# Letters
# Correspondance

## Easing the burden of mental health care

Dr Jayabarathan's editorial response[1] to the paper[2] "Shared Mental Health Care" by Rockman et al raises a number of valid issues.

If the health care system faces an "onslaught of adversity," then the mental health system reflects this by a lack of incentive to diagnose, treat, and manage mental illness. Funding issues are at the top of the list, which also includes a resource-depleted mental health system, poor distribution of specialists, and a lack of support for front-line practitioners.

The shared care model, currently in its infancy, is, in the narrowest sense, a method of assisting FPs to care for their patients; in a more ambitious way, it seeks to address some of Dr Jayabarathan's concerns.

Through early success, the shared care model is inspiring a movement to compensate FPs who are on the front line caring for mentally ill patients. The shared care model is evolving, guided by sensitivity to FP needs. For instance, based on FP feedback, shared care now embraces a spectrum of activity, including telephone, e-mail, and face-to-face backup for FPs. These approaches supplement actual patient contact, where a psychiatrist assesses a patient and provides ongoing support for FPs and patients. In some programs, shared care provides psychotherapists, case management, and language interpretation. Shared care schemes are also developing innovative CME formats, using traditional face-to-face sessions, in addition to teleconferencing, computer links, and the telephone.

I believe Dr Jayabarathan misunderstands the time commitment required of FPs who participate in the Collaborative Mental Health Care Network (CMHCN). Family physicians are *not* required to spend an hour consulting with a specialist mentor each week. In fact, a participating FP spends only as much or as little time as he or she wishes in consultation with a mentor.

As a variant of shared care, the Ontario College of Family Physicians' CMHCN mentoring program is just one step forward along a path of increasing access to mental health care and of easing the burden for FPs.

—*Tyrone S. Turner, MD, CCFP, FRCPC*
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*by fax*

**References**

1. Jayabarathan A. Shared mental health care. Bringing family physicians and psychiatrists together [editorial]. *Can Fam Physician* 2004;50:341-3 (Eng), 344-6 (Fr).
2. Rockman P, Salach L, Gotlib D, Cord M, Turner T. Shared mental health care. Model for supporting and mentoring family physicians. *Can Fam Physician* 2004;50:397-402.

## A truly humbling experience

Imagine being a rural family doctor in Canada, feeling rather isolated and overworked in your 20-bed hospital that you share with five other colleagues. Imagine meeting another rural doctor half way around the world who tells you that her rural hospital has 500 beds, she sees 6500 patients a month, and does 6000 deliveries a year. Not only is she doing this in the middle of South Africa, she is also acting as the hospital administrator and is working with only 12 doctors who double as anesthetists and obstetricians. Spotting an advertisement for the WONCA conference in Florida this October, I was reminded of this truly humbling experience.

On a cold, snowy day in Little Current, Ont, (on Manitoulin Island), I finally finished my first PowerPoint presentation on a rural high school clinic and was ready to present it at the WONCA conference in Melbourne, Australia. Keeping up my courage and trying to keep an open mind, I arrived in Melbourne and soon found myself in the midst of learning about new initiatives in women's health, such as family doctors flying around the Australian outback seeing women who rarely get a

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chance to see a female physician let alone any family doctor. Engineers and local health care workers presented a range of programs for aboriginal people, including housing initiatives where local plumbers and carpenters were identifying homes without the basics of hygiene, such as functioning faucets, and starting to improve the health of their communities.

Or how about promoting health through local football clubs? Rural doctors were buzzing around the various booths quizzing the purveyors of Palm Pilots, electronic medical records, distance education, and telemedicine. The poster presentations ranged from initiatives to promote point-of-care testing in isolated hospitals to clubs for medical students interested in rural practice. (Someone else must have noticed this booth, too, for there are few medical schools in Canada without one of these student groups today.)

It was hard to ignore the enthusiasm of the Canadian crew from Alberta with their white cowboy hats as they danced with the nursing sisters from South Africa to the latest Australian country music band. It was in this spirit of understanding and camaraderie that many serious issues were raised, such as the poaching of doctors from countries where physicians are underpaid but not necessarily undervalued by more wealthy countries such as ours. It was also enlightening to realize the power of the health care industry when someone tells you that they were parachuted in and out of Miami, Fla, to visit some US hospitals to see how they would benefit from having their hospital services contracted out to a North American firm.

In contrast, would physicians in developing countries be discouraged and mired in pessimism working with such limited resources? As my new friend explained it, imagine the outcry when a large amount of money was spent in sending the first South African into space. Sometimes there has to be a sacrifice so some truly great things can happen to provide hope and empower the rest of us. Having the chance to see the world through different eyes gave me some new ideas to bring back to my small community and a new perspective on Canadian medicine. I hope this letter inspires others to submit local initiatives to the WONCA conference and to attend the meeting in Florida this year or one of the many other meetings that happen yearly around the globe.

*—Michelle Lawler, MD, CCFP*
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*by e-mail*

## Focusing on glucosamine sulfate

I read with considerable interest the article[1] on the analgesic effects of glucosamine sulfate. Attention is now more focused on this most interesting nutraceutical, which has a range of actions including analgesic, antiarthritic, healing, and antiulcerogenic, and as a potential adjunct to other analgesics.

It is sad that glucosamine sulfate is chosen in preference to the hydrochloride form in most studies. The hydrochloride form contains 83.1% glucosamine whereas the sulfate form contains only 62.5%. The sulfate form is also unstable and needs 20% sodium or potassium chloride to maintain stability. In using the sulfate, one is not only giving 20% less glucosamine but also unwanted sodium or potassium chloride. The main reason for this is that the hydrochloride form discovered more than 100 years ago was not patentable, while the process of conversion to sulfate was, and, therefore, studies were supported by the manufacturer.

The original work on glucosamine and chondroitin synthesis was carried out by Roden[2] using the hydrochloride form. Because in the stomach, all forms of glucosamine disassociate, there are many advantages to giving the hydrochloride form, such as its higher concentration of glucosamine and no added salt. The greatest disadvantage of glucosamine hydrochloride is its lack of any substantial sponsorship. It is gratifying to note that the largest glucosamine study in the world, at present under way at the National Institutes of Health in the United States, is using the hydrochloride form in its glucosamine arm.