lated to the dreaded "length of stay" for each patient admitted in the previous year.

As a modestly successful family physician who saves the government more money than it can possibly know, I will be regarded askance if the mean length of stay for my patients is greater than that of others in my peer group. However, the data on which this appraisal of my services is based deserve closer study, as Marshall correctly points out. I admitted just 40 patients during the most recent year reviewed, their illnesses falling into 34 case management groups. There were only 5 diseases for which I cared for more than 1 patient, and none for which there were more than 3 patients. From these limited data, "they" calculate an "average" length of stay. I was taught that at least 3 data points were needed to calculate a meaningful average, and that more than 3 values would be preferable. And what about the range? The mean for case managment group 011 within my peer group was 9.90 days, but was the standard deviation 0.01 or 8.9 days? Silence on this elementary point. In addition, I found numerous statistical vagaries and even errors on my print-out.

A patient of mine who is employed in the medical records department of another local hospital knows someone who works in both that hospital and my own and who reports that the coding practices of the 2 hospitals are "quite different." We ought not to accept unknowing bean-counting.

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[The author responds:]

Dr. Ford raises an excellent point about employing administrative databases for tracking health services utilization: for such purposes, it is necessary to compare apples and apples. Nonetheless, his letter indicates to me that his hospital's program is probably having the desired effect. From the information supplied each year, he can review the distribution of his patients according to disease; the data he receives are sufficiently detailed that he can validate them, and he can, if questioned on some overall average, mount a defence based on factual information. Awareness of utilization is achieved and data are fed back to the health care provider who, realizing their importance, will in turn report back to the medical records department on issues of accuracy. Presumably, members of the peer group have the opportunity to judge the process and will respond intelligently to Ford's point.

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Studying workplace health

The review article "Wellness programs: a review of the evidence" (*CMAJ* 1998;158[2]:224-30), by Denise Watt and colleagues, addresses an important topic but has 2 important limitations. First, limiting the search to the MEDLINE database excluded many high-quality journals that often publish articles on this topic. Second, insisting that the studies for review had to have randomized controlled designs further excluded many high-quality studies.