recognize that disease no more exists than does the human spirit, or Reynolds' "human being-ness." That would require a perceptual shift in medical thinking that is no less than tectonic! However, when one considers that Schrodinger's cat, depicted on the front cover of the same issue, seriously brings into question whether any experiment or research in medicine can be unbiased (because it will always be observer influenced), it seems to me a perceptual shift well worth making, although considered unlikely by Bawa in his commentary, "A quantum leap in medicine" (*Can Fam Physician* 2007;53:386 [Eng], 390 [Fr]).

I could be labeled a heretic for suggesting that disease does not exist or that perhaps disease and the human spirit are even somehow 2 sides of the same coin. A part of the reaction or resistance to any perceptual shift occurs because of the limitations of the language we use to describe the experience. Human spirit is surely more easily recognized as a process, a work in progress so to speak; whereas we tend to see disease as being fixed and immutable. Perhaps Reynolds and I would disagree on this. Seeing disease as fixed causes us to define the cure as one for all—the same for everyone. But disease is a process, too, and we need to remember that it changes not just with time and from one human "being" to another, but also with our perceptual angle. Uncertain? Yes. But uncertainty embraced breeds humility and understanding.

—Edward Leyton MD FCFP CGPP
Kingston, Ont
by fax

Feminine fraternity

Dr Reynolds' commentary (*Can Fam Physician* 2007;53:385 [Eng], 389 [Fr]) was very much appreciated. The abuse of power and the development of the MDeity syndrome is still too prevalent in the medical fraternity. Physicians with this type of attitude create substantial time difficulties for those who choose compassion, empathy, and good social skills when dealing with patients. There is a small subgroup of physicians who are "social-intelligence challenged." They might be tired and overworked, as most of us are, but the human touch and compassion, or soft knowledge, are critical to compliance and patient satisfaction. Physicians can learn to say no, agreeing to disagree in an agreeable way. By dividing patients' human value from behaviour, one can always address behaviour, making certain that the patients know that they are cared for and that their complaints are important. Practitioners with MDeity syndrome create grief in the referral process, and much explanation is required when advising patients as to why these doctors have this cold and seemingly unlistening attitude. Such issues as this one need to be addressed in particular in the surgical residency programs. The increasing percentage of women physicians has been refreshing in this respect, as the feminine touch (even when administered by male physicians) is generally nurturing, yet direct and authoritative. We must keep encouraging each other to aggressively embrace hard knowledge intertwined with the feminine, compassionate, imaginative touch. We need more creative and compassionate medical students.

—Brian A. Shamess BAMD
Sault Ste Marie, Ont
by fax

Response

I am pleased that there has been so much positive comment on the March issue of *Canadian Family Physician* and on my paper "Hard to know. What is hard knowledge?" The thoughtful letters of Pimlott, Hardacre, Leyton, and others add much to the discussion of the essence of family medicine.

Pimlott rightly points out that the ability to manage uncertainty is an essential attribute of a good family physician. I agree that teaching this to our residents is vital. Hardacre makes a further addition: the importance of the narrative in distinction to the obvious weakness of medicine that is based only on facts,

science, or "evidence." Knowing the patient's story and our own story are critical in medicine, particularly in a relationship-based discipline such as ours. Leyton raises the intriguing conundrum of the duality of particle and wave in quantum physics. He takes tolerance of uncertainty to a new level, and that is awareness of the mysterious in life. For many who think of themselves as modern, an encounter with the mysterious results in free-floating anxiety followed by denial or liturgies of pseudocontrol. This is particularly evident in our responses to childbirth and to dying. Leyton notes that disease or illness is not a fixed point but is constantly changing. I agree.

The uniqueness of family medicine has been highlighted by these letters. Family medicine is relationship based and the narrative is core. Family doctors must be expert in managing uncertainty and, yes, allowing for the mysterious. Our traditional specialist colleagues derive most of their benefit from analysis, a method that breaks things down into smaller and smaller pieces. We are called to see the big picture, to integrate and to put the pieces of life together for our patients and for ourselves.

—J.L. Reynolds MD CCFP MSc MHSc
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by e-mail

ITN requires training

In the March 2007 issue of *Canadian Family Physician,* Dr Minty and colleagues discuss the advantages and safety of intrathecal narcotics (ITN) for labour pain and suggest this as a technique that all family physicians could consider adding to their basic skill sets.[1] Though both the Society of Rural Physicians of Canada and the Canadian Anesthesiologists' Society support family physicians in the practice of anesthesia, both societies require that physicians undergo appropriate training. As a GP-anesthetist whose practice is limited almost exclusively to anesthesia, I have concerns about the safety of the use of this technique by those without additional training and experience in anesthesia.

This article points out that "mini-spinals" can be performed safely and provide excellent analgesia to women during labour. For this to occur, however, one must be familiar with the pharmacology of the medications delivered intrathecally, as well as be able to anticipate and deal with any complications that might arise. Although family physicians are well suited to performing lumbar punctures, it is the administration and management of ITN that requires specialized skills. This is why additional training in anesthesia becomes mandatory.

Dr Minty and colleagues propose doses of ITN that are greater than or equal to what many anesthetists would give during surgical anesthesia for a cesarean section. A safety issue not discussed in the article is that the peak concentration of spinal morphine occurs 8 hours after administration and the duration of spinal morphine might be as long as 24 hours.[2-4] Additionally, peak respiratory depression has been found to occur between 3.5 and 7.5 hours after administration.[5] Those not familiar with this route of drug administration might cease appropriate monitoring once 4 hours have passed, as suggested in the article. It is because of this prolonged duration of intrathecal morphine that all anesthesia departments in which I have worked have specific protocols for dealing with side effects, most notably respiratory depression, in patients who have received morphine intrathecally. At our hospital, for the first 12 hours following a dose of intrathecal morphine, the only physician who can order additional narcotic or sedative medications is the anesthetist, as he or she is the one familiar with this route of administration.

Another safety concern not addressed by this article is that of administering intrathecal bupivacaine in combination with fast-acting narcotics. Even in low doses, this can result in profound hypotension and has also been implicated in causing uterine hypertonicity and thus fetal bradycardia.[6,7] Again, those who have not had the training and experience to deal with these uncommon yet serious side effects should not be performing the procedure.

Dr Minty and colleagues point out that ITN have a valuable role to play in the provision of analgesia for women during labour. In my opinion, however, if epidural services are not available due to the lack of an anesthetist, then ITN should not be an option. Though