Yes, being sued can be painful and perhaps even destructive. But it would be far worse, for individual patients and for society, if we failed to use the commission of an error as an impetus to be frank about our mistakes and as an opportunity to improve patient safety.

Philip C. Hébert
Department of Family and Community Medicine
Sunnybrook and Women's College Health Sciences Centre
Toronto, Ont.
Alex V. Levin
Departments of Pediatrics, Genetics, and Ophthalmology
Hospital for Sick Children
Toronto, Ont.
Gerald Robertson
Faculty of Law
University of Alberta
Edmonton, Alta.

Reference

1. Hébert PC, Levin AV, Robertson G. Bioethics for clinicians: 23. Disclosure of medical error. *CMAJ* 2001;164(4):509-13.

Take a lesson from the drug companies

The authors who recently reviewed the barriers that inhibit the implementation of hypertension management guidelines in Canada[1] neglected to mention what might be one of the most important factors: the powerful influence of pharmaceutical manufacturers' marketing campaigns on physician practice patterns.[2] The freebie phenomenon was addressed in a news item in the same issue of *CMAJ* in which the review appeared.[3] Flip through the pages of that particular issue and you will come across 5 glossy advertisements promoting angiotensin-converting-enzyme inhibitors or AT_1 receptor blockers in the treatment of hypertension. Clinical practice guidelines are reflected only in footnotes in tiny print stating that the drugs being advertised are indicated when treatment with diuretics or β-blockers is ineffective or not appropriate.

If the groups that create clinical practice guidelines are wondering how to influence physicians' practices more effectively across the country, perhaps they should take a lesson from the drug companies: give out lots of free samples and promotional items, host elaborate events at which physicians are told about the excellent safety and tolerability profiles of the recommended drugs and place glossy 2-page ads in each issue of *CMAJ*. Apparently, it works.

Daniel Roth
Medical student
Faculty of Medicine
University of British Columbia
Vancouver, BC

References

1. McAlister FA, Campbell NRC, Zarnke K, Levine M, Graham ID. The management of hypertension in Canada: a review of current guidelines, their shortcomings and implications for the future. *CMAJ* 2001;164(4):517-22.
2. Wazana A. Physicians and the pharmaceutical industry: Is a gift ever just a gift? *JAMA* 2000; 283(3):373-80.
3. Sibbald B. Doctors asked to take pledge to shun drug company freebies. *CMAJ* 2001;164(4):531.

Choosing family medicine

As a third-year medical student trying to choose a specialty, I was interested in your recent article on the residency match.[1] I am attracted to family medicine's breadth and its emphasis on the total care of the patient. I recognize the value of continuity of care: by knowing your patients, you can see their medical problems in context. In other words, you can treat the patient, not just the disease.

However, to a person in his 20s, the concept of continuity of care can seem stifling: "For the good of your patients, you must never leave!" What if you are a family physician who ends up in an underserviced community and after a few years you are miserable? If you pack up and leave, you betray your patients. Furthermore, the energy (and money) you invested in your practice may be lost.

Sadly, most family physicians must become business managers as well as doctors: they must buy their equipment, hire staff, recruit patients, struggle with office expenses and hope that their practice stays afloat. Sometimes it seems much more attractive to work as an internist in a hospital because the office, the equipment and even the patients may be provided. Thus, you are free to practise medicine instead of trying to run a business. You are also surrounded by colleagues with whom you can discuss cases, socialize and engage in research projects.

On one hand, being a family doctor who provides total care seems exciting. On the other hand, I am scared that in doing so I will be trapped forever in some isolated community, cut off from the world of research and buried under a mountain of office expenses and paperwork.

Colin Stevenson
Medical student
Faculty of Health Sciences
Queen's University
Kingston, Ont.

Reference

1. Sullivan P. Family medicine loses lustre as students "vote with feet" in 2001 residency match. *CMAJ* 2001;164(8):1194.

I was surprised your article on the 2001 residency match[1] did not mention the introduction of the 2-year family medicine residency, albeit almost 10 years ago, as a factor in the declining popularity of family medicine among medical students.

I graduated from Dalhousie in 2000 and am currently a first-year resident in anesthesia. During medical school I considered a career in family medicine and enjoyed my rotations in it during clerkship. I would love to have had a chance to practise it for a few years before ultimately deciding whether to specialize further. However, my decision to apply only to anesthesia was based, among other reasons, on the belief that it would not be worth losing 1 to 2 years of training (which is the cost of doing a 2-year family medicine residency and later beginning in another specialty program and having to repeat PGY-1 or PGY-2 or both). This and

the uncertainty that a position would be available in the specialty of my choice after several years in family practice were the 2 main reasons I did not choose family medicine.

We should consider reintroducing a 1-year rotating internship as qualification for practising family medicine. Many students finishing medical school feel they are not ready to choose a specialty, and it is likely that more of them would try family medicine if they knew they could later enter a different training program without losing time. Presumably, many of the students trying family medicine would enjoy their work experience and stay. If some chose to do further training after a few years in family practice, they would be better physicians because of the experience. In addition, at any given time the total workforce of family physicians would be larger, helping to alleviate at least some of the shortages we're currently experiencing.

Gillian R. Hamilton
PGY-1, Anesthesia
Dalhousie University
Halifax, NS

Reference

1. Sullivan P. Family medicine loses lustre as students "vote with feet" in 2001 residency match. *CMAJ* 2001;164(8):1194.

Hand-held brain extenders

I read with interest Michelle Greiver's discussion of the use of a Palm Pilot ("hand-held brain extender") in her practice.[1] She stated that her patients have not found her Palm to be intrusive; rather, they appreciate the extra information that she can now bring to their health care.

My experience has been similar. In the spring of 2000, I asked 12 of my patients to fill out an anonymous questionnaire after I used a handheld personal computer during my encounter with them. None of the patients reported having any negative thoughts or feelings about my use of a handheld personal computer during our visit, and 9 of them were impressed that I used one: they felt that I was "up to date."

Gavin Greenfield
Family physician
Calgary, Alta.

Reference

1. Greiver M. Evidence-based medicine in the Palm of your hand. *CMAJ* 2001;164(2):250.

[The author responds:]

I thank Gavin Greenfield for his comments on my article.[1] I think that research on the acceptability of this technology and the barriers to its use for both patients and health care providers may be warranted, owing to the increasing use of personal digital assistants in the medical field. *CMAJ* has started publishing the table of contents for each issue as well as selected articles in a format compatible with handheld devices (www.cma.ca/cmaj/etoc/etoc-pda.htm).

In a recent article on problems in clinical judgement, Donald Redelmeier and colleagues noted that computerized diagnostic tools have been found to be inferior to a clinician's judgement.[2] I think that the use of a personal digital assistant is qualitatively different from the use of a PC-based diagnostic tool, as the handheld does not supplant, but rather supplements, the clinician's skills.

I have found that my Palm helps me by providing information nuggets in a just-in-time manner and diagnostic information to supplement my decision-making. One example of this would be the Wells table for diagnosis of deep vein thrombosis.[3] However, such anecdotal reports may not necessarily reflect actual changes in patient care; clinical trials are needed to compare outcomes with and without Palm-based clinical tools. I look forward to reading the results of such trials in future issues of *eCMAJ*.

Michelle Greiver
Lecturer
Department of Family and Community Medicine
University of Toronto
Toronto, Ont.

References

1. Greiver M. Evidence-based medicine in the Palm of your hand. *CMAJ* 2001;164(2):250.
2. Redelmeier DA, Ferris LE, Tu JV, Hux JE, Schull MJ. Problems for clinical judgement: introducing cognitive psychology as one more basic science [editorial]. *CMAJ* 2001;164(3):358-60.
3. Wells PS, Hirsh J, Anderson DR, Lensing AWA, Foster G, Kearon C, et al. Accuracy of clinical assessment of deep vein thrombosis. *Lancet* 1995;345:1326-30.

Submitting letters

Letters may be submitted via our Web site or by mail, courier, email (pubs@cma.ca) or fax. They should be no more than 250 words long and must be signed by all authors. A signed copy of letters submitted by email must be sent subsequently to *CMAJ* by fax or regular mail. Letters written in response to an article published in *CMAJ* must be submitted within 2 months of the article's publication date. *CMAJ* corresponds only with the authors of accepted letters. Letters are subject to editing and abridgement.

eLetters

We encourage readers to submit letters to the editor via the eLetters service on our Web site (www.cma.ca/cmaj). Our aim is to post by the next business day correspondence that contributes significantly to the topic under discussion. eLetters will be appended to the article in question in *eCMAJ* and will also be considered for print publication in *CMAJ*. Beginning with the Aug. 22, 2000, issue, eLetters can be submitted by clicking on the mailbox icon at the end of the HTML text of any *eCMAJ* article.