References
1. Anderson H, Goolishian H. Systems consultation to agencies dealing with domestic violence. In: Wynne L, McDaniel S, Weber T, editors. *The family therapist as systems consultant.* New York, NY: Guilford Press; 1986. p. 284-99.
2. Anderson H, Goolishian H. Human systems as linguistic systems: evolving ideas about the implications for theory and practice. *Fam Process* 1988;27:371-93.
3. Anderson H, Goolishian H. The client is the expert: a not-knowing approach to therapy. In: McNamee S, Gergen K, editors. *Social construction and the therapeutic process.* Newbury Park, CA: Sage Publications; 1992. p. 25-39.
4. White M. *Re-authoring lives: interviews and essays.* Adelaide, Australia: Dulwich Centre Publications; 1995.
5. White M, Epston, D. *Narrative means to therapeutic ends.* New York, NY: Norton Press; 1990.
6. Poon VH. Model for counseling people in relationships. *Can Fam Physician* 2007;53:237-8.

Kudos

I am retired now after 42 years in rural practice, which covered all aspects of medicine including obstetrics, anesthesia, critical care, emergency room coverage, and regular office hours, plus geriatric care at a large nursing home. Now I have time to reflect, thank goodness! I enjoyed the article on narrative medicine by Dr Rita Charon[1] and certainly think that such programs are effective and necessary for any medical student. It's too bad this wasn't covered back in the early 60s when I graduated from Queen's University in Kingston, Ont.

—Peter Dunlop MD FCFP
Dunnville, Ont
by e-mail

Reference
1. Charon R. What to do with stories. The sciences of narrative medicine. *Can Fam Physician* 2007;53:1265-7.

Well put

I am still stunned. All that I came to realize after practising and teaching family medicine for 26 years, the essence of what I have been struggling to achieve in my career, everything was articulated perfectly by Dr Charon: "The writing renders the … treatment a healing conversation between [doctor and patient]. Until the writing, there are 2 isolated beings … both of whom suffer, and both of whom suffer alone."[1]

I just finished reading the summer story issue of *Canadian Family Physician* (August 2007), and that spark of enthusiasm was all I needed to finally get in touch with Dr Charon. I first encountered the formal term of narrative medicine in an article she wrote for the *New England Journal of Medicine* in February 2004 and again a year later in her article honouring Susan Sontag. Ever since, I have been fantasizing about taking a sabbatical at Columbia, but I felt I would be crippled by my lack of knowledge of the English language; and in those matters of creativity (to state the corollary of what Boileau once said), if one cannot express oneself clearly, one just cannot think. Maybe it would be more realistic to start by attending one of Dr Charon's seminars or intensive training workshops at Columbia University. I would appreciate direction to a specific website that would provide me with the appropriate information.

Purely as a dilettante, I started writing articles on how to better understand the practice of family medicine in light of what art, science, and literature have to convey. Last winter I spent all my weekends wrestling with Chekhov in quantum mechanics. This year I intend to tackle the immense achievement of Albert Camus and particularly his notions of absurdity and revolt. (As an anecdote, did you know that Camus went to Columbia in the spring of 1946 and gave a conference in the MacMillan auditorium? He was then introduced as Albert Camoose!) I want to thank Dr Charon for her contributions to the summer story issue.

—Daniel Marleau MD CCMF FCMF
Rouyn-Noranda, Que
by e-mail

Reference
1. Charon R. What to do with stories. The sciences of narrative medicine. *Can Fam Physician* 2007;53:1265-7.

For information on training workshops in narrative medicine at Columbia University in New York, NY, please visit **www.narrativemedicine.org**.

Response

I appreciate the thoughtful correspondence I have received in response to my August 2007 essay entitled "What to do with stories. The sciences of narrative medicine."[1] I find each of the comments rich and provocative, both intellectually and relationally. That is to say, the comments demonstrate the emergence of a fresh discourse marked by multiplicity and intersubjectivity, in which the care of the sick becomes the locus for health care practice, discovery-bound intellectual curiosity, and relation-building among members of an international community.

Dr Poon's comments prompt some clarification on my part. By no means did I mean to imply that I thought I had, single-handedly, brought narrative to medicine! Heavens! Hippocrates, Galen, Thomas Mann, and Freud did that long ago. Certainly the social constructivists had a hand in it, as did the sociolinguists, the phenomenologists, the medical anthropologists—in short, all those scholars and writers and artists who realized that the body is a portal of the self.

The case of narrative therapy interests me a great deal. Here, in the practice of family therapists, is a crystallization of the therapeutic implications of narrative medicine theory. I take—and have written on—narrative therapy as a most instructive and pioneering exemplar of the practical sequelae of thinking along the lines of narrative medicine. I hope in the short future to have a means of dialogue between

practitioners of narrative therapy and the theorists of narrative medicine. But there is so much to do!

—Rita Charon, MD Phd
New York, NY
by e-mail

Reference
1. Charon R. What to do with stories. The sciences of narrative medicine. *Can Fam Physician* 2007;53:1265-7.

Strep steps

There have been excellent points touched upon in the articles published in *Canadian Family Physician* regarding strep throat. The recent letter by Dr Pol Morton[1] sparked my interest. One way to help decide the best management for patients with symptomatic throat complaints is to engage patients (or guardians) in discussions about the risks and benefits of therapy and to conclude with informed decision making regarding therapeutic options (analgesics, antibiotics, etc).

One way to do this is to discuss the number needed to treat and the number needed to harm. Treatment with antibiotics has not been shown to affect the rate of poststreptococcal glomerulonephritis, neither has it been shown to reduce the incidence of rheumatic fever. Rheumatic fever is related to a strain of *Streptococcus* having the "m" gene. The prevalence of that gene in the community might assist clinicians in deciding whether there is a need for antibiotics.

If we look at patients with uncomplicated pharyngitis and have ruled out serious disease, then the number needed to treat for prevention of rheumatic fever has been estimated at more than 1 million. The question is, how many will be harmed by prescribing antibiotics more than 1 million times when they do not appreciably change patient-oriented outcomes?

—Mark Mensour MD
Huntsville, Ont
by e-mail

Reference
1. Morton P. Should we treat strep throat with antibiotics? [Letters]. *Can Fam Physician* 2007;53:1299.

Rules of engagement

The Practice Tip article about using lubricant for Papanicolaou tests[1] was very reassuring, as one of us (Dr Lofsky) has used small amounts of lubricant with plastic disposable specula without difficulty. He has had few problems with water-moistened metal specula and, like many others, has used specula warmed with water and temperature-tested on patients' upper legs as a further comfort measure. Plastic specula seem to have much more drag on insertion. Additionally, small specula are quite adequate and more comfortable for many first-time Pap tests and for sexually inactive menopausal women.