

(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](http://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.

*John Kelly, MD, MPH  
Department of Family Medicine  
University of Virginia*

#### REFERENCE

1. Scherger JE. Future vision: is family medicine ready for patient-directed care? *Fam Med* 2009;41(4):285-8.

## 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<sup>1</sup> 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).<sup>2</sup> EASI has been validated to facilitate family doctors' identification of elder abuse in ambulatory settings<sup>2</sup> and has been shown to have content validity in a number of cultural settings.<sup>3</sup> It is not clear that improved training or detection tools will increase the low reporting rates commented on by Wagenaar et al.<sup>1</sup> 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.<sup>4,5</sup> In others, there has

been a hesitancy to flag abuse until physicians themselves felt there was adequate justification for formal identification.<sup>6</sup>

*Mark J. Yaffe, MD  
Department of Family Medicine  
McGill University*

#### REFERENCES

1. Wagenaar DB, Rosenbaum R, Herman S, Page C. Elder abuse education in primary care residency programs: a cluster group analysis. *Fam Med* 2009;41(7):481-6.
2. Yaffe MJ, Wolfson C, Lithwick M, Weiss D. Development and validation of a tool to improve physician identification of elder abuse: The Elder Abuse Suspicion Index (EASI<sup>®</sup>). *J Elder Abuse Neglect* 2008;20(3):276-300.
3. World Health Organization. A global response to elder abuse and neglect: building primary care capacity to deal with the problem worldwide: main report. Geneva, Switzerland: World Health Organization, Life Course and Ageing Division, August 2008.
4. McGreevey JF Jr. Elder abuse. The physician's perspective. *Clin Gerontol* 2004;28(1/2):83-103.
5. Taylor DK, Bachuwa G, Evans J, Jackson-Johnson V. Assessing barriers to the identification of elder abuse and neglect: a community-wide survey of primary care physicians. *J Natl Med Assoc* 2006;98(3):403-4.
6. Helmes E, Cuevas M. Perceptions of elder abuse among Australian older adults and general practitioners. *Australian Journal on Ageing* 2007;26(3):120-4.

## 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).<sup>1</sup> 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.<sup>2</sup>