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CORRECTION

A caption accompanying an article in the Winter 2011 issue ("In SHAPE: Local pilot becomes national model") incorrectly stated that In SHAPE participant Tracy Bleyler has Down Syndrome. The *Dartmouth Medicine* team sincerely regrets the publication of this inaccurate description.

In addition, *Dartmouth Medicine*, Geisel School of Medicine, and Dartmouth-Hitchcock Medical Center strive to promote and recognize individuals by who they are and the work they are accomplishing rather than by a condition, or, in this case, an inaccurate label.

LETTERS

A timely book

Kudos to Dr. Hoyt [see "Defense Mechanism," Winter 2011, dartmed.dartmouth.edu/w11/f01]. She has touched on an extremely important issue not only with respect to bioterrorism but vaccination for common and not so common communicable diseases. This country is highly vulnerable to both and has even ignored the HPV vaccine, which could effectively eliminate deaths from cervical cancer. Our population does its own thing and has lost its respect for public health and important issues of infectious disease. I look forward to her upcoming book.

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Primary concern

I very much appreciated your article in the Winter 2011 issue regarding overtreatment of patients [dartmed.dartmouth.edu/w11/d01]. I have been a family doctor for the past 23 years.

During that time, I have seen physicians, including myself, rely more on testing and less on good judgment. I learned during medical school that the history was the most important part of the decision-making process. If I sat down and listened to the patient, he or she would tell me what the problem was. I would

then decide whether further testing was necessary to confirm my suspicions.

Now, our decisions are compromised by outside forces that lead to increased testing, much more expensive care, and, I believe, poorer outcomes. Instead of using valuable health care dollars to increase the number of patients who get good care, we are overspending on the small group that comes to see us regularly.

The patients who see us regularly have access to a large body of information on the internet. They come to us with preconceived notions of what they need done. If we disagree with them, we are perceived as being uninformed and poorly trained. After lengthy conversations with patients, I often wind up ordering an inappropriate test, because that is the only way I can put their mind at ease.

Many excellent physicians have been devastated by lawsuits even under circumstances where they did the right thing. Thus, fear of litigation plays a major role in our decision about whether or not to order a test.

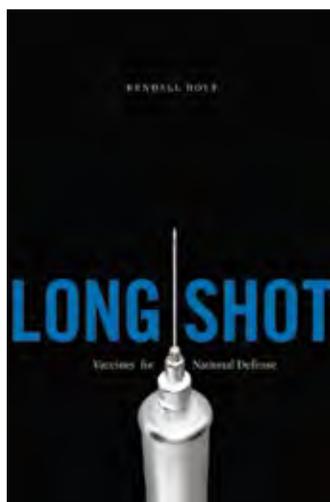
The introduction of meaningful use criteria will further increase testing. These guide-

lines assume that all patients are the same. Decisions are made solely on the basis of what illness they have. There is so much more that goes into medical decision-making. We need to consider the patient's age, other medical problems, and financial situation, and the impact that the test results will have on a patient's life.

I believe that the new guidelines and some components of medical homes made medicine into just a science. We are losing the art of medicine. I know that I am doing my best job when I treat each patient as an individual rather than clumping them into a category listed in a chart in an electronic medical record. I hate to think that we are becoming technicians with our heads buried in a computer rather than looking at our patients and trying to understand them.

It seems to me that the opinions of primary-care physicians were not taken into enough consideration during the formulation of health-care reform. I was really excited to see the article about Dr. Sirovich's study. Perhaps this is a first step toward getting the right people into this very important discussion.

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The Winter 2011 issue featured an interview with Kendall Hoyt, Ph.D., author of *Long Shot: Vaccines for National Defense*.