Letters
Correspondance

Complex issues

As a physician practising emergency medicine, sports medicine, and chronic pain management, I deal with patients with back pain on a daily basis. Although the Cheng et al[1] study suggests good criteria to help decision making when it comes to referral, it has more limitations than cited. Being a retrospective analysis evaluating the surgical route versus non-surgical route, the study does not look at outcomes of that particular path. Did patients undergoing surgery believe it ended with a successful outcome? Did the non-surgical patients perform worse on the validated pain and quality-of-life questionnaire? Did any of the non-surgical patients seek second opinions and were any of them operated on by another surgeon? If that scenario occurred, were the results successful as per their outcome measures?

Back pain and imaging are so complex, and I find it difficult to counsel patients as to their best treatment options. This is without mentioning the paucity of dedicated spine surgeons who can keep ahead of the referral piles.

—Richard Goudie MD CCFP Dip Sport Med
Barrie, Ont

Reference

1. Cheng F, You J, Rampersaud YR. Relationship between spinal magnetic resonance imaging findings and candidacy for spinal surgery. *Can Fam Physician* 2010;56:e323-30. Available from: **www.cfp.ca/cgi/reprint/56/9/e323**. Accessed 2010 Oct 7.

Missed opportunities

I do realize that the article "Management of painful wounds in advanced disease" in the September issue of *Canadian Family Physician*[1] was meant as a means to present innovative options for pain management in wound care; however, I had difficulty getting past the description of K.C., the elderly woman with advanced dementia and multiorgan failure. I feel saddened that K.C.'s case was likely not fictional and illustrates a number of key end-organ failures of our medical system, which include but are certainly not limited to the following: 1) the debate between length and quality of life, 2) truly informed versus passive consent with active treatments (including antibiotics), 3) the ability of loved ones, family members, and powers of attorney to make truly informed choices around goals of care, 4) the prioritization of financial and staff resources in an arguably unsustainable medical system, 5) the overall well-being of the patient, including issues of pain and suffering, and 6) the ambiguous definition of "do no harm."

One has to think that K.C. suffered a great deal throughout her hospitalization. Even with optimal wound management, K.C. must have experienced ongoing suffering. Was the chance to treat her sepsis with comfort measures only a missed opportunity to ease her burden?

—Brendan J. Hughes MD CCFP
Peterborough, Ont

Reference

1. Gallagher R. Management of painful wounds in advanced disease. *Can Fam Physician* 2010;56:883-5.

Editorial fellowships in family medicine

I congratulate the Scientific Editor at *Canadian Family Physician (CFP)* on the inaugural *CFP* editorial fellowship.[1] I would like to take the opportunity to inform readers about the position of Publications Fellow at *Australian Family Physician (AFP)*, which has been in place since 2007.

In Australia family physicians are known as general practitioners and the doctors in the training program are referred to as registrars. In the Australian General Practice Training Program there are academic posts that are funded centrally and allocated via a competitive application process. These positions have existed for many years and traditionally have been used for 12-month half-time appointments with university departments of general practice, which involve a mix of research and teaching. The registrars also work in half-time clinical practice. These positions are accredited as part of the training program.

A past Editor-in-Chief of *AFP* and an inaugural applicant identified that there were no opportunities for training in medical editing. A successful application was made for an academic post that combined a