Health and legal statutes do vary from province to province. In British Columbia physicians are not required to report patients who test positive for antibodies to HIV. We certainly do not suggest keeping 2 sets of records or charts: we advised that only the medical information pertinent to a request be sent to the interested party. For instance, medical information requested by an automobile insurance company should be specific to the area of concern.

There was no documentation or intent in our article to indicate that if a patient with a heart condition applied for life insurance an abridged or modified version of the chart should be sent to an insurance company. Where life insurance is concerned, all medical information must be divulged.

There is no misunderstanding here. The physician must be the patient's advocate and abide by the CMA *Code of Ethics*.

Daniel Y. Dodek, BSc
Arthur Dodek, MD
Vancouver, BC

This experiment has failed

I thank Dr. Donald G. Marshall for his letter "Our future physicians deserve better" (*Can Med Assoc J* 1997;156:1701).

Medical students do indeed experience undue anxiety about making premature career choices. Discussions with my peers have been extremely disquieting. I am concerned that their preoccupation with their future may adversely affect their well-being. In the rush to choose a career and acquire a residency spot, students too often lose sight of the purpose of medical school and why they decided to enter medicine.

I have yet to find anyone who believes the current system serves the needs of the profession, yet it takes people like Marshall to make us admit what we have all known for a long time: this experiment has failed! If during a clinical trial an intervention is found to be detrimental to patients, the experiment is stopped. Should the next generation of physicians not be entitled to the same respect as such patients?

Despite government cutbacks and disillusionment among residents and practising physicians, I look forward to the future. I remember why I decided to become a doctor. I believe that medicine can be an exciting, noble and rewarding profession. I only hope my peers and future students can feel the same way.

To those charged with caring for our education system, I make this plea: let's have no more committees or resolutions to look into the matter. Let's fix the problem! I would be delighted to work with you to ensure that our medical schools turn out the world's most humane, well-rounded, content and proficient physicians.

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Class of '99
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I heartily endorse the letter from Dr. Marshall, which says that requiring medical students to choose their future career path long before they know enough is grossly unfair.

The old system of junior rotating internships for everyone produced much more balanced graduates from both family practice and specialty programs. Very few physicians-in-training have a good sense of what true practice entails or whether they have the interest and stamina for it. Every branch of medicine deserves to have only those who want to be there. We have all experienced the lukewarm participation of those who would rather be somewhere else. For the sake of our students, our profession and, most of all, our patients, we must return to common sense in specialty training.

George T. Riley, MD
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Physician payment: incentives change with supply

The articles "Primary care reform: Is it time for population-based funding?" (*Can Med Assoc J* 1997;157: 43-40, by Dr. David Mowat, and "A new primary care rostering and capitation system in Norway: Lessons for Canada?" (*Can Med Assoc J* 1997;157: 45-50), by Drs. Truls Østbye and Steinar Hunskaar, examine different physician payment mechanisms.

Each of the recognized methods of payment results in different incentives, and these change when a certain line is crossed. The location of this line depends on whether there are too many or too few physicians in the particular market, or, more accurately, on whether the physicians involved believe that there are too many or too few of them in the market.

Fee-for-service payment provides incentives for physicians to work hard and efficiently when there are too few physicians, but when there are too many physicians with too little work it encourages the generation of unnecessary work. Capitation-based payment encourages patient satisfaction as long as the physicians are competing for patients; however, as happened in Britain, once there are too few physicians, all with full lists, this payment system encourages physicians to reduce work to a minimum. The effect of salary payment is less clear, but it goes something like this: if there are too few physicians in the system, the incentive is to reduce work to the minimum; whereas, if there are physicians trying to get into the salaried positions, the physician

has to work hard to remain valuable to the employer.

I do not mean to suggest that physicians respond only to these incentives, but it should be recognized that incentives exist and that they modify behaviour.

The success or failure of a particular system in a particular environment needs to be examined in the light of the physicians' belief concerning whether there are too many or too few physicians and their sense of security within the system. It also means that it is probably impossible to design a single system that will work optimally in both a rural and a metropolitan environment, let alone one that will work equitably across Canada.

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Hep to hepatitis C

On behalf of the Hepatitis C Society of Canada, I would like to express our appreciation for the excellent articles "Hepatitis C" (*Can Med Assoc J* 1997;156:1427-8), "Viral hepatitis: know your D, E, F and Gs" (*Can Med Assoc J* 1997;156:1735-6) and "The Krever inquiry: time to drop the appeals" (*Can Med Assoc J* 1997;156:1401-2), by Dr. John Hoey.

We echo resoundingly your call for the Krever inquiry to continue unfettered by legal challenges from the Red Cross and its coappellants and for the Krever inquiry report to be released as soon as possible. We anxiously await the report's release and its recommendations to improve Canada's blood supply system. Justice Horace Krever alone knows what has to be done.

We would like to add some new information. As early as 1981 the Ontario Ministry of Health knew of the contamination of the nation's blood supply by hepatitis C virus and warned the Red Cross that it would publicize this information.

Furthermore, a historically and epidemiologically interesting argument can be made that the contamination of the nation's blood supply was largely preventable from 1973 onward, if surrogate liver-function tests on donor blood and imported blood products had been performed by the Red Cross. This appalling failure led to hepatitis C "spilling over" into the population at large through other forms of blood-to-blood contact.

Thank you for your encouraging realization of the significance of hepatitis C as a current and future health crisis facing all Canadians and all public health systems.

Alan T.R. Powell, PhD
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Board of Directors
Hepatitis C Society of Canada
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A look at 350 years of physicians' fees in Quebec

The earliest available records reveal that Estienne Bouchard, a master surgeon, came to Montreal (then Ville Marie) in 1653. He was to serve as physician to a military company for 5 years for 146 livres a year. In addition, he contracted with 42 families to provide treatment for an annual sum of 5 livres each. (Treatment of plague, smallpox, leprosy and epilepsy was not covered, nor was the provision of lithotomy.) He could take on 1 apprentice at a time for 150 livres per year. At the time, the annual salary of a young unskilled worker was 30 to 40 livres. Assuming that Bouchard had a trainee and earned an extra 120 livres a year from treating other individual patients, his annual income of around 500 livres would have been about 17 times that of the lowest salary of a young unskilled labourer.

About 70 years later, Michel Sarrazin of Quebec City, the first actual physician in New France, was earning 2000 livres per year. He also received an annuity of 400 livres that allowed his son to study medicine. At the time, the starting salary of unskilled labourers was 40 livres for local men and 50 livres for those engaged from France. Thus, his income of 2400 livres was 60 times that of a starting unskilled labourer.

In the 19th century many medical societies established recommended fee schedules to prevent physicians from undercutting each others' fees. In 1872 the one proposed by the Quebec College of Physicians and Surgeons listed $2 as the fee for a home visit within half a mile, with an additional 50 cents per mile. The fee was the same for an office visit, but rose to $4 between 9 pm and 8 am for home visits, and to $3 for office visits. Vaccinations, venesections, hypodermic injections and tooth extractions cost $1, and a first catheterization was $3. Health certificates were $5, routine deliveries $15. Fractures, dislocations and surgical procedures were relatively expensive; closed reduction of a thigh fracture cost $25 and of a dislocation $50, and a mastectomy was $50. At the time, a starting male labourer was lucky to make $5 a week. Thus, a visit from a physician would cost such a worker almost 2 days' wages. Counting only office or home visits, 10 visits a day during a 6-day week gave physicians an annual income 24 times that of a starting labourer.

Finally, consider the fees now paid to Quebec physicians, which are among the lowest in Canada. In my specialty (plastic and reconstructive surgery), consultations in the office earn $35, in the hospital $28. I receive $15 for routine office visits, $13.50 for hospital visits and $12 for hospital clinic visits. Principal examinations, allowed once a year, earn $30 in the office and $28 in the hospital.