Editor's preface

Français à la page suivante

It is often true that we physicians understand what it is we ought to do and even why we should, yet still commit sins of omission. Inertia and the force of habit must take most of the blame, but at least some of the responsibility should be assigned to the chaos of medical practice itself: it is not surprising that physicians are sometimes unable to do what they ought to in a field that is disjointed, asynchronous and often trammelled by conflicting goals.

Richard Brull and colleagues (page 1137) show that as many as 74% of patients admitted to a general internal medicine service in a teaching hospital came into hospital without having had one or more of 10 commonly recommended preventive health manoeuvres performed and that over 60% of these patients left the service in the same state. James Douketis, reflecting on these missed opportunities (page 1171), reminds us that up to 70% of disease may be preventable. The problem, generally, is not that physicians dispute the value of the 10 recommended manoeuvres examined by Brull and colleagues but that they are busy, are under pressure to discharge patients rapidly, and frequently believe that a given manoeuvre is someone else's job. The problem could be fixed with simple quality-control procedures, such as a prevention checklist to be completed at the time of hospital admission.

Another example of a failure to do the right thing is our collective disregard, in practice, of the Ottawa Ankle Rules. Use of these rules should reduce ankle radiography by up to 26%. Cathy Cameron and David Naylor (page 1165) wondered if the lack of implementation of the rules reflected a lack of awareness of them. They provided educational sessions at 63 hospitals and then looked at the use of ankle radiography before and after the sessions. Interestingly, hospitals with the lowest rates of ankle radiography were those who refused the educational sessions because they had their own strategies for implementing the rules already in place. The problem, perhaps, is not a lack of knowledge about the Ottawa Ankle Rules, but a failure to design good implementation strategies.

When the scalpel of history dissects medicine as it was practised in 1999 we are not the ones who will be wielding it. Martin Schechter and Michael O'Shaughnessy (page 1179) examine our current disregard of evidence on the efficacy of needle-exchange and opiate substitution programs for drug addiction. They postulate a scene from a "Krever-like" commission in the year 2008. The testimony of an expert witness vividly demonstrates how poorly our collective inaction is likely to bear up under the cross-examination of history.

Fortunately, there are some counter-examples. Andrea Sue-A-Quan and colleagues (page 1145) report a modest success in the area of obstetric practice. The estimated 5%–10% of pregnancies that extend to 42 weeks or beyond are at high risk for poor fetal outcomes. There is good evidence from randomized controlled trials that elective induction of labour before the 42nd week reduces perinatal mortality. Judging from this study, it would appear that Canadian physicians and their patients are responding appropriately. There was a marked decrease between 1980 and 1995 in the proportion of births at an advanced gestational age.

Lastly, we revisit the problem of convincing Canadian-trained physicians to practise in rural areas. Queen's University has provided opportunities for students and residents in its Family Medicine program to get real experience in rural communities . Mark Easterbrook and colleagues (page 1159) were unable to demonstrate a statistically significant effect of such efforts. The only statistically robust predictor of choosing to practise in a rural area is having grown up in a rural area. Joshua Tepper and James Rourke (page 1173) comment on the study.

We welcome Jennifer Douglas as Managing Editor of *CMAJ*. Jennifer comes to the journal after 7 years at the rigorous editorial offices of the National Research Council.