Letters
Correspondance

A resident's perspective on mindfulness

Medical training has been and perhaps will always be hierarchical. In the large academic centres where we train, medical students and junior residents are frequently dispatched by superiors to fight off consultations, dodge admissions, and turf patients. To fight these battles with fellow residents, nurses, and staff, medical culture instructs (and requires) a personal and emotional distance from our coworkers. Why? So we can ultimately "win" these fights. So profound is this disconnection that when a senior colleague has a friendly chat with a nurse or off-duty resident, I am often caught by surprise.

As a medical trainee, one's body of knowledge and repertoire of skills grow by observation, practice, and repetition. When the context of this learning happens in such a potentially dehumanizing environment, when interactions with peers can go so wrong, how can we expect anything better when trying to be mindful with patients?

Unless "mindfulness meditation training"[1] can meaningfully address this issue, it would seem to offer little in the humanization of medicine.

—Danyaal Raza MD
Kingston, Ont

Reference

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

Response

Dr Dobkin and I are grateful for the interest shown by Drs Smith[1] and Raza in our article on mindful medical practice.[2] Dr Smith appears to believe that mindful practice means physicians distancing themselves from patients. He therefore hopes that it dies a swift death. If this were the meaning of mindful practice, we would completely agree with him; however, this is not the case. In fact, the aim of mindful practice is to allow physicians to fully engage with their patients. Mindful training helps practitioners practise being alive in the present moment, in a way that both relieves their stress and enhances their well-being so that this might be possible. We had hoped to make that clear in our article. With this added clarification, we hope that Dr Smith (whose core values we probably share) might join us in advocating the continued use and development of mindfulness in medicine.

Dr Raza makes a very important point about the influence of colleagues on medical practice, and wonders whether mindfulness can do anything about this. We believe that the answer is yes. He is correct—we have also found when talking with physicians that the greatest source of stress in medicine is not patients but other physicians and health care workers. This is why in the mindfulness courses and workshops that we conduct for health care practitioners we spend a substantial amount of time on mindful interactions with colleagues. We do role-play exercises in which physicians practise combining mindfulness with congruent communication (based on the work of pioneering family therapist Virginia Satir). We also teach the same approach to medical students at McGill University in Montreal, Que, using actors playing the role of other physicians in the simulation centre. In this way we hope to help individual physicians and students handle themselves more effectively in stressful interactions with colleagues and, in the long run, to change the environment in which medicine is practised. Dr Raza has raised an important issue—stressful interaction with professional colleagues—which we believe mindful medical practice can help alleviate or resolve. We thank him for his insight and interest.

—Tom A. Hutchinson MB
Montreal, Que

References

1. Smith SG. Mindful? Try thoughtful [Letters]. *Can Fam Physician* 2009;55:978.
2. Hutchinson TA, Dobkin PL. Mindful medical practice. Just another fad? *Can Fam Physician* 2009;55:778-9 (Eng), CFPlus (Fr).

A prescription for sodium

In 2007, Blood Pressure Canada, with the endorsement of many national health care organizations, released a national policy on sodium,[1] which recommended a reduction in daily adequate sodium intake to 1500 mg, with a maximum of 2300 mg. In response, the federal Minister of Health set up a sodium reduction working group comprising a 24-member panel from government, health care, and food industries. The group first met in February 2008 and was due to report this spring. Its mandate is to assist in reducing the daily intake of sodium of Canadians.

These new goals were reflected in the new Canadian Hypertension Education Program recommendations published in the July issue of *Canadian Family Physician*.[2] On the subject of lifestyle modifications, the group states the following: "Unfortunately, after a diagnosis of hypertension few Canadians improve their lifestyles; however, simple and brief interventions by health care professionals increase the probability of patients making lifestyle changes."[2]

We advocate providing all hypertension patients with a prescription for sodium, which should say, "Read the label! SODIUM—200 mg per serving for a total of 1500 mg per day."

This would have several advantages as a brief intervention:

- it would provide clear concise directions (200 mg/serving, 1500 mg/d);
- it would introduce the term *sodium* (some patients know they should reduce their salt intake, but are confused by sodium use);
- it would provide numbers and units of measure that precisely reflect current terminology, helping with label reading; and
- it would only require a prescription pad or a prescription printed from an electronic medical record. Family physicians would not need another pamphlet to add to the numerous tear-off sheets, requisitions, referral forms, application forms, and report forms that fill up office space.

—Adam Steacie MD MSc FCFP
Brockville, Ont
On behalf of the Health Promotion and Primary Prevention Subcommittee of the Ontario Stroke Network

References

1. Blood Pressure Canada. *Policy—sodium*. Calgary, AB: Blood Pressure Canada; 2007. Available from: **www.hypertension.ca/bpc/wp-content/uploads/2007/10/bpc-sodium-policy-with-endorsements-clean.pdf.** Accessed 2009 Sep 29.
2. Canadian Hypertension Education Program. 2009 Canadian Hypertension Education Program recommendations. An annual update. *Can Fam Physician* 2009;55:697-700.

How tight is too tight?

Regarding the debate on tight glycemic control published in the June issue of *Canadian Family Physician*,[1] I think it might be worthwhile to look at the hemoglobin (HbA_{1c}) levels the studies referred to actually achieved and reported, rather than what their targets were.

The achieved levels of HbA_{1c} for the UKPDS (United Kingdom Prospective Diabetes Study) follow-up were 8.5% (conventional) versus 7.9% (intensive) in the insulin-sulphonylurea group and 8.9% (conventional)