Evidence versus expectations

Dr Reid’s commentary is incredibly timely given the respiratory illnesses floating about communities in the winter months. Indeed, I felt great hope when I read her stated objective that her paper would help primary care physicians “reassure parents.” Her review of the evidence is concise and accurate. However, it regrettably falls short of her stated objective as to how to best impart this evidence to anxious, worried patients and parents.

Beyond her request for consistency, the rest of the article summarizes evidence that has been long known to the medical community and does not answer an important question: Despite decades of provider knowledge, why do we still have such difficulty appropriately managing many mild viral upper respiratory illnesses through watchful waiting?

From my view, while “knowing one thing and doing another” is a possible cause among physicians, the root cause is likely not a deficit in provider knowledge. I would wager that many family doctors would nod their heads in agreement with Dr Reid’s assertions. Rather, the challenge lies in managing patient expectations. Countless studies have shown that patients expect antibiotics for colds based on how they feel, even if they know antibiotics are not designed to treat viral illnesses.

Thus, rather than re-educating providers, a more important piece of the puzzle is how to reshape the public’s expectations after decades of antibiotic misuse. This means enacting effective policy and programs to educate the public and improve population health literacy. It also means having more family doctors to improve continuity of care and facilitate individual counseling that is culturally sensitive, based on trust, and flexible. These elements are crucial in shaping expectation and allowing physicians the chance to attenuate negative or angry responses that might arise from not providing prescriptions for antibiotics.

The ultimate success of changing minds and ideas lies many years in the future, and indeed, relies in some part on the consistency that Dr Reid identifies. However, there is much more to be done on public policy and education. We should return to the simple strategy of knowing our patients and earning their trust.

Unfortunately, Dr Reid’s article preaches to the converted; we must reach out to our patients. From simple viral illness to heroic resuscitation measures, doctors have traditionally been up against the primordial human instinct and expectation that doing something is better than doing nothing. We must somehow address and change this aspect of human nature. As a training preceptor of mine once said, “A tincture of time has tremendous power to heal.” Rather than rehash the evidence, we must continue to find effective ways to
remind our patients that doing nothing is sometimes the best thing, and to also find ways to ensure that they are receptive to that message.

—Lawrence C. Loh MD MPH CCFP FRCP
Burnaby, BC

Competing interests
None declared

References
1. Reid S. All I want for Christmas is amoxicillin. Can Fam Physician 2013;59:1261-2 (Eng), e526-7 (Fr).

Physicians receiving gifts
Further to Dr Ladouceur’s editorial, I have 42 pairs of thick wool socks of every colour, with pointed toes like the Grinch—gifts from a patient, 2 pairs per year.

—Ron VanHoof MD
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Competing interests
None declared

Reference

Correction
In the article “Falls in the elderly. Spectrum and prevention,” published in the July 2011 issue of Canadian Family Physician, some of the author’s affiliations were inadvertently omitted. The biographical information should have read as follows:

Dr Al-Aama is Adjunct Professor in the Division of Geriatric Medicine in the Department of Medicine at the University of Western Ontario in London, an internist and geriatrician at St Joseph’s Health Centre and London Health Sciences Centre in Ontario, and Assistant Professor at King Abdulaziz University Jeddah Saudi Arabia.

Reference