Letters
Correspondance

The other side of the spectrum

Mr Thoma's Reflections piece[1] and the subsequent responses highlight issues that I think are worth exploring.

Medical students are faced with a difficult task. We tell them to be self-aware and to develop their abilities to use their relationships with patients as part of the therapeutic process. Then we castigate them for their attempts.

Young men and women are still sexual beings as well as medical students, yet where in the curriculum do they have the opportunity to ask about the "what ifs" of medical examinations and procedures? They have their own fears and embarrassments, as well as concerns about patients' fears and embarrassments.

As senior colleagues, I think we ought to be thankful that someone had the courage to remind us that although we might have found ways to manage certain issues, our newer colleagues still struggle. For every one person who expresses a concern, there are many others who feel the same way but are afraid to seem foolish or ignorant by expressing themselves. If we want sensitive, insightful candidates for family medicine, we need to acknowledge their fears and concerns, rather than dismiss them.

It takes courage, insight, and ability to present one's insecurities to national scrutiny. These are qualities that any program director should value and nurture.

—Deirdre E. Andres MD
Saskatoon, Sask

Reference

1. Thoma B. The other side of the speculum. *Can Fam Physician* 2009;55:1112.

Uncomfortable reflections

Brent Thoma's Reflections article in the November issue of *Canadian Family Physician,* "The other side of the speculum,"[1] has generated more expressions of outrage and more Rapid Responses and letters than any article published in the journal within memory.

Several writers have castigated Mr Thoma both for his attempt to use humour to deal with a situation that has clearly caused him much uncertainty and discomfort and for his public expression of those feelings. In addition, criticism has been leveled at the editors of this journal for publishing the article as well as for failing to protect Mr Thoma from public exposure and criticism.

Mr Thoma's article was chosen for publication after a process that involved peer review by editorial staff, along with consultation with male and female colleagues regarding the potential of the article to upset or offend readers. Although there was not complete agreement, response was balanced and we decided to publish the article. This is the kind of uncertainty and risk that both authors and journal editors sometimes face.

The number and type of responses to this article has generated the kind of discussion that appears to have been vitally needed and was perhaps overdue. Mr Thoma's article and his subsequent response to the criticism[2] primarily reveals that he is a reflective person who has struggled with his sense of discomfort and legitimacy as a student learning to perform examinations such as Pap tests. The article and the responses to it have also highlighted a greater need for preceptors to allow trainees to openly express and discuss their discomforts and concerns about performing intimate examinations and to help them work through those concerns. Dr Andres' letter [above] perfectly explores what is at stake.[3]

It is not only the discipline of family medicine grappling with open discussion about these issues, but the medical profession as a whole: A recent article in the *Globe and Mail* by health reporter Andre Picard[4] highlighted a study by a family medicine resident and her colleagues at the University of Calgary, published in the *Journal of Obstetrics and Gynecology of Canada*,[5] which found that fewer than 1 in 5 women were aware that they might be subjected to an internal examination while in the operating room under anesthesia. Most women (72%) expected to be asked for consent before such an examination was performed. The results of this study will come as a great surprise to many and should be a cause for great concern about the medical profession's regard for informed consent, patient well-being, and the attitudes and values we are transmitting to trainees.

While we at *Canadian Family Physician* regret that Mr Thoma has been exposed to criticism and embarrassment by the publication of his article, as well as the expressions of anger toward the journal the article has engendered, we are grateful that he allowed it to be published, for his further reflections on the matter, and for the open and frank discussion that has taken place

The top 5 articles read on-line at cfp.ca last month

1. **RxFiles:** Taking the stress out of managing gout (December 2009)
2. **Research:** Demands, values, and burnout. *Relevance for physicians* (December 2009)
3. **Clinical Review:** Exercise and knee osteoarthritis: benefit or hazard? (September 2009)
4. **Reflections:** The other side of the speculum (November 2009)
5. **Clinical Review:** Early diagnosis of neonatal cholestatic jaundice. *Test at 2 weeks* (December 2009)

in these pages. That is one of the purposes of a medical journal.

The article and subsequent debate has provided the opportunity for family physicians to be much more aware of the discomforts, insecurities, and needs of our trainees as we strive to teach them to be sensitive, patient-centred practitioners.

—Nicholas Pimlott MD CCFP
Scientific Editor
—Roger Ladouceur MD MSc FCMF
Associate Scientific Editor

References
1. Thoma B. The other side of the speculum. *Can Fam Physician* 2009;55:1112.
2. Thoma B. Lessons learned [Letters]. *Can Fam Physician* 2010;56:134.
3. Andres DE. The other side of the spectrum [Letters]. *Can Fam Physician* 2010;56:221.
4. Picard A. Time to end pelvic exams done without consent. *Globe and Mail* 2010 Jan 28; Sect. L:4. Available from: **www.theglobeandmail.com/life/health/time-to-end-pelvic-exams-done-without-consent/article1447337.** Accessed 2010 Feb 5.
5. Wainberg S, Wrigley H, Fair J, Ross S. Teaching pelvic examinations under anesthesia: what do women think? *J Obstet Gynaecol Can* 2010;32:49-53.

Positive reinforcement

I spent this morning reviewing the titles of all contributions to this year's issues of *Canadian Family Physician* and "This business of caring" caught my eye.[1] I wondered, Do I respond or not? As a social worker and teacher of behavioural sciences in the Department of Family Medicine at the University of Saskatchewan in Saskatoon I am compelled to do so. Why? Because teaching communication skills involves noting a learner's strengths and reinforcing them through the use of direct and indirect compliments.

Using solution-focused therapy techniques to guide my feedback, I applaud you, Dr Bielawska, for taking the time to put to paper your observations on the struggle inherent in being both a clinician and a healer. What made you do so, and what did you learn from the process? How will you build on your reservoir of empathy and ensure it continues to play a role in patient care? On a scale of 1 to 10, with 10 being the strongest and 1 being the weakest, rate your commitment to attending to the human side of patient care. Now that you have selected a number, scale your confidence in your abilities and skills to do so. What do you need to do to move that number up a notch?

Although you mentioned that "this challenge [is] not taught in any textbook or classroom" you are clearly a young woman who learns via a variety of experiences. Perhaps the world is your textbook? Whatever you are doing you are definitely on the right track. Thank you for taking the time and energy to share your perspective; in doing so, you normalize for your colleagues the inherent struggle of a patient-centred family physician to do right by patients without sacrificing enthusiasm for the science of medicine.

—Gail Greenberg MSW
Regina, Sask

Reference
1. Bielawska H. This business of caring. *Can Fam Physician* 2009;55:947 (Eng), CFPlus (Fr).

Focused practice: broadening the scope of family medicine

There are clearly reservations about focused practice.[1] The concern seems to be a perceived threat to comprehensive family medicine. Yet, far from being a threat, focused practices offer a vital dimension by backfilling areas of medical practice that have manpower shortages (eg, FPs that handle dialysis, oncology, and palliative care) and areas in which medical education has been deficient (eg, structural assessment within orthopedics, environmental medicine, and—that great black hole of medical training—nutrition). In addition, there are areas of emerging knowledge dealing with disease entities traditionally not thought to be valid but that are proving to be very real over time (chronic fatigue syndrome, chronic Lyme disease, etc). I can think of several GPs and FPs who have been swimming for years against the current of mainstream medical opinion to work with these often very unfortunate and sick people. The extraordinary patient loyalty they often engender is something we should all note.

We should also take into account the array of complementary approaches, which have been of benefit to a substantial number of people. Some of these modalities have bodies of evidence that might surprise many doctors (eg, acupuncture, homeopathy), while others are more esoteric and remain unfamiliar to most practitioners (eg, traditional Chinese medicine, Ayurveda, anthroposophic medicine) yet have subgroups of patients who benefit from their practices.

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