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Letters ❖ Correspondance

Nova Scotia FPs involved in mental health care

The editorial[1] on family medicine and psychiatry failed to emphasize the current expertise and past performance of family practitioners in delivery of mental health care.

Family practitioners in Nova Scotia play a major role in hospital care for depression. At small rural hospitals they provide psychiatric care—there are no psychiatrists. Our study[2] found that 33% of the 4383 individual Nova Scotian patients hospitalized for depression (1989 to 1991) were hospitalized exclusively in general hospital, non-specialized units (followed through 1994); 51% of the 4383 were hospitalized at least once in general hospital, non-specialized units.

In addition, the cost of this hospital care provided by family practitioners was lower. Mean longitudinal hospital cost for patients treated exclusively in general hospital, non-specialized units was less than one sixth of those treated in psychiatric units or psychiatric hospitals.

Family practitioners in Nova Scotia do play a major role in hospitalized care for depression.

—Vincent Richman, MBA, PHD
Halifax, NS
by e-mail

References

1. Kates N, Craven M. Family medicine and psychiatry. Opportunities for sharing mental health care. *Can Fam Physician* 1999;45:2561-3 (Eng), 2572-4 (Fr).
2. Richman VV, Richman EM, Richman A. Patterns of hospital costs for depression in general hospital wards and specialized psychiatric settings. *Psychiatr Serv* 2000;51(2):179-81.

Response

Dr Richman correctly identifies the fact that family physicians are already playing important roles as providers of mental health care, especially in rural areas where access to psychiatrists might be limited.

The Canadian Psychiatric Association (CPA) and the College of Family Physicians of Canada's (CFPC) joint position paper, "Shared Mental Health Care in Canada,[1]" recognized the roles family physicians already play in this area, but also identified that mental health services have not been as helpful as they might have been in supporting this role. One of the key goals of the shared care working group, set up by the CPA and the CFPC to implement the recommendations of the position paper, is to identify ways in which collaboration between psychiatrists and family physicians can support and enhance the role of family physicians as mental health care providers. The working group would welcome hearing any suggestions as to how this could be achieved or of examples of communities that have addressed this issue successfully.

—Nick Kates, MB, BS, FRCPC
Canadian Psychiatric Association
Co-Chair,
CPA/CFPC Conjoint Working Group on Shared Mental Health Care
—Marilyn Craven, MD, CCFP, PHD
College of Family Physicians of Canada's Co-Chair,
CPA/CFPC Conjoint Working Group on Shared Mental Health Care
Hamilton, Ont

Reference

1. Kates N, Craven M, Bishop J, Clinton T, Kraftcheck D, LeClair K, et al. *Shared mental health care in Canada.* Ottawa, Ont: Canadian Psychiatic Association; 1997.

Make your views known!

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Setting the record straight

In a recent editorial[1] in *Canadian Family Physician,* Dr William Maurice raised an important issue that deserves serious consideration. All treating physicians are better able to assist their patients when they are fully aware of all pertinent details surrounding their health. Sexual practices and problems are often important components of social and medical problems. His recognition of the difficulties still faced by some physicians in proactively obtaining such information is important.

I hope that his raising of this issue in *Canadian Family Physician* will assist those teaching and advising members of our profession.

There is one error in the editorial, however, concerning the particular

case that was the subject of a discipline hearing at the College of Physicians and Surgeons of Ontario. Although discussion of case details is accurate, the outcome of the case was not. In this case, the penalty ordered was a recorded reprimand and suspension of licence for 2 months.

Thank you for bringing this important issue to the attention of your readers.

—John M. Bonn, MD, LLB
Toronto, Ont
by mail

Reference

1. Maurice WL. Talking about sexual matters with patients. Time to re-examine the CMPA's policy. *Can Fam Physician* 2000;46:1553-4 (Eng), 1558-60 (Fr).

Clarification needed for raloxifene use

I appreciate the content and design of *Canadian Family Physician*, particularly its clinical relevance to my practice.

In the Prescrire article[1] in the August issue, two potential uses of raloxifene were suggested in the "Possibly Helpful" box at the beginning of the article. The first use said "in early menopause, when *estrogen is contraindicated*..." (emphasis added). I was unaware that estrogen is contraindicated in early menopause. Can we no longer switch women from oral contraceptive pills to hormone replacement therapy? Is this what the author meant? Is there a reference that would help me?

—M. Reinders, MD, CCFP
Orillia, Ont
by e-mail

Reference

1. Prescrire. Evidence-based drug reviews. Raloxifene. Not better than estrogen [Prescrire]. *Can Fam Physician* 2000;46:1591-6 (Eng), 1598-1603 (Fr).

Response

We should have been more precise. Of course, treatment with estrogen is not generally contraindicated in early menopause: indeed, some disorders linked to menopause are indications for estrogen-based drugs.

But there are circumstances that contraindicate treatment with estrogen and that can occur in early menopause, such as breast cancer and genital hemorrhage of undetermined origin. In these cases, raloxifene is not contraindicated and can therefore be useful. Of course, deep vein thrombosis contraindicates both estrogen and raloxifene.

—Dr Bruno Toussaint
Editor-in-chief
La revue Prescrire
Paris, France

Eligibility for MAINPRO-C credits

I am a member of the College of Family Physicians of Canada (CFPC) residing outside of Canada. I recently passed my first sitting of the American Family Practice Board examination and was disappointed to learn that my initial certification is not eligible for MAINPRO-C credits, although recertification is eligible.

Because members are allowed to claim only two life support courses (ie, Advanced Cardiac Life Support, Advanced Trauma Life Support, Advanced Life Support in Obstetrics) per cycle, it becomes very difficult for non-resident members to acquire sufficient MAINPRO-C credits, as most MAINPRO-C activities are based in Canada. If a member has sampled the Self-Learning Suite and has not found it conducive to ongoing medical education, this further limits the availability of MAINPRO-C credits.

I would like to see the CFPC consider allowing the American FP certification examination count for MAINPRO-C credits. Practitioners are not eligible to sit this examination until they have been in practice for at least 1 year, and many CFPC members will have been practising family medicine for well over a year when they first take the American certification examination.

I propose that the CFPC consider allowing non-resident members to claim more than two life support courses per cycle for MAINPRO-C credits, in light of the barriers (for non-residents) to accessing many MAINPRO-C activities.

—Andrea Hillerud, MD, CCFP, ABFP DIPLOMATE
Madison, Wis
by e-mail

Response

The College of Family Physicians of Canada's National Committee on Continuing Medical Education (NCCME) is aware that some of our members in the United States and abroad find it difficult to access