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Letters ❖ Correspondance

Getting both sides of the story

Ah...to be a resident again—to see patients and be free to ask "what was this family physician thinking? Any fool can see... ." Alas, I am older and wiser now. Recently I had a patient tell her obstetrician that I had insisted she have a repeat cesarean section after I had spent three prenatal visits encouraging her to consider a vaginal birth after cesarean.

This experience illustrates the perils of criticizing physicians without hearing the other side of the story. The scenario that Dr Hotson[1] describes might be more of a case of denial than lack of communication. The clue to this is that "despite many hours of discussion and examinations by many teams" the patient and his family did not change their opinions.

I am also curious to know how staff had time to spend many hours with a patient who arrived at 10PM and arrested at 3:05AM. This hospital must have much more resources than my hospital!

—Merle McMillan, MD, CCFP
North Bay, Ont
by fax

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Where is the primary care viewpoint?

The General Practice Psychotherapy Association (GPPA), a nation-wide association of physicians involved in the practice of psychotherapy, is concerned that the recommendations for depressive disorders[1] might not be relevant to the daily practice of family physicians. The CPA/CANMAT guidelines, from which the recommendations are derived,[2] have been developed by and for psychiatrists. The clinical evidence was taken primarily from studies of psychiatric treatment of patients with major depressive disorders (MDD) in secondary and tertiary care settings. To extrapolate such evidence to recommendations for the primary care, family practice setting might be misleading.[3] More studies need to be done in primary care.[3]

Further, the article appears to have had very little input from the very family physicians for whom the recommendations are meant. Two of the three authors of the recommendations are psychiatrists, and the authors of the guidelines[2] are psychiatrists and psychologists. Yet several researchers have noted that more mental health care is provided by family physicians than by specialty mental health care providers.[4-6] Hence, family physicians have developed considerable expertise in managing MDDs. A cross section of family physicians in both community and academic settings could have provided valuable feedback on the recommendations.

Considerable debate has taken place about the applicability and reliability of evidence-based psychotherapy,[7-10] and practising therapists long have complained that therapy research bears only a remote resemblance to what goes on in actual clinical practice.[9]

The article stresses that only the empirically validated cognitive behavioural or interpersonal models ought to be applied. However, absence of evidence is not evidence for the absence of efficacy of other models of psychotherapy. The CPA/CANMAT guidelines[2] agree with this position by stating, "Practising physicians, however, are more likely to use an eclectic mix of strategies from different models"[2] and "These guidelines may not be applicable to an informal and personalized combination of strategies."[2] Most family physicians will indeed have an eclectic, informal, and personalized approach to psychotherapy to meet the eclectic needs of their patients. Psychotherapy involves a relationship between a patient and a clinician that transcends technique.[11]

The article states that family physicians "must have sufficient training (including supervision of therapy patients)." If the word "must" is used, then the guidelines have become standards. While it is widely accepted that supervising or mentoring is a useful adjunct to providing competent psychotherapy, evidence is lacking to suggest it should be a requirement

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for practising psychotherapy in family practice. The GPPA has developed a graduated system of training, credentialing, certifying, maintaining competence, and mentoring to continually improve the quality of psychotherapy provided by primary care physicians.

The article[1] states, "For most patients with MDD who present to family physicians, the cornerstone of treatment is antidepressant medication." However, the authors acknowledge a potential bias toward drug therapy by virtue of their declared affiliations with pharmaceutical firms.

The GPPA suggests that the cornerstone of treatment for patients with MDDs is the doctor-patient relationship, with or without medications or specific therapeutic techniques. One of the authors of the recommendations, Dr Morris, has previously noted:

> Family physicians are unique in their continuing affiliation with individuals and families over time, allowing them to observe the dynamic connection of patients' diseases in a holistic context of family, community and work. The trust and confidence that goes with this ongoing relationship allows counselling interventions to have more of an effect because they are in the context of the whole person.[4]

We agree wholeheartedly.

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—Lynn Marshall, MD, FAAEM, FRSM
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by fax

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Response

Drs Murphy and Marshall bring up several important issues for discussion. We are sure that they would agree with others in family medicine[1] that "usual care" for patients with depressive disorders is not "good enough" and that care could be improved at both primary and specialist levels. In this context, clinical guidelines are one strategy to improve clinical care for patients. We remind Drs Murphy and Marshall that clinical guidelines are definitely not standards of care, in that specific clinical situations might call for treatments outside guideline recommendations. However, in evidence-based medicine, clinical guidelines are a reasonable starting place for providing good clinical care.

We clearly state in the article that these guidelines were not developed specifically for primary care, but instead were summarized from guidelines developed by the Canadian Psychiatric Association and the Canadian Network for Mood and Anxiety Treatments.[2] While we agree that more studies need to be conducted in primary care, many of the recommendations are supported by studies in primary care populations, and we felt that these recommendations would also be relevant to family physicians. Partnering with a family physician, Dr Brian Morris, to write the summary ensured that the primary care viewpoint was represented. For example, the concept of clinical remission (in contrast to clinical response) as an objective of acute treatment has not yet disseminated into many primary care settings, yet studies show that the remission rates in depression studies of primary care patients are equal to, or higher than, those in studies of patients in psychiatric settings.[3]

We thank Drs Murphy and Marshall for including some of our caveats from the original guidelines about the psychotherapy recommendations. Condensing a 92-page supplement[2] into a 3-page summary meant that some information was necessarily omitted. However, we stand by our recommendations for evidence-based psychotherapies as first-line treatments, and we note that many of these psychotherapies (including problem-solving therapy, which was developed specifically for primary care) have been validated in large randomized controlled trials in primary care settings. And, although we may argue about the use of a word such as "cornerstone," antidepressants remain the most widely used and validated treatment for depression, hence the importance of pharmacotherapy guidelines for primary care physicians.

In British Columbia, clinical guidelines for treating major depressive disorders are now being developed for primary care with a working group that includes family physicians, psychiatrists, psychologists, and consumer association representatives. We invite Drs Murphy and Marshall to participate in the external review of the draft that will be specifically directed at primary care physicians.

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—Sidney H. Kennedy, MD, FRCPC
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Lack of interest in family medicine also in the United States

Drs MacKean and Gutkin[1] make an impassioned plea to all Canadian doctors and to all concerned Canadians for immediate action to remedy the growing disparity between demand for primary care medical services and supply of primary care doctors. The main reason for this inequity, according to the authors, is the declining interest in family medicine among our future doctors, due in large part to inadequate pay and low prestige. These concerns are shared among US family physicians, too.

The precipitous decline in interest in family medicine among US senior medical students began 7 years ago and has resulted in many family medicine residency training programs closing their doors or shrinking. Of all the family practice positions offered during the North American Residency Matching Program (NRMP) match of 2003, only 76.2% were filled during the match. This is the lowest in a decade and way down from its high 7 years ago of more than 90%.[2] Similarly, only 42% of these matched positions were filled by American seniors, down from its historic high 7 years ago of 72.6%.[3] As a former director of a family medicine program, I found the job of recruitment particularly challenging given the strong lure of medical specialties offering greater remuneration and perceived status. My one selling pitch to US-trained medical students has been that the field of family medicine is the most academically challenging. The clarion calls all family doctors to get involved in boosting our profession in order to make it a viable specialty for the 21st century.

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SARS wars: family physicians undeployed soldiers

Severe acute respiratory syndrome (SARS) has declared war on the human race for the last few months. With fear as its accomplice, it has threatened much more than our physical well-being. It has attacked basic notions of a civilized society, including respect for human dignity and public good. Language of discrimination and blame has been directed at a particular ethnic group; individuals suspected of having SARS have knowingly violated quarantine orders and put others at risk. I presume a lot of these behaviours are fueled by misinformation, and it is this presumption that leads me to reflect on family physicians' role in the war against SARS.

I believe family physicians have key functions as educators and advocates for communities[1] in a time of crisis. As family physicians are community-oriented, their organization and active participation in culture-specific educational events can help dispel myths and fill information gaps about the disease. Appropriate information, conveying the equal importance of public participation and medical ingenuity in the battle against SARS, enables the public to see quarantine as acts of altruism that contribute to our liberation from the disease.

As advocates for communities,[1] family physicians should be a strong voice against discrimination directed at ethnic communities, as well as at patients with SARS. Discrimination has grave health and moral consequences to society, as witnessed by our experience with HIV.[2] Prejudice against people with a particular disease violates human rights.[3] With stigmatization, efforts in curbing the spread of SARS can be compromised by secrecy about the disease and delayed treatment.

Due to the trusting and long-standing nature of our relationships with patients, we are likely the ones they will turn to should they have questions or symptoms. Informed advice, as well as teamwork with public health, can facilitate both treatment and quarantines.

The significance of family medicine's contribution in the fight against SARS is irrefutable. However, it is crucial for our government to recognize and support our functions by way of easily accessible, clear, and timely information about SARS without which family physicians will be like soldiers with no weapons.

—Renata M.W. Leong, MD, CCFP
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by e-mail

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