As indicated in the case description, patients often present with other somatic complaints that are the physical manifestations of their histories of abuse. Many such patients undergo repeated investigation for skin lesions and other somatic complaints without finding disease.

As well as treating the skin lesions, family physicians have an opportunity to raise the issue of self-abuse with their patients and to explore abuse in patients' intimate relationships. Patients might not be able to give good histories of how the injuries occurred because they often dissociate while they self abuse. The long-standing relationships that family physicians have with their patients can make it easier for both patients and physicians to discuss these and other difficult situations.

Psychotropic medication, including antipsychotics, might be helpful in certain clinical situations but is unnecessary for all cases of self-abuse. Appropriate referral to other community resources with expertise in assisting patients who self-abuse, including self-help groups available in some communities, is an important adjunct to treating these skin lesions.

— Barbara Lent, MD, CCFP,
Cathy MacLean, MD, CCFP,
and Jo-Anne Willing, RN
London, Ont

References

1. Adams SP. Dermacase. *Can Fam Physician* 1997;43:437, 446.
2. Herman J. *Trauma and recovery.* New York: Basic Books; 1992.
3. Miller D. *Women who hurt themselves.* New York: Basic Books; 1994.

Response to onsert

In reply to the letter from Dr Carl Whiteside who objected to the onsert, "Meeting Report. Acid-related Gastrointestinal Disorders," with the January issue of *Canadian Family Physician*, we would like to outline the strict criteria to which we adhered in developing this publication.

The content of this meeting report was developed by a multidisciplinary Advisory Council composed of three family physicians, three gastroenterologists, and two pharmacists; all are independent professionals currently practising in Canada (and not employed by any pharmaceutical company). These medical professionals brought their knowledge of and clinical expertise in the management of gastrointestinal diseases and disorders to two day-long meetings. The meeting report was reviewed and approved by the Advisory Council because these professionals are responsible for the content of this publication, not the sponsor. Credible, peer-reviewed references recommended by the Advisory Council were used to support statements throughout the text. Great care was taken to produce useful and evidence-based information for family physicians.

Despite Dr Whiteside's less than favourable response to this publication, as Editor and Advisory Panel Chair on this project, we can only say that the response to this meeting report and many other projects like it has been overwhelmingly positive.

— Devon Phillips
Senior Editor,
Pegasus Healthcare International
Montreal
— Bernard Marlow, MD, CCFP
Toronto

Referral for psychosocial assessment

In the April issue of *Canadian Family Physician*, the BATHE and DIG techniques were reviewed in Dr Vincent H.K. Poon's article.[1] I respect Dr Poon's sincerity regarding family physicians' lack of time and training where counseling is concerned.

Dr Poon used a case study to demonstrate the BATHE technique. In

the case study, a patient is seen by the doctor for an upper respiratory tract infection (URI). The doctor notices the patient is bothered and uses the BATHE technique. The patient discloses that she is unable to cope with her work environment and related stresses. The doctor responds with empathy and suggestions for dealing with the URI. The patient leaves, thanking the doctor and feeling more relaxed. The patient has received a brief diversion from her psychosocial stresses in addition to treatment for the URI.

In my opinion, the next step should be to direct the patient to a professional mental health counselor for psychosocial assessment and counseling. The patient will then be BATHED with complete physical and psychosocial treatment.

— *Don Johnston, RN, CPMHN(C), BSN*
Barrie, Ont

Reference

1. Poon VHK. Short counseling techniques for busy family doctors. *Can Fam Physician* 1997;43:705-13.

Response

As stated in the article, the BATHE technique is a short counseling technique, not a substitute for detailed psychotherapy. However, it has the advantage of letting patients know their doctors care and listen. Often, this opens up further communication. In subsequent visits, doctors can find out how patients are doing or patients can volunteer more information. When there are serious psychosocial stresses, doctors should do one of two things: spend more time exploring and dealing with the issues, or direct patients to other mental health professionals for further assessment and management.

— *Vincent Poon, MD*
Toronto

The art of medicine

The two articles, "Reconsidering sore throats,"[1,2] confirmed my own feelings that we physicians take an unscientific approach to diagnosing and treating this common problem. However, the solutions offered make me wonder if we are looking too hard at a simple concern.

The authors suggested taking throat cultures from patients presenting with two or more symptoms from a "sore throat score." Fifty-five percent of patients presenting with sore throats fall in this category. In an average week, which includes weekend coverage, I might see 50 patients with sore throats. Our local laboratory informs me they charge the health care plan $22 for one throat culture. Is this a cost-effective way of doing things? It does not include the extra time spent calling patients to stop or start antibiotics.

Where is it written that every diagnosis must be verified by a test? My best preceptors always made me ask the question, "Will the test change the management of this case?" before I ordered the test. In this era of fiscal restraint in health care, we must remember that every x-ray or laboratory test uses funds from our global budget. As clinicians and researchers, we must have a collective consciousness of how we use our resources. Where is the confidence in our clinical judgment? Do we need an algorithm for every medical problem we see?

It is vital for our profession to critically appraise what we do. Should this apply to every medical diagnosis? I fear in our quest for scientific validation, we will lose an important part of medicine... the art of medicine.

— *Richard A. Nishikawa, MD, CCFP*
Lacombe, Alta

References

1. McIsaac WJ, Goel V, Slaughter PM, Parsons GW, Woolnough KV, Weir PT, et al. Reconsidering sore throats. Part 1: Problems with current clinical practice. *Can Fam Physician* 1997;43:485-93.
2. McIsaac WJ, Goel V, Slaughter PM, Parsons GW, Woolnough KV, Weir PT, et al. Reconsidering sore throats. Part 2: Alternative approach and practical office tool. *Can Fam Physician* 1997; 43:495-500.

Response

Dr Nishikawa asks, "Is this a cost-effective way of doing things?" Cost effectiveness is more than the difference in the costs of two approaches. The effectiveness of services provided in achieving a particular objective must also be considered. It is only where approaches are equally effective that cost becomes the determinant. Therefore, one must first ask, "Are alternatives equally effective in the management of patients with sore throats?"

Office visits for sore throats are considered necessary to identify Group A streptococcal (GAS) infection for treatment. The article[1] presents all studies we could find on how accurate physicians are in picking up such infections. Family physicians appear to miss 25% to 50% of GAS infections when using clinical judgment. The "score" has been estimated to miss 15% of cases. Thus, the score is likely more effective than clinical judgment for identifying patients with GAS infections; it is certainly not worse.

Prescription of unnecessary antibiotics has become an important outcome for assessing effectiveness, as it can no longer be considered inconsequential.[2] In treating sore throats, unnecessary antibiotics would be those prescribed to patients who do not have GAS infections. Typically, 80% to 90% of sore throat patients do not have GAS infections.[1] Using clinical judgment as a basis for deciding to prescribe might lead to 20% to 40% of such patients receiving antibiotics. The score is most effective in reducing unnecessary antibiotic prescriptions.

The score is really just another form of the more traditional clinical judgment to which Dr Nishikawa refers. It uses the same clinical findings that family physicians currently

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