

Letters to the Editor

Joseph Scherger, MD, MPH
Editor, Letters to the Editor Section

Editor's Note: Send letters to the editor to jscherger@ucsd.edu. We publish Letters to the Editor under three categories: "In Response" (letters in response to recently published articles), "New Research" (letters reporting original research), or "Comment" (comments from readers).

In Response

AAFP/Coke Alliance

To the Editor:

We are writing in response to the commentary regarding the AAFP and its recent alliance with Coke that was published in the January 2010 issue of *Family Medicine*. As the commentary discusses, the American Academy of Family Physicians (AAFP) accepted a financial donation from Coke to support their familydoctor.org Web site.¹ Since this relationship was announced, the leadership of STFM has been following multiple dialogues regarding this decision. It is obvious from these discussions that many of our members have strong feelings about this issue. We understand your concerns and respect your passion and engagement.

Since the decision was announced, STFM leaders have been in contact with the AAFP's leadership regarding their decision. The AAFP is well aware that many of their members, family medicine educators, others in the medical community, as well as in the general public are upset over their decision to partner with Coke. The AAFP Board of Directors reviewed their decision in light of their mission and comments they received and have chosen to maintain the

relationship. For future alliances, they have formed a review committee to provide input regarding these decisions. As STFM president, Terry Steyer, MD, will be serving as a member of this committee. It is hoped that this committee will be able to review future alliances and provide a broader input that will help the AAFP Board of Directors make the decision that they feel is in the best interest of the Academy and its members.

We will continue to monitor the situation and to engage in dialogue with AAFP leadership and senior staff about this relationship and potential relationships in the future. We encourage you, as either individual members or as friends of the AAFP, to share your individual concerns directly with their leadership. They are responsive and want to know and understand the feelings of their membership and the greater community of family medicine.

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1. Murray JL. Coke and the AAFP—The Real Thing or a Dangerous Liaison? *Fam Med* 2010;32(1):57-8.

Patient-directed Care Works Best With Family Physicians Specialized in Their Care

To the Editor:

I enjoyed the article by Joseph Scherger, MD, MPH, on patient-directed care and the future of medicine in the Web-enabled era.¹ It raises a number of relevant points, and I was encouraged that he did not paternalistically act as if we have all the answers. One of the more difficult things for most of us in medicine is to deal with cases where there is no clear or "correct" answer. We tend to focus on what we feel we have knowledge about and leave off or ignore the areas we do not. We may, for example, adjust statin dosing and say nothing about cholesterol intake, though in most cases the potential impact of adjusting statin dosing is far less than the impact of improving diet. (I do not mean to ignore the instances in which this may not be so or those cases where the patient has refused dietary change.)

I think a likely way the transition of which he writes may take place will be for family physicians and other primary care physicians

(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 al¹ 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 settings² 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