alternative hypothesis is that the vagueness of the definitions of intermediate and minor assessments may lead physicians to use the mean I–M ratio as a de facto standard. Each time the mean shifts upward (for example, as recent graduates with higher I–M ratios enter the system), the de facto standard also shifts upward. Physicians with lower I–M ratios might examine the mean and conclude that their definition of an intermediate standard is more conservative than that of their peers and raise their I–M ratios accordingly. This behaviour may reflect not inappropriate motives but simply a desire to be treated fairly. Nonetheless, the result is a continually increasing de facto standard. As one family practice colleague suggested to me, the billing profiles that the Ontario Health Insurance Plan sends to each physician may, ironically, be contributing to fee code creep.

An analysis of these group dynamics would make for an interesting dissertation for a psychology major but would not alter the key message of our study: we need clearer guidelines as to what constitutes an appropriate office visit. The demonstrated variation in I–M ratios suggests that there is no consensus on the basic issues of how much time a physician should spend per patient visit and what is an appropriate level of detail for the visit. Some physicians have high-volume practices with brief visits, others have low-volume practices with more detailed visits. Which is preferable for our patients? It is high time that we, as a medical profession, did some hard thinking about the model of care we should be encouraging.

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3. Statistics Canada. *Consumer prices and price index*. Cat no 62-010-XPB. Ottawa: Minister of Industry; quarterly.

Editor's note: In addition to the letters published here, we received at least one unsigned letter commenting on the articles by Dr. Chan and colleagues. Although we will consider protecting the identity of correspondents in certain circumstances, we do not publish anonymous letters.

Paying physician managers

In the article "MDs aiming for hospital boardroom may face humbling experience, CEO warns" (*CMAJ* 1998;158[7]:918-9), it was a pleasure to see a balance in the description of Dr. Jeffrey Lozon's approach to administration and management activities by physicians. Just as physicians need to change from a quarterback role to a management role, in which they communicate as equals, it is also important for managers to treat physicians as equals.

The notion that physicians are to be equals in leadership roles but to work as volunteers in these duties has always been a poor concept, and I am glad that Lozon recognizes this by compensating his program managers at St. Michael's Hospital.

Physicians will continue to donate their time to worthwhile endeavours such as hospital boards and committees, but not all of their duties outside direct patient care should be performed gratis.

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Abortion in proportion

There is an inaccuracy in the Pulse column dealing with "Abortion and the married woman" (*CMAJ* 1998;158[7]:992), by Lynda Buske. She states that "Canada's abortion rate for these women is about average" when compared with the rates in other nations. However, for these comparisons she uses data on the *proportion* of married women receiving abortions in 5 other nations, not data on abortion rates. The proportions mentioned in the article are meaningless without the rates.

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[The author responds:]

Canada's comparative ranking in terms of the proportion of therapeutic abortions involving married women should not have been described as a rate. The point being made in the paragraph in question is that the proportion of women receiving abortions in Canada who are either married or in common-law relationships, about 25%, is not unique in international terms.

Lynda Buske, BSc
Chief, Physician Resources Information and Planning
CMA

Perverse incentives for all

In his editorial "Practice patterns and billing patterns: Let's be frank" (*CMAJ* 1998;158[6]:760-1), Dr. Charles Wright demeans Ontario physicians who prefer fee-for-service billing by implying that only they are susceptible to "perverse incentives."

Most physicians, whether paid through fee for service or an alternative payment plan, provide an appro-