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The comments you'll see on websites that rate physicians tend to be extremes. Doctors have to remember the vast majority of patients are content but can't be bothered to post their thoughts online.

## SPIRIT OF MEDICINE

# Put 'RateMDs.com' in perspective

*Patients may love or hate you, but rarely do you hear from those who are content*

by Melissa Yuan-Innes

ONE OF MY FRIENDS recently called me in a panic about RateMDs.com: "I couldn't sleep last night after I read my reviews."

"Hang on, let me check them out," I said, surfing to the popular website that

allows patients to provide their opinions—good or bad—about any doctor. I soon found my colleague's rating page.

"Wait a second, this is great! One patient said you 'took the time to listen to me after two other doctors had ignored me. He found that I had cancer. I am so grateful.' That's awesome.

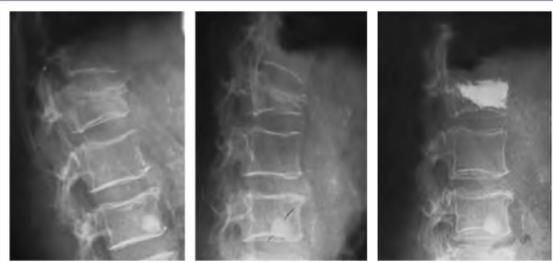


## Vertebral Fracture Management

Are you doing the best for your patients?

A common but often silent consequence of osteoporosis, vertebral compression fractures (VCFs) are likely to become more common than ever as the population ages. The functional, physical and psychological consequences of VCFs can dramatically impact quality of life and even shorten lifespan. In the five-year Canadian Multicentre Osteoporosis Study, for example, people with VCFs in the second year of follow-up had a 2.7-fold increased risk of death.<sup>1</sup>

### Correction of Angular Deformity



Immediately post-fracture  
Kyphosis = 16°

Post-fracture + 4 days  
Kyphosis = 25°

Post-kyphoplasty  
Kyphosis = 10°

Despite these negative outcomes, VCFs remain seriously underdiagnosed. "Only one or two out of every 10 VCFs are diagnosed," says Dr. Maziar Badii, a rheumatologist and spine specialist at the Vancouver General Hospital, explaining that "back pain is common and doctors don't often think of fractures." According to Dr. Badii, failing to diagnose VCFs – whether painful or not – carries a risk. "The underlying osteoporosis needs to be treated." Important signs for recognizing vertebral compression fractures include loss of height; sudden severe back pain; increased stoop or "dowager's" hump.<sup>2</sup>

In 2005, a consensus panel of Canadian physicians prepared recommendations for treating VCFs in primary care, including:<sup>3</sup>

- Calcium and vitamin D supplementation, antiresorptive and anabolic agents help prevent secondary VCFs.
- Magnetic resonance imaging is the most useful test for evaluating a fracture.
- Vertebroplasty or balloon kyphoplasty should be considered for patients with progressive deformity or intractable pain.

For patients with painful VCFs, Dr. Badii recommends pain medications and bed rest for two to three months, followed by kyphoplasty or vertebroplasty if the patient hasn't shown sufficient improvement. "Kyphoplasty can yield pain relief within days," he says. "It's important to refer patients with painful VCFs, who often continue to experience a reduced quality of life along with the bother of opioid side effects."

Kyphoplasty involves the use of a balloon to restore vertebral body height and angular deformity correction, then filling in the resultant vertebral space with bone cement.<sup>3</sup> Prospective clinical trials have yielded rapid and sustained improvement in back pain for up to two years after the procedure.<sup>5,6,7</sup> In the FREE trial (Lancet 2009), back pain scores decreased by 2.2 points more in the kyphoplasty group than in the nonsurgical control group after one week and remained significantly lower after 12 months ( $p = 0.0034$ ).<sup>5</sup> Physical function, social function and quality of life also improved to a greater degree in the kyphoplasty group.<sup>5</sup>

Two 2009 studies (NEJM<sup>8,9</sup>) showing that vertebroplasty did not outperform conservative treatment raised some controversy about the effectiveness of surgical intervention for VCFs. Both the Society of Interventional Radiology (SIR) and the North American Spine Society (NASS) responded with statements pointing out the studies' limitations and noting their prior clinical experience with vertebroplasty had been positive.<sup>10,12</sup>

Compared to conventional vertebroplasty, kyphoplasty has the further potential advantage of vertebral body height restoration and angular deformity correction,<sup>3,6</sup> in addition to its improved safety profile.<sup>11</sup> "It's a non-invasive procedure that takes about an hour for a single level," says Dr. Stephan DuPlessis, vice-chairman of the University of Calgary Spine Program. "It's one of the best procedures available as long as patients are selected appropriately. Our results have been excellent."

### References

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### Important Safety Information

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## Practice notes

### Waiting for a miracle

My fantastic and loyal medical office assistant, Irene, comes from the Calabria region of southern Italy and grew up a devout Roman Catholic. She can rattle off the names of patron saints for just about anything, particularly those who have to do with caring for the sick and injured. Although years of working in medical offices has certainly made her appreciate the effectiveness of modern medicine, there is still a good part of her that believes in a higher form of healing.

One day, my 84-year-old patient Charlie came in to see me for a routine checkup. All was well, but Charlie's memory was not quite what it used to be; I realized he forgot his cane in the examining room as he made his way, somewhat unsteadily, through my busy waiting room area. Irene looked up from her desk and jumped to her feet. "It's a miracle, everybody! St. Daniel has done it again!" —Dan Ezekiel is a family physician in Vancouver and a preceptor for medical students at the University of British Columbia.

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You saved that patient's life! How many walk-in clinic doctors can say the same thing?"

"I know that's a good one," he responded. "But I can't stop thinking about the people who said I was 'rushed.'"

"Who isn't rushed? I'm excited if there's a day I'm not rushed."

"It still really bothered me. It's a walk-in clinic. I hardly take time to go to the bathroom, but all they talk about is the waiting time and that I'm rushing them through."

"No, mostly they say that you're great and they're really happy that you're their doctor."

"I know," he sighed.

I kept talking, but I knew he wasn't convinced.

I've since checked out a few other doctors' ratings and I'm always struck by the extreme nature of a lot of comments. The patients are often either wildly grateful or off-the-charts angry. The majority, I assume, are merely content with their care and can't be bothered to post comments online because they have other things to do with their lives.

#### Screen comments

As a writer, I get reviews of my published work. My writing mentors caution me not to read them unscreened because they mess with your head and then you can have trouble writing. "Get a trusted friend to read them and only pass on the

**Any personality-disordered patient can criticize you and smear your name over the Internet. But it takes brains and sheer grit to improve people's lives, day after day.**

good ones," they say. I have occasionally read unscreened reviews and the one or two digs did bother me, although not enough to shut down my laptop.

The real problem, of course, is that doctors don't like to be rated and found wanting. I remember a general surgeon saying that he sometimes gave the residents an average evaluation with the following explanation: "Yes, you were the

top student in your class. But now you're in surgery and for a surgeon, you're average."

That may be true, but it's pretty tough love for a group of people who are used to (or possibly addicted to) praise and straight As. And then the mind games begin. Are you really average or worse than average? Are you a bad doctor? Are you a bad person? Do you have bad breath?

Let's get real. Any personal-

ity-disordered patient can criticize you and smear your name over the Internet. But it takes brains and sheer grit to improve people's lives, day after day.

As for my own RateMDs ratings. . . First of all, I work in an emergency room, so people can hardly get to know me. Second, no one can pronounce or spell my last name within 60 seconds of me introducing myself, which further discourages feedback. And third and most importantly, I have never read any of my ratings.

I've got to keep my sanity somehow.

*Melissa Yuan-Innes is an emergency physician in Cornwall and Alexandria, Ont.*

## Patients keep you on your toes

Physicians try to stay in control during the office visit, but this can be difficult. In particular, it's troublesome when the patient stands up after being asked, "What seems to be the problem?" He may approach you with a gob of phlegm in a tissue. He may strip to his waist to wave an armpit in your face. Worse, he may drop his pants and turn about in the "mooning" position to display his hemorrhoids inches from your face. Another way the patient may assault us if we are still sitting is with a foot. My favourite is the "one-legged bunny hop." If the problem is a plantar wart or a toe problem, the patient may decide to undress his foot, then hop over on his good leg while holding the bad foot in the air. Should he hop too close, you might get overly familiar with his toes. All of this is avoidable if the physician stands up when he senses what is about to happen, and asks the patient to climb on the examination table for closer perusal. It is all a matter of timing. And self-preservation.—  
*David Rapoport is a Toronto family physician.*

## And in the category of 'misheard at the doctor's office . . .'

The other day, a new patient explained to me that his family doctor had performed a biopsy of an unusual mole on his back. Apparently it turned out to be fine, but he informed me that he has since developed a "keister" that is red and itchy. I explained that more likely he had developed a "keloid," unless of course the mole had been removed from his buttocks.—  
*Benjamin Barankin is a Toronto dermatologist.*

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