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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2. *Schedule of benefits: physician services under the Health Insurance Act* (versions 1981 to 1988). Toronto: Ministry of Health; 1981–1988.
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 Although we will consider protecting the identity of correspondents in certain circumstances, we do not publish anonymous letters.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.

Patrick J. Potter, MD
Department of Physical Medicine and Rehabilitation
University of Western Ontario
London, Ont.

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.

Islam Mohamed, MD
Cross Cancer Institute
Edmonton, Alta.

[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-

priate mix of services and allocate their time appropriately in response to patients' needs. In either system, a measurable proportion of physicians adjust their practice patterns to suit personal and financial needs. Because of a failure to enforce the provision of the Canada Health Act that guarantees arbitrated settlements, there have been no increases in the Ontario fee-for-service schedule for 6 years. This pressures physicians to increase the number of patients they see and to reinterpret fee-schedule definitions.

In alternative payment plans such pressure would affect time commitments, leading to the well-known practices of "skimming the cream," reducing the frequency of visits to the minimum and spending the time thus freed up in other activities. Perverse incentives are not the sole property of fee-for-service medicine; rather, they are part of the human condition.

The result is a tendency for increased availability of services in fee-for-service systems and decreased availability in alternative payment plans. Forcing a massive change from one system to the other would therefore necessitate consultation with the public, who may prefer a system that errs on the side of increased service availability.

Stanley Lofsky, MD
Willowdale, Ont.

The nature and type of remuneration physicians receive are important aspects of medical care, and research and data are available. Unfortunately, Dr. Wright's commentary holds more personal opinion than facts. He assumes that high-billing physicians with numerous patients are not able to maintain practice standards. However, medicine is full of "work addicts." When the Ontario Health Insurance Plan reviewed high billers back in the 1970s (and published their names), it was found that most of these physicians were highly efficient, busy practitioners. Dr. Wright states that "[t]he personal price paid by these physicians and their families is high," but what proof is there for this assertion? Common sense dictates that physicians who are ill, depressed or otherwise disabled will in fact see far fewer patients. He speaks of abolishing the fee-for-service system but provides no data about the superiority of other methods.

It is probably time for all of us to study more closely the working patterns of some of our highly efficient, work-addicted colleagues; we might all learn something from them. I wish I had the energy to be one of them.

Robert Richards, MD
Toronto, Ont.

I am responding to Dr. Wright's outrageous proposition that the increase in use of the intermediate assessment is attributable to wilful manipulation of the system by physicians. Wright must not be a family physician, and he is avoiding the exercise of scientific investigation to pass off his own opinion as fact.

Active family physicians have witnessed the requirement to supply increasing levels of health promotion and health counselling as a standard of care. As patients age and as the number of conditions that can be diagnosed and treated increases because of technology and health promotion, the complexity of patient visits also increases — I have witnessed a significant decrease in straightforward patient visits. Even visits that could be simple are now complicated by the extensive information patients gather from various consumer publications and the Internet. If there is a concern that physicians are misusing the intermediate assessment code, then it should be substantiated with an effective primary care audit, not opinion.

My other significant concern is that *CMAJ* would publish this unsubstantiated and inflammatory opinion under the guise of an objective editorial. Last year I responded[1] to a similar article[2] advising physicians that we had it good and were greedy to advocate for ourselves. Would it not be more appropriate in these difficult times for our own journal to at least represent our profession in an objective manner?

Paul Leger, MD
Lakefield, Ont.

Reference

1. Leger P. Different views on privatization [letter]. *CMAJ* 1997;156(6):770-1.
2. Carver C. It's time for CMA to put the lid on privatization. *CMAJ* 1996;155:1156-7.

The best treatment may be no treatment at all

In their article "Management of common musculoskeletal problems: a survey of Ontario primary care physicians" (*CMAJ* 1998;158[8]: 1037-40), Dr. Richard H. Glazier and colleagues imply that there is an optimal way to treat a patient with an undefined shoulder problem. However, the case scenario described does not make it clear what is being treated, and no diagnosis is given. This is not surprising, as there is poor agreement on the diagnosis and the use of radiography in such cases.[1]

The optimal treatments for the problems presented in this study were determined by the consensus opinion of a multidisciplinary panel, not by a review of the relevant evidence. For the shoulder problem, undefined physiotherapy was recommended. Does this mean 6 weeks of hot packs? Ultrasound treatment? Exercise? Such a recommendation is similar to prescribing a medication without specifying the drug name, the dose or the duration of treatment.

A recent systematic review has concluded that ultrasound "does not seem to be effective in treating pa-