## Logic of care

Balancing evidence-based medicine and patient preference is of huge importance to the current practice of family medicine. Certainly, family physicians must not act as "controller[s] of the decision-making process."[1] But I disagree that family physicians act as mere "broker[s] of choices."[1]

In her book *The Logic of Care*, ethnographer Annemarie Mol argues against a focus on patient preference and patient decision making. Her "logic of care" actually aligns more with the way I think we ought to practise family medicine: "to act without seeking to control. To persist while letting go."[2] For example, she describes a physician who warns a patient with poorly controlled diabetes about blindness, but counsels another patient with diabetes who is too hard on himself that he cannot always expect to have a blood sugar level of less than 11 mmol/L. "Caring professionals" seek to cultivate patients' minds. We convey insights, ask probing questions, or try to reassure; we "try not just to reflect back what [the patient] thought already. In the hope of making [the patient] more balanced, [we] give counterbalance. [We] encourage [the patient] to take good care of [himself], without feeding the illusion of control."[2] Family physicians play an important role in collaborating with our patients' knowledge and values, jointly "exploring ways of shaping a good life"[2] in the face of disease and illness. Furthermore, an emphasis on patient choice leads to 2 difficulties. First, it gives the false hope that control is always a possibility—sometimes there are limits to what can be chosen or changed. Second, sharing the responsibility for medical decision making can impose a considerable burden on patients.

While I believe that Canadian family physicians often practise using a logic of care, I think exploring Mol's theory and arguments more deeply in the Canadian primary care discourse would be worthwhile.

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**Competing interests**
None declared

**References**

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2. Mol A. *The logic of care: health and the problem of patient choice.* New York, NY: Routledge; 2008.

## Clinical review or Hypothesis?

I thank Dr Genuis and Mr Tymchak for presenting their interesting article, "Approach to patients with unexplained multimorbidity with sensitivities."[1] As they point out, these unfortunate patients do present us with both diagnostic and therapeutic dilemmas. However, I think this article more properly belongs in the Hypothesis section of the journal rather than the Clinical Review section.

According to *Canadian Family Physician* guidelines, clinical review articles in the "Update" category should give a "practical and comprehensive overview of diagnosis and treatment."[2] I was disappointed that the only guidance to the reader for diagnosis and treatment consisted of the sentences "a diagnosis of SRI [sensitivity-related illness] should be considered whenever a presentation of plural diagnoses or multisystem complaints exists with associated food or chemical sensitivities" and "management strategies can be found in recent scientific literature."[1] I find these recommendations neither comprehensive nor practical.

The guidelines for authors[2] also request the inclusion of a section on quality of evidence and ask of authors, "When recommendations are based on specific evidence, provide references and give level of evidence." Despite the extensive reference list attached by the authors, there was no attempt to describe the actual evidence or even appraise or grade it. I can only assume that despite the existing research, there is not enough evidence to make recommendations, even those highlighted as key points by the editor.

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**Competing interests**
None declared

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