(PCPs) to "specialize" in the type and degree of patient-directed care they are comfortable with, rather than most PCPs providing care for a diverse spectrum of patient directedness? In my experience, I find patients and PCPs tend to "select" for the type they are most comfortable with. Thus, I suspect we will continue to see family physicians getting a pretty homogenous training but then gravitating to the practice model and patient type they are most comfortable with.

I have known since before entering medical school (at age 48) that I did not care for hospital-based care or acute, emergent care. A good friend thrives on ED trauma, something I prefer to let others like him handle. It does nothing pleasant for me. On the other hand, I thrive on shared medical appointments and group visits providing lifestyle intervention services, something many of my colleagues might not think of as "medicine." I want my patients to see me as an expert consultant, but my expertise has limits they sometimes exceed in specific areas. I do not feel inadequate because my patient knows more than I do about their care, but that was not the case for most of my colleagues and teachers during my medical education. They seemed to want to at least appear to know it all and always be right. As Dr Scherger points out so poignantly, we must surrender such paternalistic attitudes and approaches and become comfortable with the fact that, while we know a lot, we do not know it all—most of our knowledge is incomplete.

We need a model for primary care built around what is being called "lifestyle medicine." Lifestyle interventions are the real solution to chronic disease, for both treatment and prevention (www.lifestylemedicine.org). Unfortunately it has been seen as outside the realm of medicine, relegated to the domain of patient choice. But, we no longer see smoking in this light and are coming to realize that unhealthy eating and activity patterns are just as much in the domain of primary medical care as smoking cessation is. While we cannot force any patient to change any behavior, we would be remiss if we did not do all we could to motivate and empower patients to maximize their health.

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Detection and Reporting of Elder Abuse

To the Editor:

A meaningful approach by physicians to elder mistreatment requires at least three components: (1) awareness of signs and symptoms of elder abuse, (2) detection, and (3) reporting. Wagenaar et al[1] examined the approach taken to elder abuse education within residency training programs in Michigan and conclude that expanded curricula are necessary. In addressing detection, these authors report an absence of screening tools validated for use in primary care settings.

At McGill University, my colleagues and I developed the Elder Abuse Suspicion Index (EASI).[2] EASI has been validated to facilitate family doctors' identification of elder abuse in ambulatory settings[2] and has been shown to have content validity in a number of cultural settings.[3] It is not clear that improved training or detection tools will increase the low reporting rates commented on by Wagenaar et al.[1] In some jurisdictions, for example, physicians are reluctant to report abuse because mandatory reporting laws interfere with the sense of control they want over their practices.[4,5] In others, there has been a hesitancy to flag abuse until physicians themselves felt there was adequate justification for formal identification.[6]

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Health Care for the Homeless

To the Editor:

Woodhead et al, in their "New Research" Letter to the Editor, "Attitude Change Following a Homeless Clinic Experience, Use the Health Professionals' Attitudes Toward the Homeless Inventory (HPATHI).[1] We developed the HPATHI in conjunction with the Houston Outreach Medicine Education & Social Services (HOMES) Clinic, a sponsored project of Healthcare for the Homeless-Houston. HOMES was founded in 1999 on the belief that providing students' clinical experiences with the homeless followed by a facilitated time to reflect on those experiences would help impact the negative attitudes toward homeless patients.[2]

This free student-managed clinic was initiated as a collaboration between Baylor College of Medicine, The University of Texas Health Science Center at Houston's Medical School and School of Public Health, the University of Houston Graduate College of Social Work, and the University of Houston College of Pharmacy and provides students the opportunity for hands-on clinical training in a multidisciplinary setting. Subsequently, the HOMES LACE (Longitudinal Ambulatory Care Experience) track was developed as an option for third-year medical students with the desire to practice underserved medicine. This track provides students the opportunity to work at the HOMES Clinic as part of a 1-year course focused on homeless health care. The HPATHI is administered to students on the track before and after experiencing at least 10 clinical visits to HOMES and explores if, in fact, such clinical experiences changed the attitudes of the students.[3]

We have found that knowledge and encouragement matched with a positive experience for the student results in increasing the self-efficacy of both patient and provider.[4] For the provider, this is done by teaching the practice of goal-negotiated care (GNC).[5] The model used at Healthcare for the Homeless-Houston clinics engages patients in their treatment plans in a way that traditional models of care, which are largely physician-led encounters, may fail to do. GNC shifts the encounter to a patient-centered approach, incorporating the patient's experience of illness, psychosocial context, and shared decision making. The process includes actively negotiating with patients how to connect their goals with their health care plan. This aids in the development of a sense of ownership and buy in, which in turn provides them opportunities to experience personal successes rather than failures. We have found that this process reinforces the success of both the student and the patient. The students are not frustrated by what they see as the patients' inability or unwillingness to adhere to the treatment plan they prescribed. Further, unanticipated failure to attain goals is an opportunity to identify barriers or misunderstandings.

Woodhead et al propose that "Attitudes might change more notably in the positive direction if we expanded the clinic experience to include more didactics and personal experience with the homeless population."[1] It has been our experience working with medical students in the HOMES Clinic experience, and didactic classes must be combined with improved self-efficacy to positively impact students' attitudes. Over the years, through input from the students and examination of the results of the HPATHI, the class has evolved to provide a more rich experience in terms of how to be successful in providing care for this population. The class is shaped in a way that combines both the clinical and didactic so students feel armed with the tools needed to work with a population who undoubtedly faces numerous barriers to care, lack of preventive care, rampant mental health and substance abuse issues—"the difficult patients."

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Authors' Reply:

We appreciate Dr Buck's and Ms Brown's response to our letter. Indeed, it seems likely that enhancing family medicine residents' patient-centered communication skills and self-efficacy regarding care of the homeless would bolster positive attitudes toward these patients.[1,2] The authors' point underscores the challenge in identifying and measuring the variables that promote attitude change and behavior change. We look forward to the continued integration of existing and new research, particularly related to developing and refining training experiences for family medicine residents.

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Comment

The Family Doctor's Pledge

To the Editor:

After reflecting upon years of patient care in diverse environments and considering recent commentaries and conversations about the future of family medicine, I propose a new "pledge" for our profession, one that embodies established family medicine's values