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
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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-

tients with shoulder disorders. . . . [and] there is insufficient evidence to draw conclusions on the effectiveness of low level laser therapy, heat treatment, cold therapy, electrotherapy, exercises, and mobilisations."[2] Perhaps the "optimal management" is no treatment at all.

Perry J. Rush, MD
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2. Van der Heijden GJMG, van der Windt DAWM, de Winter AF. Physiotherapy for patients with soft tissue shoulder disorders: a systematic review of randomised clinical trials. *BMJ* 1997;315:25-30.

[One of the authors responds:]

Dr. Rush highlights areas of controversy in the diagnosis and treatment of shoulder problems. A recent systematic review[1] concluded that there is currently no uniformity in the way shoulder problems are labelled or defined. It also found little evidence to support or refute the efficacy of common interventions for shoulder pain. In the absence of evidence from randomized trials, it is appropriate to "follow the trail to the next best external evidence and work from there".[2] It is for this reason that we asked a multidisciplinary panel to help define a current standard of practice for common musculoskeletal problems.

Rush's opinions about the utility of radiography and the efficacy of physiotherapy interventions for shoulder problems may be valid. However, without evidence to support or refute those opinions, it is difficult for us to endorse the notion that patients should undergo no investigation or treatment at all. Further clinical trials are needed to determine the optimal treatment strategies for shoulder pain.

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2. Sackett DL, Rosenberg WM, Gray JA, Haynes RB, Richardson WS. Evidence based medicine: What it is and what it isn't [editorial]. *BMJ* 1996;312:71-2.

Conference organizers, please take note!

I applaud Dr. Kendall Ho and his coworkers for their initiative in providing day-care facilities during the March International Conference on Emergency Medicine, as described in Heather Kent's article "Emergency medicine's reach expands" (*CMAJ* 1998;158[9]:1123-4). But emergency medicine is not the only specialty that attracts young physicians who might need child-care assistance during conferences. My husband and I are family physicians working in James Bay and the parents of 2 (soon to be 3) young children. Our greatest challenge in attending conferences is trying to organize day-care services for our family so that we can both attend all the sessions.

It is ironic that in an effort to attract business, many hotels and holiday packages offer children's programs, day camps and babysitting services, yet our own meetings and educational programs lag desperately behind. I imagine that many other physicians would be as delighted as we to pay for the convenience of on-site day care at conferences.

Ingrid Kovitch, MD
Waskaganish Clinic
James Bay, Que.

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