Letters
Correspondance

"No" supports "Yes"

While arguing against physician self-treatment, Dr Richer's argument,[1] paradoxically, supports Dr Bereza's argument.[2] I was disturbed that Dr Richer trotted out the addiction phobia to make her case. It actually highlights why the physician-patient in Dr Bereza's case study might have felt the need to self-medicate. Repeatedly, patients with malignant pain are undertreated because of ill-founded fears of addiction to strong opioids, even though most of these patients need such drugs. The more appropriate argument would have been for Dr Richer to express concern for a physician-patient who might be self-prescribing strong pain medication; I would be apprehensive about the patient's ability to recognize cognitive side effects, particularly as her illness progressed. Who would be the one to decide if her judgment was still intact? In Dr Bereza's case study, the alternative offered was in-hospital care; however, her treatment there might not have been any better because of a lack of expertise. It sounds to me that we might have to consider this an example of Dr Richer's first exception—"an acute and potentially fatal condition for which the physician must treat himself while awaiting the required assistance"[1] (that might never come).

—Robert Sauls MD CCFP(EM) FCFP
Mississauga, Ont

References
1. Richer S. Should family physicians treat themselves or not? No. *Can Fam Physician* 2009;55:781-2 (Eng), 784-5 (Fr).
2. Bereza E. Should family physicians treat themselves or not? Yes. *Can Fam Physician* 2009;55:780,782 (Eng); 783,785 (Fr).

Another reason to treat oneself

Back in the 1970s a journal called *Emergency Medicine,* conducted a poll of their readers with the following question: "How many of your colleagues would you trust with your life?" A hard-core 15% of respondents answered "None." As long as one has sufficient self-confidence, this constitutes a powerful incentive to resort to self-treatment—the number of physicians involved would appear to be substantial.

—David M. Maxwell MD CCFP(EM)
Middle Lehave, NS

How to treat a physician-patient

I read with great interest the articles about physician-patients.[1,2] I think that what is important is the patient's relationship with the treating physician. Some physician-patients might want a physician who takes complete charge of their care. Other physician-patients might want to be more involved in the decisions relating to their care. I believe it is important to respect the physician-patient position. I also believe that the treating physician should show flexibility of management when his or her style differs from that of the physician-patient. I suspect that this sort of interaction will challenge the treating physician like no other patient interaction can. Treating physicians need to balance confidence and comfort when attending physician-patients or else refer them to someone who can provide this type of care.

—Gabriel Attallah MD CCFP
St Catharines, Ont

References
1. Richer S. Should family physicians treat themselves or not? No. *Can Fam Physician* 2009;55:781-2 (Eng), 784-5 (Fr).
2. Bereza E. Should family physicians treat themselves or not? Yes. *Can Fam Physician* 2009; 55:780,782 (Eng); 783,785 (Fr).

Accepting help

Doctors can treat themselves and family members for simple ailments. For chronic cases, it is always better to ask for a second opinion—and follow the advice. For surgeries and deliveries (for family members), it is always good policy to have some other doctor take over, however competent the doctor might be. We will always have help from our colleagues in our time of need.

—N.P. Viswanathan
Bangalore, India

Auto-traitement?

Cher Roger, vous avez bien raison.[1] Plusieurs médecins se traitent en urgence ou pour des problèmes bénins et ce sans contrevenir à leur Code de déontologie. Malheureusement, quelques-uns d'entre

The top 5 articles read on-line in August

1. **Clinical Review:** Brief interventions for depression in in primary care. *A systematic review.* (August 2009)
2. **RxFiles:** Taking the stress out of insulin initiation in type 2 diabetes mellitus (June 2009)
3. **Critical Appraisal:** Intensive glycemic control. *Implications of the ACCORD, ADVANCE, and VADT trials for family physicians* (August 2009)
4. **Child Health Update:** Use of dexamethasone and prednisone in acute asthma exacerbations in pediatric patients (July 2009)
5. **Clinical Review:** Complementary and alternative medicine for the treatment of type 2 diabetes (June 2009)

nous outrepassent cette ligne de conduite acceptable et utilisent à mauvais escient leur privilège de prescription. On doit encourager nos confrères à accepter d'être de simples patients et à éviter les prescriptions de médicaments dangereux ou pour les traitements sur le long terme de certaines maladies chroniques. Rationnellement, il ne peut en être autrement. Notre jugement ne peut être objectif pour nous comme pour nos proches pour la prise de décisions difficiles et nous pouvons avoir besoin de support dans certains cas. Un médecin de famille c'est bon pour tout le monde.

—Marc Billard MD CCFP FCFP
Rosemère, Que

Référence

1. Ladouceur R. Se traiter ou non [Éditorial]? *Can Fam Physician* 2009;55:776 (Eng), 777 (Fr).

Mindful? Try thoughtful

After almost 50 years in family practice, both in the community and in academia, I felt I must comment on Hutchinson and Dobkin's article on mindful medical practice.[1] As the authors themselves speculated, I am convinced and hopeful that it is indeed just a fad. It seems that the more physicians distance themselves from their patients, the more determined many are to generate an epistemology that justifies such distancing, which academic family medicine has for so long abhorred. The 9-to-5 student, resident, and physician seek a philosophical justification for closing down the practice at 5 PM and abandoning their patients to walk-in clinics and emergency departments. Likewise, and not unreasonably, they have become more preoccupied with the quality of their own lives. Nothing is wrong with that. However, although I believe a physician should make a good living, the shaping of general practice by eliminating the unprofitable or more demanding activities clearly flies in the face of the comprehensive health care that we have held for so long as one of the sacred vows of family medicine. If we are ready to dispose of these principles as impractical and inimical to the health care industry we now espouse, by all means let us do so. Please let us not be so hypocritical as to pretend we are doing this in the interests of patients. Please let us not attempt to generate another empty epistemology called *mindful medical practice.* Let us hope that it will quickly be recognized as the fad it is and die a swift death. Perhaps it is time to create a new concept: thoughtful medical practice.

—S.G. Smith MA MD CCFP FCFP
London, Ont

Reference

1. Hutchinson TA, Dobkin PL. Mindful medical practice: just another fad? *Can Fam Physician* 2009;55:778-9 (Eng), CFPlus (Fr).