

extent of the relationship need to be clear; we must recognize that each specialty serves a different purpose.¹⁰ Certainly, linkages exist that warrant careful attention (eg, around vaccinations, screening, reportable diseases, and using population data in diagnosis). However, suggesting that family doctors should lead on broader population health planning ignores the training and primary work of their public health physician colleagues.¹¹

To that end, I want to believe that the authors intended to call for better exposure to public health concepts in family medicine training, with the goal of improving the existing partnerships between public health and family medicine. Indeed, while I am grateful for the authors' interest, I cannot help but feel that a better understanding of the real work of public health would have helped to clarify many of the concepts as presented in the original article.

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Competing interests

None declared

References

1. B-Lajoie MR, Chartier L. Wanted: better public health training for family physicians. *Can Fam Physician* 2016;62:471-3 (Eng), e294-6 (Fr).
2. Loh LC. Public health and why terminology matters [blog]. *BMJ* 2016 May 26. Available from: <http://blogs.bmj.com/bmj/2016/05/26/lawrence-loh-public-health-and-why-terminology-matters>. Accessed 2016 Jun 24.
3. Canadian Public Health Association [website]. *12 Great achievements*. Ottawa, ON: Canadian Public Health Association. Available from: www.cpha.ca/en/programs/history/achievements.aspx. Accessed 2016 Jun 24.
4. Canadian Public Health Association [website]. *Reducing deaths and injuries on our roads*. Ottawa, ON: Canadian Public Health Association. Available from: www.cpha.ca/en/programs/history/achievements/07-mvs/roads.aspx. Accessed 2016 Jun 24.
5. Warner KE. Tobacco control policies and their impacts. Past, present, and future. *Ann Am Thorac Soc* 2014;11(2):227-30.
6. Moloughney BW. Public health medicine, public health practice, and public health systems. *Can J Public Health* 2013;104(2):e115-6.
7. Loh LC. Please stop calling it a "health system." *Can J Public Health*. In press.
8. Royal College of Physicians and Surgeons of Canada. *Objectives of training in the specialty of public health and preventive medicine*. Ottawa, ON: Royal College of Physicians and Surgeons of Canada; 2014. Available from: www.royalcollege.ca/cs/groups/public/documents/document/y2vk/mdaw/-edisp/tztest3rcpsced000887.pdf. Accessed 2016 Jun 24.
9. Canadian Medical Association [website]. *Health equity and the social determinants of health*. Ottawa, ON: Canadian Medical Association. Available from: www.cma.ca/En/Pages/health-equity.aspx. Accessed 2016 Jun 24.
10. Corber S. Medical officers of health, public health and preventive medicine specialists, and primary care physicians: how do they fit? *Can J Public Health* 2013;104(2):e111-2.
11. Loh LC, Harvey BJ. A look to the past as we look ahead: the specialty of public health medicine in Canada. *Can J Public Health* 2013;104(2):e108-10.

Some cold water on the realities of modern public health

As someone who completed the additional training (a Master of Public Health degree through part-time studies) suggested by Drs B-Lajoie and Chartier,¹ and even worked part time for a number of years at an Ontario public health unit, I agree that public health is something of a forgotten stepchild in medicine. However, before initiating an expansion of public health training for physicians, we need to think carefully about what it is we are hoping to achieve.

With regard to the education component, I enjoyed my Master of Public Health program, but would be lying if I thought that most of the curriculum applied to medical work. In fact, a good chunk of the material went well beyond the scope of activities performed in public health work, and bordered on promoting a particular political leaning. *Many* doctors I know are strongly devoted to their patients and their art, but have little patience for being told what to think about tax policy and politics.

The typical job of a public health doctor is also something of an elephant in the room. Yes, there is good work to be done on health promotion, and medical insight is essential in managing an outbreak. But large parts of the job—tedious ministry teleconferences, hostile (often personality-driven) media, political agendas of governing boards, organizational administration, squabbles over budgets—could hardly be construed as medicine. What exactly is the goal of training more doctors in public health, if not to work at a public health unit?

Finally—and this situation might be unique to Ontario—we also have to bear in mind that a pivot to work in public health constitutes a change in scope of practice. That triggers the College of Physicians and Surgeons of Ontario (CPSO) to begin its intensive meddling into one's career. My own experience tells the tale, as the CPSO continually moved the goalposts on me, demanding ever more red tape and supervision, despite my ever greater experience on the job. Had I known the CPSO would see fit to do as it did, I would not have bothered at all.

I suppose we can all champion having more public health content in medical school. But how do you convince a brand-spanking-new class of science-minded medical students that if they really want to save lives, they need to take action on poverty and homelessness? As memory serves, the material and themes were there, and were even stressed in medical school—they were just promptly forgotten once we started rotating on the wards.

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Competing interests

None declared

Reference

1. B-Lajoie MR, Chartier L. Wanted: better public health training for family physicians. *Can Fam Physician* 2016;62:471-3 (Eng), e294-6 (Fr).

Routine screening pelvic examinations have a negative effect on patients

Jones et al stated that researchers and doctors should not harm patients and should work to help individual patients, not patients in general.¹ In 2016, the Canadian Task Force on Preventive Health Care recommended not performing pelvic examinations in asymptomatic women. Dr Ladouceur proposes that discontinuing

routine pelvic examinations “could ... have a negative and unexpected effect on physician competence—and, by extension, on women’s health.”²

A pelvic examination takes time, causes embarrassment and discomfort, and worst of all initiates the diagnostic cascade: if the doctor finds something, he or she feels compelled to order more tests, including biopsy. The likelihood that 2 pathologists will agree on the interpretation of a slide is 80%.³⁻⁷ This means that if a woman is diagnosed with ovarian cancer, there is a 20% chance that another pathologist would say that the patient does not have cancer.

Recently, a 65-year-old woman asked if I would consider helping her die. She has chronic pain from multiple vertebral fractures due to severe osteoporosis. When she was 26 years old she was found to have an ovarian cyst. The first 2 pathologists who studied the tissue were not sure what to call the pattern. The third pathologist said, “It’s cancer.” The patient had bilateral oophorectomy.

I agree with the recommendation of the Canadian Task Force on Preventive Health Care that we should not do pelvic examinations on asymptomatic women. If a doctor wants to maintain competence in a skill, the doctor should take a course in which the human participants know they are being used for training.

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Competing interests

None declared

References

1. Jones DS, Grady C, Lederer SE. “Ethics and clinical research”—the 50th anniversary of Beecher’s bombshell. *N Engl J Med* 2016;374(24):2393-8.
2. Ladouceur R. Recommendations for the routine screening pelvic examination. Could they have a negative effect on physician competence? *Can Fam Physician* 2016;62:460 (Eng), 461 (Fr).
3. Baak JP, Lindeman J, Overdiep SH, Langley FA. Disagreement of histopathological diagnosis of different pathologists in ovarian tumors—with some theoretical considerations. *Eur J Obstet Gynecol Reprod Biol* 1982;13(1):51-5.
4. Eriksson H, Frohm-Nilsson M, Hedblad MA, Hellborg H, Kanter-Lewensohn L, Krawiec K, et al. Interobserver variability of histopathological prognostic parameters in cutaneous melanoma: impact on patient management. *Acta Derm Venereol* 2013;93(4):411-6.
5. Farmer ER, Gonin R, Hanna MP. Discordance in the histopathologic diagnosis of melanoma and melanocytic nevi between expert pathologists. *Hum Pathol* 1996;27(6):528-31.

6. Paech DC, Weston AR, Pavlakis N, Gill A, Rajan N, Barraclough H, et al. A systematic review of the interobserver variability for histology in the differentiation between squamous and nonsquamous non-small cell lung cancer. *J Thorac Oncol* 2011;6(1):55-63.
7. Present CA, Russell WO, Alexander RW, Fu YS. Soft-tissue and bone sarcoma histopathology peer review: the frequency of disagreement in diagnosis and the need for second pathology opinions. The Southeastern Cancer Study Group experience. *J Clin Oncol* 1986;4(11):1658-61.

Correction

In the “Family Medicine Forum Research Proceedings 2015” supplement to the February issue of *Canadian Family Physician*, an author was inadvertently omitted from the abstract “‘How is it for you?’ Residents’ and faculty experience with a new family medicine competency-based curriculum.”¹ The byline should have appeared as follows:

Maria Palacios DDS MSc PhD Keith Wycliffe-Jones MBChB CCFP
Vishal Bhella MD CCFP Sonya Lee MD CCFP FCFP

Canadian Family Physician apologizes for this error and any embarrassment it might have caused.

Reference

1. Palacios M, Wycliffe-Jones K, Bhella V, Lee S. “How is it for you?” Residents’ and faculty experience with a new family medicine competency-based curriculum [abstract]. *Can Fam Physician* 2016;62(Suppl 1):S59.

Correction

In the article “Fetal outcomes following emergency department point-of-care ultrasound for vaginal bleeding in early pregnancy”¹ in the July issue of *Canadian Family Physician*, an error was inadvertently introduced in the order of authorship. The byline should have appeared as follows:

Catherine Varner MD MSc CCFP(EM) Dahlia Balaban MD MSc CCFP
Shelley McLeod MSc Sally Carver
Bjug Borgundvaag PhD MD CCFP(EM)

Canadian Family Physician apologizes for this error and any embarrassment it might have caused.

Reference

1. Varner C, Balaban D, Borgundvaag B, McLeod S, Carver S. Fetal outcomes following emergency department point-of-care ultrasound for vaginal bleeding in early pregnancy. *Can Fam Physician* 2016;62:572-8.

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