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Response

The letter from Drs Campbell and Abbass and our article[1] both serve as reminders to physicians to consider all of the important causes of chest pain, including GERD and psychiatric disease. We whole-heartedly agree with several important points in their letter. Anxiety disorders meeting *DSM-IV* criteria are common among patients visiting the emergency department for chest pain.[2] Optimal care would diagnose and manage anxiety at an early stage in order to reduce suffering and improve outcomes. We believe FPs have the expertise to provide a patient-centred approach to care that encompasses the range of physical and psychological issues involved in chest pain.

The complex interplay between the brain and the gut warrants additional emphasis. Studies show that people suffering with either chest pain or GERD will often have concomitant anxiety.[2,3] Furthermore, having an anxiety disorder does not immunize an individual against other causes of chest pain, including cardiac causes and GERD. In the same way that overemphasis on acid-related causes could distract our attention from the patients who have anxiety disorder, we must not overlook GERD or coronary artery disease in patients with panic disorder or other anxiety disorders. Comorbid conditions are common in patients with chest pain, and appropriate management is needed for both the psychological and physical components of their conditions.[2] The brain-to-gut and gut-to-brain connections are real and very important when assessing and managing GERD patients presenting with chest pain.[4,5]

If a patient's chest pain is caused by GERD, treatment with proton pump inhibitors can completely resolve symptoms and restore health.[6] It is not common to have this degree of success with treatments for the other causes of chest pain and comorbid conditions. Family physicians are well positioned by virtue of their skills and ongoing care to diagnose and manage both physical and psychological diseases associated with chest pain.[7] We are proud of the important role FPs play in the evidence-based management of chest pain, anxiety disorders, and depression.

—Nigel Flook MD CCFP FCFP, *Edmonton, Alta*
—Peter Unge MD PhD, *Stockholm, Swed*
—Lars Agréus MD PhD, *Stockholm, Swed*
—Björn W. Karlson MD PhD, *Mölndal, Swed*
—Staffan Nilsson MD, *Norrköping, Swed*
by e-mail

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Cause of confusion

I read with interest Dr Gillson's letter in the January 2007 issue (*Can Fam Physician* 2007;53:29-30) regarding the North American tendency to confuse progesterone and progestogen and found myself in such violent agreement that I needed to inform him that this is not purely a North American phenomenon. The same confusion and fuzzy terminology is widely encountered in Ireland and the United Kingdom. This is surely just one example of the insidious effects of pharmaceutical marketing on our thinking, despite the fact that there is widespread belief that medical professionals are somehow immune to subliminal advertising!

—Ailís ní Riain MB MICGP MBA
—Dublin, Ireland
by e-mail

When the law calls

I am writing in response to the article by Dr Dalby in the January 2007 edition of *Canadian Family Physician* entitled "On the witness stand. Learning the courtroom tango."[1] Much of Dr Dalby's article will be very helpful to family doctors who are asked or called to give testimony; however, some statements in the article might mislead family physicians in the following areas: the definition of an expert in the context of Canadian law, the responsibility

of a physician in responding to a subpoena, and the obligation of a treating physician to maintain confidentiality. I also note that all of Dr Dalby's references are from the psychological literature published in the United States. I have appended a list of some Canadian references that are more pertinent to Canadian physicians (see next page).

In my experience as a medical officer, most family doctors testifying in court have treated the patient in question and are there as fact witnesses, not as experts. In these instances, doctors are asked to testify to the facts of their involvement with the patient—what history was obtained, what evidence of injury (physical or emotional) they observed or detected, and what diagnosis and prognosis they gave to the patient. Diagnosis and prognosis require doctors to use their professional expertise, but this does not make treating physicians expert witnesses as the term is used in the legal system.

Doctors called to give evidence as fact witnesses might well be subpoenaed and must remember the subpoena is only an order to attend[2] at court so as to be available to be called to give testimony. Subpoenas might also require doctors to bring material (eg, medical records) in their possession. A subpoena does not otherwise relieve doctors of their obligation to maintain patients' confidentiality.[3] Therefore, whether the lawyer calling them represents their patient or some other party in the litigation, the doctor should take part in pretrial preparation conferences, as suggested by Dr Dalby, only after receiving the patient's written consent.[4]

On occasion, treating family doctors called to give fact evidence might also be qualified as experts, provided that certain pretrial procedural requirements (eg, service of an expert report)[4] are met. Participation as an expert is strictly voluntary; no one can be compelled to act as an expert.[4,5]

Family doctors might also be asked to act as independent experts. Unlike a fact witness, an expert might be asked to comment on the cause of the

patient's condition, and (when the defendant is another doctor) the standard of care to be expected.[4] The lawyer calling the expert witness will be required to show that the expert has sufficient qualifications and the depth of knowledge necessary to provide guidance to the court. Physicians asked to act as experts might negotiate appropriate fees to do so; however, fees should not entice experts to become advocates for the party that has called them—doctors have been criticized and their evidence discounted by judges who believed them to be advocates, rather than objective advisers.

I believe these points I've raised will help doctors avoid problems when called upon to give testimony.

—P.G. Winkelaar MD CCFP FCFP
Medical Officer, Canadian Medical Protective Association
Ottawa, Ont
by fax

For further reading

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Response

In my recent article "On the witness stand. Learning the courtroom tango,"[1] I presented general, nontechnical information to help family physicians prepare for and deliver testimony in courts and judicial hearings. Dr Winkelaar's letter highlights some important areas to expand upon in exploring this role for physicians.

Physicians need to understand that law governs their participation in courts—some of this is federal law (criminal cases) and many times it will be statute derived from provincial legislation (eg, child protection, dependent adults). Law takes precedence over professional guidelines. In the same issue of *Canadian Family Physician*, it is noted that "[9%] of the 11 041 family physician respondents to the 2004 National Physician Survey (NPS) indicated that legal or medicolegal consultations were part of their practice."[2] Many physicians are, therefore, involved in presenting information to courts and participating in medical evaluations for legal purposes. While not suggesting that a law degree is necessary for such legal participation, Dr Winkelaar points out that it is advisable that physicians augment their medical knowledge with relevant readings in Canadian law specific to the task in which they are engaged. He provides an excellent list of resources in that regard.

As to the issue of whether physicians are called as (ordinary) fact witnesses or expert witnesses, this remains an empirical question and important area of discussion. In the defining case of R. vs Mohan,[3] the Supreme Court of Canada unanimously delineated when an expert is needed and who qualifies as such. This directive states that expert testimony must be relevant to the issue before the court; that it be necessary for the trier of fact; that it should not trigger exlusionary rules; and that it must be delivered by a properly qualified expert.

I pointed out in my article that all family physicians would be recognized as being qualified as experts in general medicine. In hundreds of trials, I have never seen a treating family physician offered as a fact witness because of the strict limitations on questioning non-experts. Fact or ordinary witnesses cannot offer opinions. Being an expert witness subsumes the role of fact witness, and experts can both speak to their direct observations and offer opinions and respond to hypothetical situations.

Some physicians have told me of attempts to have them qualified only as fact witnesses rather than experts; they perceived this as a means of avoiding paying them as expert witnesses (ordinary witnesses receive only a small stipend). I have encouraged physicians who had such concerns to notify their provincial and national professional bodies for a review of such practices.

Although treating physicians are allied to their patients through the helping role, this does not preclude their concurrent objectivity and credibility required as an expert. I remain of the firm opinion that, except in rare circumstances, family physicians should take the role of expert in court, not only based on status of their education and experience but also drawing on the rules defined in Canadian law and in acknowledgment of the full purpose of their participation in legal cases. Reporting in court what a patient's blood pressure was at a given examination can be included in the fact witness's role (this could as easily be derived from the written record) but offering a medical prognosis is, by definition, an opinion and the sole domain of an expert. The weight of the expert's testimony is also very likely to be greater than that of a fact witness.

Dr Winkelaar correctly reminds readers of the need for express informed consent when consulting with any third party outside the patient's circle of care before a trial—even the patient's own lawyer. No protection of confidentiality can be given when a physician takes an oath in court to provide testimony. However, patient information should not be discussed outside that forum and only details necessary to the facts should be disclosed in court. If physicians believe that questions asked of them in court stray from the issues, seeking clarification from the judge is always a prudent action. Not all legal proceedings require the production of an expert report before

testimony, but some do insist on a written substance of opinion (short summary of evidence to be given at trial) within a strictly defined time before the trial commences. These time limits vary between jurisdictions. It is vital for physicians to discuss all the legal requirements and role expectations before involvement in legal proceedings.

As the confluence of medicine and law grows, a continuing dialogue about expectations and functions of the family physician in courts is warranted. I thank Dr Winkelaar for his contribution to this discussion.

—J. Thomas Dalby PhD RPsych
Calgary, Alta
by mail

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Feeding stereotypes

I read with great interest and agree with Dr Bailey's statement regarding family medicine as a specialty (*Can Fam Physician* 2006;53:221-3). Whether family medicine was a specialty was not a question for me when I decided to specialize in family medicine. However, I think that several factors are contributing to the "non-specialist" stereotype of general practitioners (GPs) in the eyes of medical students when they consider family medicine as a career.

First, the Certification by the College of Family Physicians of Canada (CFPC) differs from the rest of physicians and surgeons. This reinforces the stereotype of GPs by separating family physician from other physicians (Fellows of Royal College of Physicians and Surgeons [FRCPS]) who are the "specialists." In order to change the stereotype but continue to remain GPs, family physicians should be designated in the same way other physicians and surgeons are. Hence, the Certification in Family Medicine examination should be 1 among other Royal College of Physicians and Surgeons of Canada (RCPSC) examinations and lead to a designation of FRCPS in family medicine.

Second, tremendous efforts have been made to improve financial reimbursement of family physicians, who carry a substantial burden of patients' care by providing primary, obstetric, emergency, hospital, palliative, geriatric, and other health services. Most rural communities rely almost solely on family physicians. This burden often leads to overworked physicians who, after years in practice, give up previously provided services. In spite of all the improvements to reimbursement formulas for family physicians, the improvements are not comparable with professional (eg, multiple problems per visit, obstetric and other commitments) and new financial demands (eg, electronic medical records, Internet) of general practice. This can be interpreted as a lack of appreciation for the great contribution that family physicians make to health care. This reinforces the stereotype of GPs among medical students.

Finally, patients' appreciation of family physicians' services, in addition to medical knowledge and skills, depends on the time spent with patients and the quality of interactions. Often inadequate remuneration limits the length of patients' visits, and family physicians prefer to refer patients to other specialists for treatment and procedures of minor complexity. This produces an image among patients of a family physician as a referring physician, thus reinforcing the stereotype of GPs in the wider community, including medical students.

In spite of all this, I believe that those who choose family medicine as a career truly represent the specialty of family medicine.

Nevertheless, career choices of graduating medical students will continue to be influenced by this stereotype unless it is changed.

—Val E. Ginzburg MSc MD
Toronto, Ont
by e-mail

Response

I appreciate the opportunity to comment on this letter from Dr Ginzburg, which raises several important points.

The CFPC is aware that there remain substantial differences in remuneration when comparing family doctors to many other specialists. This has had an effect on many medical students when choosing careers, particularly with the increasing debt that students are now facing upon completion of their formal training. And there is evidence that remuneration issues have also affected the style of practice of many family doctors who no longer have the time to support patients in the manner that both they and their patients would prefer.

Much work remains to be done to improve the image and prestige of family medicine, and no single change (such as acknowledging family medicine as a specialty) will bring this about on its own. Clearly other changes, such as those suggested by Dr Ginzburg, might be required to reinforce the important role of the family doctor.

Revitalizing the relationship and clarifying the changing roles of family doctors and other specialists is another