



the fact that vertebral fractures are a surrogate outcome, where a radiologist measures the x-ray with a ruler, and patients are usually asymptomatic. In the Critical Appraisal series we try to focus on outcomes that are most important to patients and family doctors, because this allows us to wade through the medical literature and prioritize the most effective therapies. In this case it is hip fracture rates that were not statistically different from the placebo group despite the large number of women in this trial. I still stand by the sentence, as I do believe this trial's outcomes were predominantly based on radiographic findings that largely did not affect the quality of patients' lives.

2. Concern was raised about the effectiveness of raloxifene and the effect of calcium and cholecalciferol because doses, particularly for cholecalciferol, were less than those used in other trials to prevent fractures. Dr MacIver assumes that prevention was, therefore, due to raloxifene. This might be true, but it might also mean that the true benefit of raloxifene over calcium and cholecalciferol is less than what is reported in this trial.
3. Dr MacIver states that "Further analysis of the MORE trial demonstrated that the number of women withdrawing from the study due to adverse events was about the same in the raloxifene groups as in the placebo group." I am not sure whether he is referring to another analysis of this trial, but in the main outcomes the authors state that "[W]omen in the raloxifene groups withdrew from the study more often because of adverse events and developed more thrombosis (1% vs 0.3%)." I do agree with Dr MacIver that this medication can be well tolerated, but I find the thrombosis rate quite worrisome given the seriousness of the condition.

4. Dr MacIver concludes by stating, "After appropriate discussion of the risks and benefits of therapy, I will continue to prescribe raloxifene to my patients, and it should remain an important option for osteoporosis patients for years to come." I agree with this. I am particularly interested in following the story of breast cancer prevention. At this point, my own position is that alendronate has the best evidence (ie, hip fracture prevention data), etidronate is the most practical (inexpensive, easy to take with good supporting cohort data), and hormone replacement therapy is most helpful for the symptoms of menopause. I look forward to further data on selective estrogen receptor modulators and possibly changing my position.

—*Michael Evans, MD, CCFP*  
(*Co-author Dr Hathirat is in Thailand and could not be reached for comment.*)

## Aboriginal health and family physicians

I read Dr Smylie's reference in her December 2001 article,<sup>1</sup> "Building dialogue," quoting me from a newspaper article about the problems in Sheshatshiu, Lab: "This is a spiritual issue and no amount of money can heal the spirit." This is followed by her declaration that "As an Aboriginal person, I have been taught that I can speak only for myself. To speak for others, especially members of a community of which I am not a part, would be to show disrespect."

I ponder these words, look at their context, and feel their bite. Yet, I agree with her. To speak for another person is disrespectful. Further, this has not only to do with being aboriginal, it has to do with being a decent and respectful human being. It is also especially true when the person whose voice is usurped is perfectly capable of speaking for himself or herself. I can understand the frustration that

perhaps Dr Smylie and all aboriginal people feel when you perceive that, as Peter Penashue, President of the Innu Nation said, "Another outsider is telling you what to do." Certainly, the silencing of aboriginal voices since white people arrived in North America has left a devastating legacy.

At this moment in history, however, there is a heartbreaking catch. What about the children, neglected and abandoned by parents gone to bingo, perhaps even with money distributed by the election campaigns of the band council? What about the babies turned to cinders in burning homes while their parents are drunk on the day that the Child Tax Credits arrive in the mail? What about the babies born with fetal alcohol syndrome? Those little children all have names and lovely faces. In one small community, I know them. I know all the ones who died. I held them when they were born and said a quiet prayer in the hope that healing would come soon to their circumstances.

The challenge, then, for me has been this: when is it disrespectful to speak about a community to which I do not belong, and when is it impossible to stay silent? When is my silence simply an extension of the silence of all of those little, dead children? We each have our own breaking point in this dilemma. I can only listen to, and hold the intentions of love and compassion in, my own heart.

Dr Smylie is a Métis woman and a family physician. I am very interested in finding out how she has responded to these impossible circumstances in her own practice. Of course, I will go to the websites suggested in her article. At the same time, I would be very interested in "building dialogue" with her concerning these issues. I know there are many other caregivers who have practised medicine in cross-cultural settings. Some have been similarly dismissed when very real issues of corruption and neglect have been brought to the table. It is true, no doubt, that some of these caregivers



might have been the “white” stereotype: domineering, disrespectful, pompous, and insensitive to the sacredness of the earth. But I know that this is not always the case. In my view, many of these white caregivers simply have circled too close to the shadows within the present system. Except for a book called *A Poison Stronger than Love*,<sup>2</sup> and some writings by Professor Taiaiake Alfred of the University of Victoria in British Columbia (specifically an article in *Windspeaker*, entitled “Managing pain is big business”<sup>3</sup>), I have not seen or participated in an honest and open discussion about what is really going on in the health care of aboriginal people.

—Jane McGillivray, MD  
Northwest River, Lab  
by mail

#### References

1. Smylie J. Building dialogue. Aboriginal health and family physicians [editorial]. *Can Fam Physician* 2001;47:2444-6 (Eng), 2452-5 (Fr).
2. Shkilnyk A. *A poison stronger than love*. New Haven, Conn: Yale University Press; 1985.
3. Alfred T. Managing pain is big business. *Windspeaker* 2001;18(9). Available from: [www.ammsa.com/windspeaker](http://www.ammsa.com/windspeaker). Accessed 2002 Mar 11.

## Response

Thank you for your very articulate and sensitive response to my editorial. I thought carefully about how to best phrase the opening paragraph in which I included your quote from the newspaper. Using the situation in Sheshatshiu was a problem for me from the beginning because, if I were truly adhering to the ethic of speaking strictly for myself, I would never have used it as the introduction to the editorial. I am not from Sheshatshiu, and I certainly do not know what it is like to live there or to have been a solo family physician to the community for 10 years. So to you and the community members of Sheshatshiu, I must say that I meant no disrespect or judgment in my discussion of your situation. I hope that what follows will clarify and provide some insight into why I chose to discuss a situation about which I knew very few specifics, other than what I could glean from news reports.

I chose to include this introduction, despite my misgivings, to raise awareness and understanding of the building of effective family practice relationships with Aboriginal\* people and communities among my family practice colleagues. I knew that images of gas-sniffing children in Sheshatshiu would be remembered by many readers. My Eurowestern-trained and acculturated mind told me that this would be an effective “hook.” As I listened and read about the controversy following your letter and the community response to it, from my perspective and sensitivities

as a Métis woman who has worked as a family physician in a variety of Aboriginal and non-Aboriginal settings, it appeared that at least some of what was happening was the result of very different styles of communication and problem solving.

In my experience, such differences, especially when they are not explicitly and carefully articulated and understood, are a notable contributor to the health challenges facing Aboriginal people and communities and the health practitioners who work in these communities. In this situation, it appeared that an Aboriginal community was losing a dedicated and skilled provider. The editorial was meant to provide information and resources that might begin to bridge this type of misunderstanding.

You have clearly stated your dilemma: “When is it disrespectful to speak about a community to which I do not belong, and when is it impossible to stay silent?” To answer this question is very difficult, because I have not experienced the context. When someone has worked in a community for 10 years, attended births, and watched children grow and sometimes die, however, he or she begins to become part of that community regardless of

\*The term Aboriginal is used as an inclusive term referring to people of First Nations, Inuit, and Métis ancestry.

race or culture of origin. As a member of a particular Aboriginal community, I may be expected to put family and community success ahead of my own personal needs, responsibilities, and rights.

When trying to effect change in my work with Aboriginal people and communities, I must be aware of the ethic of “non-interference,” which Brant has defined as “a behavioural norm of North American Native tribes that promotes positive interpersonal relations by discouraging coercion of any kind, be it physical, verbal, or psychological.”<sup>1</sup> The act of an individual community member writing a letter about a community and having it published outside of the community, while commonplace and acceptable by Western democratic standards, would violate the value system described above. The community’s strong reaction against this act would be predictable.

You might have known this when you wrote your letter. I do not believe that any individual or group, Aboriginal or non-Aboriginal, can come up with the answer to “impossible circumstances” alone. I frequently find myself feeling overwhelmed. I think the solutions will need to be collaborative. Some of the questions I ask myself are: How can I work within this community to mobilize change? Who are the people in the community who have ideas about how to improve things? How can I work together with them? Am I able to recognize and respect their wisdom and inherent knowledge? And, most importantly, what would happen if discussions about Aboriginal health between Aboriginal people and communities and their health care providers were open and honest and *mutually understood*?

Thank you again for the opportunity to discuss these issues.

—Janet Smylie, MD, CCFP

#### Reference

1. Brant C. Native ethics and rules of behaviour. *Can J Psychiatry* 1990;35:534-9.

## “Cyber” column meets a need

I really enjoy the CyberSearch column by Dr Cathy Risdon in *Canadian Family Physician*. I am a true neophyte in Web-based searching for answers to clinical questions and have been waiting for someone to make it easy and accessible enough for me to actually bother. Time is so tight that a lot of the evidence-based medicine is just not practical for me, even though I believe in the end result.

I had training in OVID and even that was too cumbersome; I have not used it once. I do have a Palm Pilot, which I use a lot, and I have UpToDate, which I find very helpful, but it was not until I read Dr Risdon’s CyberSearch columns that I really found a way to get into the Internet without getting lost and hopelessly behind on other things.

I think this column is meeting a real need. I am especially interested in topics other than internal medicine, such as pediatrics, orthopedics, obstetrics, psychiatry, and the surgical specialties, from a family medicine perspective.

—Larry Willms, MD, CCFP  
Sioux Lookout, Ont  
by e-mail

## Response

Thank you for your comments on CyberSearch. I am happy to hear the column is increasing your ability to navigate the World Wide Web in a way that makes sense for your practice.

Thank you for your request about favourite sites. What a great topic for a future column! I will take up the challenge to find a good general surgery site and let you know what happens.

As well, in the next several months I will be introducing a tool for storing favourite sites that will allow users to be at home on any computer with an Internet connection. I think some of the sites I have been accumulating will be helpful to you. Stay tuned....

—Cathy Risdon, MD

## Remuneration: looking for a better way

It was interesting to read the tug-of-war between Rosser and Kasperski<sup>1</sup> and Pamela Mulligan.<sup>2</sup> The problem is that each ignores the facts.

The facts are that Rosser and Kasperski’s vision of a blended funding model is not that of the Ontario Family Health Networks. There is no “sessional fee” or any other incentive for taking care of complex illnesses, although this would be desirable. There is no fee-for-service component for after-hours emergency call that is specifically *included* in the global coverage. To be fair, there is fee-for-service payment for obstetrics and visits by non-enrolled patients, although it is capped.

On the other hand, Mulligan makes no argument to deal with the current intolerable situation of walk-in clinics “skimming” the easiest problems, and of committed family physicians being rewarded only for the high-volume component of their practices.

No one has yet proposed that the fee-for-service model could be modified to provide just the incentives necessary for comprehensive care. As a matter of fact, the current fee schedule in Ontario actively discourages comprehensive care by limiting the number of counseling sessions to three per patient per year no matter how many problems a patient has. In my opinion, the “relative value-based” fee schedule currently in preparation in Ontario will not provide the right incentives either.

I agree with Mulligan that capitation puts us in a position of conflict of interest: providing fewer services increases our hourly wage. Fee-for-service puts us in conflict, too: we must balance volume and quality. There is no perfect way.

Overall, I think Rosser and Kasperski’s proposals are the best compromise, but this model is not being implemented in the real world, and so those of us looking for a better