As such, it is disappointing that Hamilton and associates did not present any age-specific smoking results. The reported incidences (in Table 3) represent an average of high rates of starting smoking in teenagers and of low rates in older respondents. It is also disappointing that the survey collected no data on children under age 15. Data from surveys such as the Ontario Health Survey suggest that up to 50% of smokers start smoking by that age.[1] Hence, the Statistics Canada survey may have missed important trends in the rates of starting smoking.

I am also concerned that the survey used a panel design rather than interviews of separate groups of subjects at each time point. The panel design has 2 implications. First, a bias may be introduced into the subjects' responses. For example, subjects may be more reluctant to admit having started smoking in later rounds because the repeated questions about smoking may have made them self-conscious about the fact that smoking is socially undesirable. Second, people who had started smoking in an earlier round would not be able to start again. Hence, the rates of starting smoking could underestimate the true rates in the Canadian population.

Because of these concerns, I think we should not be too reassured by the observation that smoking prevalence continued to drop despite the tobacco tax cut. The cautions proposed by Hamilton and associates need to be emphasized and more aggressive legislative actions pursued to prevent children from starting to smoke.

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Reference

1. Birkett NJ. *Smoking prevalence in Ontario: a reconstructed cohort analysis of the 1990 Ontario Health Survey for people born between 1940 and 1975* [working paper]. Ontario Tobacco Research Unit; 1996.

[The authors respond:]

Dr. Birkett notes that we did not report age-specific smoking results. The analysis we reported is the initial step in a study funded by the National Health Research and Development Program in which we are studying the impact of a number of factors on cigarette smoking; these factors include tobacco taxes, age, education, income and family composition. Given the potential correlation among sociodemographic variables, we were reluctant to report age-specific results at this stage.

The survey indicates a difference of 0.25 percentage points in smoking uptake immediately after the 1994 tax rollbacks between adults (20 years of age and older) living in provinces with tax cuts and those living in provinces without tax cuts (1.77% v. 1.52%). In contrast, the difference in smoking uptake among youth (those 15 to 19) between provinces with and without tax cuts is 1.53 percentage points (5.62% v. 4.09%). Thus, the fact that this survey does not contain information on even younger Canadians may underestimate the overall impact of the tax cuts on smoking behaviour. However, we prefer to reserve judgement on this issue until we have had the opportunity to conduct an in-depth multivariate analysis.

Birkett is also concerned that repeated surveying of subjects may have caused them to be more reluctant to admit that they had started smoking in later rounds of the survey, leading to further underestimates of smoking behaviour. We know of no studies that identify such behaviour. In addition, this behaviour would have had to occur at systematically different rates in provinces with tax cuts and in those without tax cuts to bias our estimates. Birkett's claim that people who had started smoking in an earlier round would not be counted as new smokers if they quit and then started again during the survey is incorrect.

Although we found a decrease in smoking prevalence in all provinces during the survey, it was never our intention to understate the negative health implications of the 1994 tobacco tax rollback. Our results imply that the tobacco tax cuts slowed declines in Canadian smoking prevalence substantially. We also noted the importance of analysing the impact of these cuts on youth. As an initial examination of this issue, the descriptive statistics noted above certainly support Birkett's argument for more aggressive legislative actions to prevent children from starting to smoke.

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CMPA fees

Patrick Sullivan's recent article ("Dubin calls on CMPA to eliminate fee differentials, adopt flat fee for all physicians," *Can Med Assoc J* 1997;156:685-7) made me recall the "old days," when the Ontario Medical Association tariff and economics committees distributed the allocated percentage of fee increases to the different specialties. A portion of these increases was reserved to compensate specialties facing higher Canadian Medical Protective Association (CMPA) fees.

This meant that Ontario physicians were subsidizing the increased CMPA fees of certain specialties by having a smaller percentage allocated

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.

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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.

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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.

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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