Letters Correspondance

Collaborative learning a long-term journey

I was pleased to read the March issue of *Canadian Family Physician*, which was devoted to mental health care. A number of articles addressed challenges and opportunities for the delivery of mental health care at provider and systems levels. Dr Jayabarathan's editorial[1] organized the related articles into a useful framework, and the comments were frank and to the point. I particularly agree with Dr Jayabarathan's statement that shared mental health care "…is poised to develop into a long-term journey of collaborative learning."

Identifying the limitations in our current system of mental health care is especially important for those engaged in the process of improving the system. People developing and proposing solutions to the challenges of mental health care require input from the various stakeholders in order to achieve outcomes that are meaningful to providers and consumers alike. Our mental health care system in Canada is one of the most advanced in the world and yet is in its infancy relative to other facets of our health care system. Given that it is still very young, the mental health system, itself, is in "a long-term journey of …learning." The Ontario College of Family Physicians' Collaborative Mental Health Care Network (OCFP CMHCN) is an excellent example of a solution that encourages feedback and is learning from its feedback.

Since Rockman et al[2] wrote their article, the network has already addressed several issues identified by Dr Jayabarathan. Nurse practitioners are being invited to join, and the Ontario Psychiatric Association has been asked to collaborate with the Ontario Medical Association's family physician section to lobby for an indirect fee code from OHIP that would allow family physicians and psychiatrists to be remunerated for time spent on the telephone discussing patients.

In addition, proposals have been made to incorporate the collaborative care model in family medicine and psychiatry residency programs at the University of Toronto. These ongoing developments have arisen from the dedication of Dr Rockman and others in the network who envision the collaborative network as a work in progress rather than a *fait accompli*.

Programs such as the OCFP CMHCN should be actively supported through constructive criticism and other actions. For instance, ministries of health need to endorse collaboration through remuneration and other forms of support for mental health providers who communicate regarding mutual clients. This would help to shift collaboration from a few highly motivated parties to a larger proportion of providers. We also need to teach collaborative skills in all residency programs, emphasizing patient care and two-way learning of practice contexts, skills, and knowledge.

I hope that the editorial comments by Dr Jayabarathan serve as a call to support programs, such as the OCFP CMHCN, rather than an invitation for readers to dismiss genuine attempts to improve the system of mental health care.

—Jose Silveira, MD, FRCPC
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by e-mail

References

1. Jayabarathan A. Shared mental health care. Bringing family physicians and psychiatrists together [editorial]. *Can Fam Physician* 2004;50:341-43 (Eng), 344-6 (Fr).
2. Rockman P, Salach L, Gotlib D, Cord M, Turner T. Shared mental health care. Model for supporting and mentoring family physicians. *Can Fam Physician* 2004;50:397-402.

Response

Thank you for your feedback on my editorial. It is gratifying to see that you have responded to the issues raised not only by advocating for the "growing" nature of the network's model of collaborative care but also by notifying us that tangible solutions are being worked out even as the ink dries on our correspondence.

Thank you also for your philosophical perspective on the editorial. Too often, constructive feedback is viewed as criticism; as a result either the original idea or the feedback might be rejected. The purpose of my editorial was to stimulate thought and discourse on emerging models of collaborative care. Having a venue in which we can all participate in this discourse, such as the Letters section of *Canadian Family Physician*, adds the strength of our collective perspectives and experience to our lifelong "journey of learning."

—A. Jayabarathan, MD, CCFP

Methodologic points to consider

I enjoyed reading Dr Huff's "consumer report" article on probiotics[1]—more eye-opening evidence of what we often get with non–government-regulated, over-the-counter "pharmaceutical" products. I noticed that Dr Huff is a second-year resident, and I congratulate her for excellent work. I wish to emphasize, however, a few methodologic points that she might consider for future research projects.

In the abstract, her project is described as a randomized double-blind trial. This is an error. A randomized clinical trial (RCT) is a study in which people are allocated at random to receive one of several clinical interventions.[2] A randomized clinical trial is often referred to as a randomized controlled trial, but in fact there are always by definition at least two groups—one experimental group and one control group—in a randomized trial. The control group is a no-intervention group, a placebo group, or another active intervention group. The term "controlled" is then a pleonasm, and I prefer using "clinical."

I am sorry to reduce this research to a simple descriptive study. This should be mentioned and corrected in the journal. Otherwise, I read in the Methods section of her article that she purchased sample products at random. What method of random selection did she use? What was the total "population" of products? How was sample size calculated or decided? I really wish to believe she selected a random sample of products, but I need more methodologic details to do so. Blinding to substances the person who handled the products in the laboratory was a wise decision to minimize measurement bias and thus increase the validity of the results.

I hope these elements will be useful to Dr Huff and also to her fellow residents and their supervisors. Beside these few points, her work is really remarkable and can be cited as an example.

—Michel Labrecque, MD, PHD, FCMF
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by e-mail

References

1. Huff BA. Caveat emptor. "Probiotics" might not be what they seem. *Can Fam Physician* 2004;50:583-7.
2. Jadad AR. *Randomised controlled trials.* London, Engl: BMJ Books; 1998.

A coat of nail polish might work

I really enjoyed the April issue of *Canadian Family Physician*. It was good to see a medical student involved in the Dermacase article[1] on nickel allergy.

I have found that, when there is contact dermatitis of this type and a patient cannot easily avoid wearing glasses or a watch, applying a thick coat of clear nail polish or similar substance to the object usually prevents the problem for some time. The object must be well cleaned with lacquer thinners first and even abraded slightly to create a good "key" for the polish to stick well. I have used this procedure for clip-on earrings with fair success. Repeat applications are required at frequent intervals. Just a thought!

—Bruce L.W. Sparks, MD
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Reference

1. Kalia S, Adams SP. Dermacase [Clinical Practice]. *Can Fam Physician* 2004;50:553, 557.