchers to explore new and innovative ways to measure cause and effect, it will also be their scientific if not moral obligation. We owe our patients nothing less.

—Keith D. Ogle MD CCFP FCFP
Saskatoon, SK

Competing interests
None declared

Reference
1. Shaw E, Walsh AE, Saucier D, Tannenbaum D, Kerr J, Parsons E, et al. The last *C*: centred in family medicine. *Can Fam Physician* 2012;58:346-8 (Eng), e179-81 (Fr).

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4. **Clinical Review:** Treatment and prevention of herpes labialis (December 2008)
5. **Case Report:** Chronic vulvar irritation: could toilet paper be the culprit? (April 2010)