to their own specialty. This is equivalent to having a flat CMPA fee for Ontario specialists, whether they realize it or not.

I am not aware of the situation in the other provinces, but if the uniform flat fee were adopted in Ontario it would only be fair to go back to square one — to calculate and remove the extra percentages that were allocated to specific specialties in the past and redistribute the "extra" evenly to all physicians in the province. Failure to make the necessary fee-schedule corrections would punish family physicians twice, first when the schedule was tilted to give a greater percentage to specialties facing high CMPA fees, and then again if uniform CMPA fees were adopted.

Maybe we should take Justice Charles Dubin's theory one step further — "in the spirit of collegiality and in the interests of ensuring the continued provision of high-quality health care both for the sake of the profession and for the sake of all Canadians" we should have a uniform-fee structure not only for the expense side of the equation, but also for the income side.

Chris Stefanovich, MD
Queen Elizabeth Hospital
Toronto, Ont.

In this article, Justice Charles Dubin suggests that "in the spirit of collegiality, physicians should equally share the responsibility of the cost of professional insurance." I suggest that, in the spirit of reality, we keep our malpractice insurance regulated by actuaries and based on group risk.

There are many inequities in this world, but it is not for the people at the bottom of the decision-making ladder to have to smooth them over. Government, which ultimately pays physicians in this country, and medical associations and registration bodies, which are involved in the regulation of the fee structure, need to ensure that physicians in high-risk groups receive more money to be able to afford their malpractice coverage.

We cannot allow the legal system and litigants to remove huge sums of money from the medical establishment in the form of claims settlements without realizing that we will have to pay more into the system. If we practised under a private fee schedule, patients requiring the services of a physician in a high-risk category would have to pay more for that service because of the insurance costs involved. The answer appears simple. Pay the high-risk physicians more so that they may insure themselves adequately.

Finally, I assume no one needs reminding that we already have a differential fee structure. As the pay differentials are adjusted over time, the cost of insurance should be taken into account.

Christopher J. Galanos, MB, BCh
Radville, Sask.

Sleep statement for adults only

I would like to congratulate the Standards Committees of the Canadian Sleep Society and the Canadian Thoracic Society for the article "Standards for polysomnography in Canada" (*Can Med Assoc J* 1996;155:1673-8). It is an excellent summary of factors to be considered in adults with sleep disorders. Those who prepared it have considerable expertise in understanding, investigating and managing sleep disorders. However, the article seems to deal only with adults, although this is not stated in the title or the text.

Following the lead of these societies, the Respiratory Section of the Canadian Paediatric Society will prepare a similar document for children.

I recommend that all groups preparing standards state explicitly in their published statements which populations are targeted.

Ian Mitchell, MB
Chair
Respiratory Section
Canadian Paediatric Society
Calgary, Alta.

Radical mastectomy now outdated

The articles "Patterns of initial management of node-negative breast cancer in two Canadian provinces" (*Can Med Assoc J* 1997; 156:25-35), by Dr. Vivek Goel and associates, and "A surgical subculture: the use of mastectomy to treat breast cancer" (*Can Med Assoc J* 1997; 156:43-5), by Dr. Adalei Starreveld, make fascinating reading. Not only is it remarkable that the patterns of practice differ so much between Ontario and British Columbia, but one is left wondering why outdated radical mastectomy procedures are still being performed in such large numbers, especially in older women and women in rural areas in BC. Is this largely a function of how recently the surgeon has been trained and his or her academic affiliation, or a more general reluctance to keep up-to-date with current scientific evidence?

It has been evident for at least 10 years that breast-conserving surgery, followed by timely radiation therapy, is equivalent to mastectomy in terms of outcome. Adjuvant chemotherapy with such agents as tamoxifen should be part of the program, to lower the rate of recurrence.

In BC an additional factor is the shortage of radiation machines. Although such therapeutic equipment is available in Vancouver and Victoria, the existing machines in Victoria are inadequate to deal with the demand, and proposals to upgrade and expand equipment have recently been