United States much healthier because my mandate is clear — to provide the best care feasible in a timely and efficient way. I knew that I had made the right decision when I treated my first patient in the emergency department here. I was sewing up a compound nasal fracture on a young lady when her boyfriend turned to me and said, "It sure must take an awful lot of training to learn to do what you're doing, Doc."

Physicians who choose to stay in Canada can only be happy if they resign themselves to doing their bit to keep the country united, balance the budget and take care of emergencies. It they try to maintain the high standards that they were taught in medical school, they will only continue to be depressed, for no one who makes decisions about funding health care really cares about medical standards. Medicine in Canada has been devalued too much for too long by too many people.

Andrew Reid, MD, FRCSC
Findlay, Ohio

[The author responds:]

I am grateful to Dr. Clein for setting me straight about Ambroise Paré. History was never one of my strong subjects, although I seem unable to resist the occasional temptation to stick my nose into it.

Dr. Reid's comments about Canada's medicare system echo many that are heard throughout this land, and I am sure he knows that there are many who share his views. The often-stormy relationship between Canada's physicians and medicare certainly constitutes one of the reasons for low physician morale in this country and doubtless accounts for the departure of many fine physicians for the less restricted pastures of the United States.

Unlike Reid, I like to believe that the ills of our society will, in the long run, work themselves out. However, I cannot blame him for having neither the conviction nor patience to wait for this to happen. Perhaps, being older, I am no longer as feisty as I once was. He gives me another reason to regret this.

Douglas Waugh, MD
Ottawa, Ont.

Lessons learned from Britain

Dr. W. Grant Thompson is to be commended for his article "Contemporary English health care: What lessons can we learn from it?" (*Can Med Assoc J* 1996;155:581-4).

Although Britain, like all Western countries, is having difficulty coping with the cost of health services, people there are generally well serviced and have remained free to use private services if they wish. This is much more effective than the situation in the United States, where a third of the population is inadequately served and another sizeable group of people are impoverished by their efforts to obtain private services.

I was taught that one should use words as though they were bullets from a rifle, not shots fired out of control from a shotgun. Thompson crystallized for me the present situation in Canada. Everything is being revised at the same time, like shots from a shotgun. Thompson has fired from a rifle and identified specific developments in Britain that would change the Canadian situation constructively. We should organize our family medicine (general practitioner) services as they have in Britain, and we should allow the development of private services to meet any excess demand, including general practice, specialist care and hospital services.

We can all learn from Thompson's timely contribution and deal with specific services and issues rather than reorganize all aspects of our health care system.

Charles A. Roberts, MD
Victoria, BC

[The author responds:]

Dr. Roberts enthusiastically cites two examples from my article. The first is a suggested organization of primary care, which I believe may correct many of the abuses and inefficiencies of the present Canadian system. However, in the case of the development of private services, he has overinterpreted my article. There seems little need for privatized primary care. Like many, I am troubled by the notion of a completely separate private health care system. A public system of primary care, like that in Britain, can assure every citizen of prompt attention from his or her family physician while realizing savings through avoidance of duplication of services.

Nevertheless, we do need the freedom to innovate in the management of expensive secondary and tertiary services, for which public funding is under serious strain. An infusion of private money through private coverage for certain elective services, such as cataract or hip surgery, may be the only way to avoid the long waiting lists that are the bane of the British system. Properly managed, private coverage for such services for those who can afford it could reduce the pressure on the public system to everyone's advantage. We cannot be so smug about our vaunted system that we allow ourselves to be restrained from such innovation by the ideological provisions of the Canada Health Act. Single-tier health care is an unattainable dream in a global

economy, and mindless pursuit of equality may result in equal impoverishment.

W. Grant Thompson, MD, FACP, FRCPC
Professor of Medicine
University of Ottawa
Ottawa, Ont.

Correction

In the article "Prevention and management of osteoporosis: consensus statements from the Scientific Advisory Board of the Osteoporosis Society of Canada. 1. Introduction" (*Can Med Assoc J* 1996;155:921-3) Dr. David A. Hanley was erroneously listed as being affiliated with the University of Alberta. His correct affiliation is Professor and Head, Division of Endocrinology and Metabolism, Department of Medicine, Foothills Hospital and University of Calgary, Calgary, Alta. — Ed.

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