Generalism: the princess and the pea

Is population screening the remit of the family physician?

I hesitate to type these words—it feels a shocking question, provoked by Ladouceur's recent editorial.[1] Preventive health practices are integral to my daily schedule. I feel good when someone who has long avoided a Papanicolaou test finally agrees to have one. I am upset when a patient has positive screening results and is subsequently diagnosed with early cancer. I anticipate a difficult road for us both, but I commit to that journey, feeling that something beneficial has been achieved.

Yet increasingly I practise such medicine with some disquiet. It's like a hard pea under my metaphorical mattress, represented by an ever expanding layer of tasks. Reeve et al describe the risk of family medicine as being defined by our range of work, rather than by our expertise.[2] Herein lies my discomfort. Effective screening necessitates substantial time investment and coordinated action. For example, for a family physician to satisfy US Preventive Services Task Force screening recommendations, 7.4 hours per working day are required.[3] Most screening initiatives are based on a single intervention; in practice, we advise multiple tests, often in patients with other illnesses, as we weigh priorities across diseases.[4] Obtaining informed consent is complex, especially in areas where conflicting guidance exists, which seems to increasingly be the case.[4] Keeping up to date amid a sea of ever changing landmark studies is challenging. Informing patients of results, particularly those requiring follow-up, is involved, especially when the follow-up procedure is invasive or requires a time interval. Dealing with false-positive results (eg, false-positive HIV or syphilis test results) is rarely an isolated consultation but has repercussions beyond that particular event. Recent work indicates that advising older patients to stop screening can undermine the doctor-patient relationship.[5]

Greenhalgh writes, "What makes sense for a population, however stratified, may not make sense for an individual."[6] Greenhalgh writes about a patient so distressed by multiple invitations for screening that she avoids seeing her family doctor. I have patients who refuse screening for a variety of reasons, some of which make perfect sense to me. This causes further rankling. The increased move toward incentivized payments to family doctors to increase uptake of preventive services seems to be at odds with my belief in personal autonomy and informed decision making. Patient refusal is a recognized reason for low uptake, yet one that is relatively underexplored. In a recent multifaceted intervention to increase uptake of Pap tests and mammograms in Ontario, 25% of women decided not to avail themselves of screening.[7] While happy to advise patients on the risks and benefits, I respect my patients' decisions and am concerned by a metric that measures my ability based on uptake. Rather, it reminds me of Epstein and Street's description of "the drudgery of productivity-driven assembly-line medicine, which makes medical care anything but caring or patient-centred."[8]

I contrast this glorified technician role with what I love about being a family doctor: knowing my patients, integrating their health issues with a shared understanding of who they are and where they are coming from, and aiming to reach their personal nirvana of "being healthy." Reeve et al define this as the essence of generalism: using interpretive practice to define and address need specifically for each individual.[2] This involves moving from evidence-based practice to evidence-informed practice.[9] A key finding of a recent qualitative study investigating how family doctors contribute to population health outcomes emphasized the importance of flexible decision making informed by a thorough knowledge of the patient.[10]

I am bruised as I toss in bed, considering these tensions: my desire to be a good physician, the increasing demands on family physicians, and recognition that if I am to be a "jack of all trades," I will consistently under-perform, failing myself and my patients. I think about this pea and wonder: What if it were stolen from the museum, allowing me to focus on what I do well—meaningful, relevant, contextualized patient care?

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Competing interests
None declared

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Adverse health effects of industrial wind turbines

We are pleased to see the interest generated by our article in the May issue.[1] Much of the feedback has been constructive and should help advance awareness of the health risks of placing industrial wind turbines (IWTs) too close to humans. However, the opinions expressed by blogger Mike G. Barnard deserve comment.[2]

The Society for Wind Vigilance is not an "anti-wind" campaigning organization. It is a not-for-profit organization, the purpose of which is to ensure safe positioning of wind turbine facilities based on human health research; educate through the dissemination of facts and references on the risk of adverse health effects of human exposure to IWTs; work constructively with interested parties to ensure that guidelines for wind turbine facilities will protect the health and safety of communities; and achieve vigilance monitoring and long-term surveillance regarding the risks to health of IWTs.[3] Society board members are authors of peer-reviewed articles on the effects of IWTs.[4-8]

The term *industrial wind turbine*

Mr Barnard states that the term *industrial wind turbine* is "emotionally laden" and "propaganda terminology."[2]

Our use of the term is not intended to invoke an emotional response, but to differentiate consumer turbines from industrial-scale turbines that have a blade radius of greater than 40 m, are greater than 140 m in height, generate multiple megawatts of electricity, and produce approximately 105 dBA of sound power.

Eighteen reviews

Mr Barnard states we "do not cite the 18 reviews worldwide of the peer-reviewed evidence ... that found no evidence of harm from wind turbines to human health ..."[2]

We were aware of and carefully reviewed the 18 articles. We found some reviews had substantial weaknesses, including the failure to consider indirect health effects. Horner et al (2011) conducted an audit and commented on the completeness, accuracy, and objectivity of these references.[6]

One of these aforementioned 18 reviews that was cited in our article was a panel literature review (Colby et al, 2009) sponsored by the American Wind Energy Association and the Canadian Wind Energy Association.[9]

Two authors of that paper, Dr David Colby and Dr Geoff Leventhall, have provided consulting services to members of the wind energy industry and wind industry trade associations. In other references, Dr Colby[10] and Dr Leventhall[11] mentioned that

> It appears that there is no specific Wind Turbine Syndrome, but there are stress effects from low levels of noise, either high frequency or low frequency noise, which affect a small number of people. It is the audible swoosh-swoosh which, when it occurs, is the cause ...