Make way for the private sector

I am fascinated by the way in which Charlotte Gray depicts private enterprise as the villain with regard to the underfunding of Canada's health care system.[1]

Contrary to her views, YFMC Healthcare Inc. provides practice-management services to physicians for a fee that is derived from the fees physicians charge to provincial governments whenever patient visits occur. Absolutely no extra costs are generated in the process. As Gray points out, by allowing physicians to be more efficient and contain their overhead costs, companies like ours essentially contain government spending, because there will be less pressure on the system to increase funding.

Physicians have turned to our company for practice-management services because health care spending has not kept pace with the costs of running a practice. By allowing doctors greater efficiency than solo physicians would normally enjoy, our company is able to offer physicians acceptable financial returns and professional practice-management skills. This means that they can concentrate on caring for patients, not on overhead costs and administrative issues.

The federal and provincial governments often hire private, for-profit companies to perform services that will save them money. Unlike Gray, we believe that the public health care sector should have the right to benefit by doing the same thing.

Don Wilson, MD
President
YFMC Healthcare Inc.
Ottawa, Ont.

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[The author responds:]

Nowhere in my article do I suggest that organizations such as YFMC Healthcare are "the villain[s] with regard to the underfunding of Canada's health care system," nor would I ever make such an obviously specious argument. At the political level there is still a debate as to whether the system is underfunded. I specifically argue that Don Wilson's company is a "healthy private-enterprise goose to the public sector" and that the public sector could emulate its streamlined management practices.

As governments contract for an increasing number of services from the private sector, we must rethink some fundamental assumptions about supply-and-demand issues in health care. It is a shame that providers who are prepared to experiment with different options feel as defensive about their choices as Wilson does.

Charlotte Gray
Ottawa, Ont.

Is feverfew a pharmacologic agent?

In a 1998 *CMAJ* article[1] William Pryse-Phillips and colleagues discuss alternative medical practices[2] in the management of migraine. They suggest that "a trial of feverfew may be appropriate in prophylaxis (class B recommendation)." Feverfew, *Tenacetum parthenium*, contains parthenolide, a compound that acts as a serotonin antagonist[3] and also inhibits serum proteases and leukotrienes.[4] Thus, feverfew should be considered a pharmacologic rather than a nonpharmacologic agent.

There is wide variation in the quantities of active compound in individual plants, plant parts, and fresh and dried preparations. As is the case for other proprietary herbal medications, some commercial feverfew products have been found to contain little or no active phytocompounds. Therefore, only standardized extracts should be used.[5]

In the article by Pryse-Phillips and colleagues feverfew is recommended as an option for migraine prophylaxis, but there is no guideline with respect to the duration of the trial. Prolonged use may be a concern because, as the authors point out, "there are no studies documenting [feverfew's] long-term safety or efficacy." Because of its pharmacologic properties, feverfew should not be used in combination with other migraine medications or with aspirin.

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Competing interests: None declared.

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thenolide content and bioactivity of feverfew (*Tanacetum parthenium* (L.) Shultz-Bip.). Estimation of commercial and authenticated feverfew products. *J Pharm Pharmacol* 1992;44(5):391-5.

[One of the authors responds:]

Dr. Wong suggests that feverfew should be regarded as pharmacologic therapy. However, we included this agent in our discussion of nonpharmacologic management of migraine for 3 reasons.

First, as Wong points out, some preparations of feverfew do not contain any of the active ingredient. Second, for preparations that do contain the active ingredient, the concentration is unknown. Thus, it seems inappropriate to dignify such products by calling them pharmacologic agents. Finally, many of the agents used to treat medical conditions, including vitamins and foodstuffs, as well as the manipulation of diet to avoid certain foods, might be considered to alter a person's ingestion of chemicals, whether they be called pharmaceuticals or not.

For these reasons, and because we prefer to regard pharmacology as the scientific study of compounds used in medicinal treatment, we included feverfew in the paper concerning nonpharmacologic management of migraines.

William Pryse-Phillips, MD
St. John's, Nfld.

Competing interests: Dr. Pryse-Phillips has received consultancy fees and honoraria for work related to the treatment of headache.

Kitchen-table medicine

Catharine Dewar's thoughtful, well-written and poignant article about Evelyn and her experience with balloon pneumoplasty[1] reminded me of my now-deceased father, John McLennan, born in August 1901. The first time that I can remember seeing him naked to the waist was when I was a teenager (he was very Scottish). I noted with much curiosity and a little horror a remarkably invaginated scar in the midaxillary line of his lower left chest wall. I was told that this scar was the result of an operation performed in his home to treat empyema. My father actually used that word to describe the condition and told me that a section of rib had been taken out to accomplish the drainage. He was quite certain that the operation had taken place in his preteen years, as his father had not yet gone off to fight with the Argyll and Sutherland Highlanders in World War I.

My father emigrated from Scotland to Canada with his family in 1906, and the surgery was performed in Hamilton, Ont. Thus, the operation can be dated to between 1907 and 1914. After I became a physician, I began to wonder about the details of his ordeal. For instance, why resect a portion of rib? Would that not have posed a risk of osteomyelitis? Perhaps the offending organism was not a bone invader. Unfortunately, our curiosity often does not develop until the sources of information are unable to help with the answers.

I know that my father made a good recovery, because he used to show me photos of him (in his early 20s) and his team-mates on the ironically named "Tin Ribs" basketball team. I cannot say whether he had to blow up balloons as part of his recovery.

D. William McLennan, MD
Grimsby, Ont.

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I compliment Catharine Dewar on her article about kitchen-table surgery for empyema.[1] As someone who underwent kitchen-table tonsillectomy under ether anesthesia, I can relate to the experience of Dewar's patient, Evelyn.

Perhaps more important is Dewar's recognition of the innovative commitment of Dr. William Hamilton to his patients. The bottom-line, administrator-driven protocols so common today don't seem to leave room for such individual initiative.

Douglas Alton, MD
Hospital for Sick Children
Toronto, Ont.

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1. Dewar C. Balloon pneumoplasty, 1926. *CMAJ* 1998;159(1):61-2.

Catharine Dewar's article[1] is a fascinating and well-written reflection on the contrasts between the medicine of today and that of 80 years ago, as well as a testimony to the impressive diagnostic and treatment skills of the physician in the case, Dr. William Hamilton. Dr. Hamilton was my great-uncle, the youngest brother of my grandfather, Rev. James Hamilton. He was born William Thompson Hamilton in Motherwell, Ont., near Stratford, on July 22, 1875, the youngest of 7 children.

William became a general practitioner surgeon in the east end of Toronto. His office was in his home on Broadview Avenue, and meals were often interrupted by the needs of patients. He was a fellow of the American College of Surgeons, but as far as I know he was not certified by the Royal College. During World War II he had a practice in the Medical Arts Building on Bloor Street and was on staff at the Toronto Western Hospital. When the physicians with academic medical staff appointments returned from war service, he had to move to another office on Bloor Street, where he finished his professional career.

When I was a medical student at U of T in the late 1940s and early 1950s, I often went to the home of Bill and