The paper is based on our clinical notes and the radiology requisitions and is thus a retrospective audit. The reason for requesting PNU is not always completely represented on the radiology slip. For Dr. Thompson and her university-based colleagues to conclude that 96 of 125 second or subsequent examinations were "unnecessary or inappropriate" is, we feel, the height of academic conceit, particularly since the author had not, at that point, ever practised independently.

We strongly resent that this study was sent for publication without our having a chance to review it. We practise obstetrics in a community hundreds of kilometres by air from specialist obstetricians, pediatricians and radiologists. In an emergency we have to rely on our surgeon and anesthetist. If we do 2.16 scans per pregnancy, it is because we feel they are needed. This paper is unlikely to change the way we practise.

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Tom Costello, MD
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[One of the authors responds:]

Our intent in writing this paper was to examine current medical practice as exemplified in a particular community and to compare it with one possible interpretation of accepted guidelines and with clinical outcomes. The paper was not intended to point fingers, and I regret that the physicians of Labrador City felt it did. As mentioned in the paper, I believe that these physicians provide excellent care under challenging conditions. I also believe that we physicians in general are doing an excellent job, but in order to maintain that excellence we must continually look for ways to improve, for example, through critical reviews of both the literature and our practices. One of the ways we do so is through the free exchange of ideas — not only with those in practice but with residents. Residents exchange up-to-date academic knowledge and a fresh perspective in return for the wisdom of experienced physicians, and all parties benefit.

In reply to concerns about "academic conceit" and pre-publication review, I should point out that I presented the paper twice — first during special rounds at the hospital in Labrador City and again during the Residents' Research Day. The authors of the letters were invited to attend both events, to give them ample opportunity to review the results and conclusions. It is unfortunate that they were unable to do so.

Although it is true that I had not practised independently at the time the study was conducted, I began practising in rural Alberta before submitting the paper, and in the year that has followed I have found no reasons to reconsider my conclusions.

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Answering the hard questions about thrombolysis

Dr. James M. Brophy and colleagues, in their article "The delay to thrombolysis: an analysis of hospital and patient characteristics" (*CMAJ* 1998;158[4]:475-80), comment that the reported delays in drug preparation and in performing electrocardiography (ECG) should be reduced. I agree wholeheartedly. However, to effect such improvements the cause of delay at each phase of case management must be identified.

Why was there a 22-minute delay in drug preparation? Could it be that an on-call pharmacist had to approve the use of thrombolytic agents? Did the hospitals insist that the thrombolytic drugs be sent from the pharmacy each time that a patient presented with myocardial infarction (MI)? Did the pharmacist have to come in to the hospital to unlock the pharmacy? Clearly, such policies are arcane, even though they were probably initiated with the aim of limiting costs. In fact, they will not limit costs, but they will probably limit survival.

Why was there a 15-minute delay in performing ECG? Was the triage nurse authorized to request ECG? Were these tests done at triage or were they done after the patients had been settled into their rooms? Did a nurse perform the ECG? Or an ECG technician? Was the ECG technician really a respiratory therapist or a laboratory technician doing double duty? Was the ECG technician dedicated to the emergency department, or was he or she responsible for the whole hospital?

To respond to such difficult questions, we need specific data, data that will make administrators realize that changes are needed; otherwise, patient care will continue to be suboptimal. Although published research may help to prompt such change, some administrators will listen only to numbers from their own institutions. In collaboration with other specialists, emergency physicians must study the situation in their own departments and implement the solutions that are most likely to reduce the overall "door-to-drug" time.

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Dr. Brophy and his colleagues are to be commended for their work in establishing the Quebec Acute Coronary Care Working Group. However, 2 concerns are raised by their results.

First, only 36.3% of patients with