Letters
Correspondance

Approaching spider bites

I appreciated the publication of your CME article[1] on spider bites in the August issue. Within a day of reading your summary, I had yet another patient presenting with an alleged "spider bite." It was a joy to pull out your "British Columbia–based" article and discuss the pictures and key points with the medical student who was about to assess the patient. My compliments to both Robert Bennett and Richard Vetter for a well written, well presented review article.

—George Pugh, MHSC, MASC(EE), MD
Vancouver, BC
by e-mail

Reference

1. Bennett RG, Vetter RS. An approach to spider bites. Erroneous attribution of dermonecrotic lesions to brown recluse or hobo spider bites in Canada. *Can Fam Physician* 2004;50:1098-101.

Poverty and health care reform

I thank Dr Powles for his editorial[1] in the July issue. His article struck a chord with me. I have often cited the facts regarding income spread and health of populations when discussing such things as taxes and potential health care reforms in Canada with friends, family, and colleagues. I appreciate his positive and rational message: improvement in health is possible and comes by giving people tools and the support to use them.

A pervasive view of health care simplistically seems to see only the immediate bottom line, not the long-term implications. Economically, can we afford to ignore the poor?

—Helena Swinkels, MD, CCFP
West Vancouver, BC
by e-mail

Reference

1. Powles WE. Peering down the vortex [editorial]. Poverty and human health. *Can Fam Physician* 2004;50:963-5 (Eng), 969-71 (Fr).

The suffering of all patients

I would like to raise a few points in response to Dr Daneault and Dr Dion's exploration of the nature of suffering and our profession's approach to it.[1] Every clinical encounter, whether with a family physician or a specialist, is initiated because a patient is suffering in some way, and it is remarkable that we do not explicitly teach a basic approach to suffering in our medical schools. I hope Dr Daneault and Dr Dion's introduction will initiate many discussions in undergraduate lecture halls and hospital corridors throughout the country.

Although it is natural to focus on the nature of suffering of severely ill patients, it is also important to recognize that all patients suffer. Even a minor cosmetic injury can be devastatingly disfiguring to an actor, and a sprain that seems trivial to us might put an athlete's career in jeopardy. Unless we recognize that all patients seek our counsel because of a genuine affliction, we risk dismissing their complaints and thereby dismissing their integrity as individuals. If we accept Cassell's view,[2] this paradoxically increases their suffering.

Recognizing suffering and the reason for it is crucial, but we should also challenge ourselves to help patients come to terms with it. Invariably, this means assigning some meaning to the suffering. This is a very personal endeavour; however, we as physicians can aid patients in examining, and thereby accepting, an apparently random misery. Some will find solace in their religious traditions, whether they explain suffering as retribution for a previous offence or as a necessity that only a greater power can understand. Some will see the potential for growth through suffering, or the potential to teach and inspire others. Even the most cynical might see some value and

meaning in the purely biological struggle to survive. No matter what the approach, Viktor Frankl reminds us:

> We must never forget that we may also find meaning in life even when confronted with a hopeless situation, when facing a fate that cannot be changed. For what then matters is to bear witness to the uniquely human potential at its best, which is to transform a personal tragedy into a triumph, to turn one's predicament into a human achievement. When we are no longer able to change a situation—just think of an incurable disease such as an inoperable cancer—we are challenged to change ourselves.[3]

When the path to this transformation is difficult to discern in a busy office, I ask my patients to reflect upon it, and to write about it. This can help to define the suffering and to lend an understanding to it. One patient writes: "What is the point of living with this disability? I have become lazy, lonely and bored. But because I still feel these things means that I am alive. I need to move on."

Our focus on physical pain as the only kind of suffering that we can remedy, and on treating disease without always considering patients' interpretation of that disease, has weakened us as a profession. We can and must do better. Our countless research dollars cannot keep up with the ingenuity—and ultimately the immutable reality—of disease. We must not see this as a failure, for we are key to helping patients confront this reality. If we do not, suffering will continue to isolate our patients, and helping them will become increasingly pointless.

—David Ponka, MD, CCFP
Ottawa, Ont
by e-mail

References

1. Daneault S, Dion D. Suffering of gravely ill patients: an important area of intervention for family physicians [editorial]. *Can Fam Physician* 2004;50:1343-5 (Eng), 1348-50 (Fr).
2. Cassell EJ. The nature of suffering and the goals of medicine. *N Engl J Med* 1982;306:639-45.
3. Frankl V. Man's search for meaning. New York, NY: *Washington Square Press*; 1959.

Mandatory third-year training an unmanageable financial burden

Can we please put an end to the idea of a mandatory third-year training program for family medicine?[1] Have we forgotten that interest in family medicine is at an all-time low? Have we forgotten that almost all of the family medicine programs across the country were unmatched last year? Do people realize that medical students graduate with debt in excess of $100 000? Many students are turning to specialty programs for financial reasons. If we add another year, I believe many more will choose a 5-year program in order to secure financial independence. Wouldn't you in this scenario?

I encourage access to flexible third-year funding for those who wish to pursue extra training. Mandatory third-year training will make family medicine even less appealing than it is at present. We will head toward the American experience where only 8% of physicians are family doctors, compared with the 50% that Canada currently boasts.

—Rupa Patel, MD, CCFP
Kingston, Ont
by e-mail

Reference

1. Saucier D. Second thoughts on third-year training [editorial]. *Can Fam Physician* 2004;50:687-9 (Eng), 693-5 (Fr).

Physicians playing a role in health care reform

The editorial "Reinventing primary health care" in the October issue[1] is at best preaching to the converted, and at worst a waste of editorial space. What, after