

physician fees cannot decline in real terms indefinitely.

More important, the authors' data do not penetrate the effects of financial restraint on quality of care, a fact that they themselves point out.<sup>1</sup> But this issue is the very crux of the perceived health care crisis. What happened to waiting lists for referrals, surgery and diagnostic tests? How were health outcomes affected? Is it appropriate to assume that age- and population-adjusted fee expenditures *should* remain the same (in real dollars) over this time period? Moreover, physician fees account for only 24% of health care spending in British Columbia;<sup>2</sup> if there is a funding crisis, physician fees are only a small part of a larger problem.

A sustainable system must both control costs and provide appropriate health care. Barer and colleagues establish that the government of British Columbia controlled costs, but they do not establish that it did so in a sustainable manner.

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#### References

1. Barer ML, Evans RG, McGrail KM, Green B, Hertzman C, Sheps SB. Beneath the calm surface: the changing face of physician-service use in British Columbia, 1985/86 versus 1996/97. *CMAJ* 2004;170(5):803-7.
2. Resource summary. In: *Budget 2004*. Service plan 2004/05-2006/07. Victoria: Ministry of Health Services; [date unknown]. Available: [www.bcbudget.gov.bc.ca/sp2004/hs/hs.pdf](http://www.bcbudget.gov.bc.ca/sp2004/hs/hs.pdf) (accessed 2004 Apr 5). p. 12 (2003/04 restated estimates).

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#### [Three of the authors respond:]

**W**e strongly support Mark Fruitman's point that "[a] sustainable system must both control costs and provide appropriate health care." Our purpose<sup>1</sup> was to identify the key components in physician billings as a means of isolating both what was and what was not happening. The observation of major changes in the patterns of contact between patients and general practitioners is, we think, quite new: we found that GPs are increasingly shar-

ing their patients, yet the net impact on costs is minimal. It appears that neither patients nor physicians are abusing the system or, if they are, that abuse has not been increasing. This situation might raise concerns about continuity of care, but such concerns take us beyond these data.

In contrast, the care of elderly patients after they pass the GP "gatekeeper" and enter the specialty system is much more expensive. As Fruitman points out, our data cannot say whether these dramatic increases in cost are appropriate. But if one is truly concerned about both the appropriateness and the cost of care, these sectors and this patient group would seem obvious places for further scrutiny.

Fruitman suggests that our conclusion regarding sustainability had its basis in costs for physicians, whose real fees declined over the period in question. But even if fees had increased at the rate of inflation, the average annual increase in expenditures would have been 6.8% rather than 5.8%, hardly enough difference to support claims of "unsustainability." Furthermore, this calculation presumes that the change in (age-specific) utilization per capita would have been the same, irrespective of the change in real fees. It seems conceivable that faster growth in fees would instead have been associated with slower growth in utilization — the fact that the increase in use almost precisely offset the decline in fees may be more than coincidence. In any case, physician fees in British Columbia have been the highest, or among the highest, in the country for decades.

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#### Reference

1. Barer ML, Evans RG, McGrail KM, Green B, Hertzman C, Sheps SB. Beneath the calm surface: the changing face of physician-service use in British Columbia, 1985/86 versus 1996/97. *CMAJ* 2004;170(5):803-7.

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## Reducing adverse events

**F**urther to the landmark work of Alan Forster and coauthors<sup>1</sup> at the Ottawa Hospital–Civic Campus in identifying levels of adverse events at discharge and revealing the extent of the gap in continuity of care, particularly drug management, I wish to point out measures that have been taken in this region to diminish the problem.

In 1995 a group of Ottawa-area health care professionals — hospital and community pharmacists, physicians and a nurse — gathered to promote solutions to the gaps in seamless care.<sup>2</sup> We recommended 2 major innovations: pocket drug profiles to be used by community pharmacists for patients receiving long-term medication, as well as formal discharge communications from the hospital to the family physician and the community pharmacist. The latter recommendation was instituted the next year at the Ottawa General Hospital (now the Ottawa Hospital–General Campus) in a form called "Prescription and Discharge Notes," which provided complete information on discontinued medications, medication incidents and recommendations for ongoing care. A pilot project was instituted on a surgical floor, and a chart review followed. The review indicated that on average half of each patient's medications were changed before discharge and that potentially 61% of the discharge forms reported drug-related problems, only half of which were resolved before discharge.<sup>3</sup> A later study on a medical floor showed an even greater number of changes and potential drug-related problems.<sup>4</sup>

This form has now been updated and its use extended to the Civic Campus and to other institutions. A further study showed that use of the form on the medical ward of a Montreal hospital increased the accuracy of patient profiles maintained by community pharmacists.<sup>5</sup> It would be interesting to determine if this form makes a difference in the negative outcomes that Forster and coauthors<sup>1</sup> so clearly identified.