of contents on it, à la *New England Journal of Medicine* or *The Lancet*.

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Reference

1. Bellan L, Mathen M. The Manitoba Cataract Waiting List Program. *CMAJ* 2001;164(8): 1177-80.

The stethoscope as a postural aid

I read with interest and amusement the paper by William Hanley and Anthony Hanley[1] and the subsequent comments by David Leak[2] and John Campbell[3] regarding the wearing of the stethoscope. My stethoscope has a rather heavy head end and when I carried it in the traditional (T, or U) manner I found it to exert undue pressure against one or other (or both) carotid sinus(es) when it slipped on my neck. Rather than wearing it draped around my neck in the cool (C) position, I carry it draped over my left shoulder, which I shall now call the S position. Benefits of this style are that it is seen from behind as well as from the front and it helps one maintain an erect posture.

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References

1. Hanley WB, Hanley AJG. The efficacy of stethoscope placement when not in use: traditional versus "cool." *CMAJ* 2000;163(12):1562-3.
2. Leak D. The stethoscope at ease [letter]. *CMAJ* 2001;164(6):747-8.
3. Campbell JD. The stethoscope at ease [letter]. *CMAJ* 2001;164(6):748-9.

Improving the quality of discharge summaries

In 1995, Carl van Walraven and Anthony Weinberg reported in *CMAJ* on the assessment of quality in a discharge summary system.[1] In a further report they noted that the quality of the reporting decreased as the length of the discharge summary increased.[2] We evaluated the discharge summaries of 1712 sequential patients discharged from the respiratory division of Tsukuba University Hospital between April 1992 and December 2000.

Chief complaints, medical history, hospital course and discharge diagnosis were documented in all of the discharge summaries. However, physical examinations were not completely documented in 10.5% of the summaries, significant laboratory tests in 9.9% of the summaries and discharge medications in 3.4% of the summaries. The discharge summaries of the 171 patients who died in hospital were less likely to be complete than those of patients discharged alive in the categories of physical examination (83.0% v. 90.3%, p = 0.003) and significant laboratory tests (84.8% v. 90.7%, p = 0.014). However, the discharge summaries of the patients who died in hospital were not shorter than those of the patients discharged alive (1.48 v. 1.43 pages, p = 0.44).

For the records of patients who survived to discharge, summary length correlated significantly with completeness of reporting. The mean length of discharge summaries with complete reporting was 1.48 pages compared with 1.12 pages for summaries with incomplete reporting ($p < 0.001$).

We believe that discharge summaries should be routinely audited. This will ensure that problems with documentation are addressed and may improve completeness. It will also reinforce the importance of discharge summaries to physicians in training.

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1. van Walraven C, Weinberg AL. Quality assessment of a discharge summary system. *CMAJ* 1995;152(9):1437-42.
2. van Walraven C, Rokosh E. What is necessary for high-quality discharge summaries? *Am J Med Qual* 1999;14:160-9.

Dysfunctional title

The report by Evangelos Michelakis and colleagues on erectile dysfunction was misnamed.[1] The title should have been "Sildenafil: from the bench to the bedroom"; I have never seen a case of acute or chronic erectile failure in a hospital.

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Reference

1. Michelakis E, Tymchak W, Archer S. Sildenafil: from the bench to the bedside. *CMAJ* 2000; 163(9):1171-5.

A missing candidate

A news item in *CMAJ* gave the names of physicians who sought a Commons seat in the Nov. 27, 2000, federal election,[1] but mine was missing from the list.

I was a candidate for the Progressive Conservative Party in the riding of Edmonton Southwest; I did not win the seat.

Joseph T. Fernando
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Reference

1. Sullivan P. Eight physicians elected to Commons. *CMAJ* 2001;164(1):80.