centage of today's physicians are involved in child rearing, which could reduce the number of hours they practise. They also failed to point out that the number of subspecialties has increased and this could contribute to the shortage as well.

They were correct to observe that doctors are increasingly concerned about lifestyle issues, which may mean a reduction in practice hours, but they did not question whether this trend is due to the type of students we now select to enter medicine. In the past, medicine was considered a vocation: the physician dedicated his life to medicine and had few outside interests. Today, medicine is a profession like any other.

Increasing medical school enrolment is important, but it is also important to select students who are going to dedicate most of their time to the practice of medicine and less time to other pursuits.

J.J.P. Patil
Physical medicine specialist
Halifax, NS

Reference

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Improving management of depression

We wish to report the follow-up results of a previously described randomized controlled trial[1] to evaluate an educational strategy to improve family physicians' use of clinical practice guidelines for the detection and management of depression. We measured depression using the Centre for Epidemiologic Studies Depression (CES-D) scale.[2] The primary outcome was the "gain" score (the difference between the first and last CES-D scores).

At 6 months, the mean gains for patients in the intervention and control groups were 17.9 and 16.5 respectively ($p = 0.04$) (Table 1). One year later, 18 months after the intervention, the corresponding gain scores were 17.9 and 13.4 ($p = 0.09$) (Table 1). There was an apparent, but not significant, deterioration of CES-D scores in the control group over the 12-month interval; the scores of the intervention group remained stable.

The numbers of patients available for follow-up dropped from 85 to 65 between 6 and 18 months; despite a greater difference in mean gain score at 18 months, the result is not statistically significant.

We also examined whether patients who saw a physician of their own gender did better than those who saw a doctor of the other gender. Interestingly, gender-matched physician–patient dyads showed higher mean gain scores (21.26 [SD 14.90]) than gender-unmatched dyads (16.40 [SD 13.91]) but, again, the sample was too small and the variance was too great for this difference to approach statistical significance ($p = 0.18$).

Although the loss of patients to follow-up in our study means that the results should be cautiously interpreted, and despite the various factors affecting retention, it is encouraging that the modest benefits that we detected at 6 months in our study appeared to be maintained at 18 months. The long-term effects of this and other medical education strategies require further investigation.

Table 1. Self-reported depressive symptoms at 6- and 18-month follow-up assessments

	CES-D scores					
	O mo		6 mo		18 mo	
Group	Mean (SD)	*n*	Mean (SD)	*n*	Mean (SD)	*n*
Intervention	37.3 (8.95)	91	19.4 (13.55)	57	19.4 (12.73)	40
Control	38.7 (8.11)	56	22.2 (11.73)*	28	25.3† (12.70)	25

*Gain = 16.5.
†Gain = 13.4

Graham Worrall
Frank J. Elgar
Megan Robbins
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Whitbourne, Nfld.

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2. Radloff LS. The CES-D scale: a self-report depression scale for research in the general population. *Appl Psychol Meas* 1977;1:385-401.

The move away from fee-for-service care

A recent *CMAJ* article asked if fee-for-service is on the way out in Ontario.[1] The answer is uncertain but probably should be Yes. The detailed arguments appear in the 50-page document that the article cited (www.cfpc.ca/ocfp), which is easy to download but more difficult to read.

A couple of points can be stressed. Income based on capitation provides financial security, and the move away from fee-for-service payments removes disincentives to collaborative care involving nonphysicians. As well, rostering of patients promotes continuity of care.

However, 2 statements in the *CMAJ* article disturbed me. One was that "patients register with a single family practice that has from 7 to 30 physicians." Presumably these larger practices mean that a doctor may be on call only once a month. Although this may seem a wonderful prospect for some overstressed physicians, it makes nonsense of the notion of true continuity of care outside the office setting.

The article also stated that "physicians would be expected to see large numbers of people for very short periods (6 to 10 per hour)." How is this different from the high-volume walk-in clinics that we so rightly criticize? True patient-centred care should be reflective and thoughtful, and it can be in the

Canadian context. A key reason for developing a collaborative relationship with nurses and others with expanded roles is to free up more physician time for those patients who need our medical skills. Surely we can do better than 6 minutes per patient.

Brian Dixon-Warren
Family physician
Saturna Island, BC

Reference

1. Sibbald B. Is fee-for-service on the way out for Ontario FPs? *CMAJ* 1999;161(7):861.

The aftermath of the Swissair crash

I congratulate Patricia Rockman for her extraordinary and sensitive article concerning the Swissair crash.[1] I do not think I have ever read such a beautiful and poignant piece in a medical journal. I was horrified as I watched CBC TV's live broadcast of the events of that fateful evening, and having some knowledge of aircraft I realized the horror that was likely to be faced by those trying to intervene at the scene. Rockman's article ought to be the definitive piece on triumph over tragedy.

Martyn Thornington
Family physician
Almaty, Kazakhstan

Reference

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You say she looks like a tomato, I say she looks like a tomahto

The portrait of Maude Abbott recently published in *CMAJ*[1] was painted by my great-aunt, Mary Alexandra [Bell] Eastlake, a lifelong friend of Dr. Abbott's. After finishing the portrait, my great-aunt told Dr. Abbott that she looked like a large red tomato in the painting.

Frances Budden
Internist and geriatrician
Toronto, Ont.

Reference

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Assessing quality of care

The article by Nicole Hébert-Croteau and colleagues[1] is another attempt to prove that hospital caseload is a determining factor in adopting new therapeutic modalities, in this case for breast cancer, and that larger hospitals are more likely to give optimal treatment. Having worked as a surgeon for many years in a tertiary care hospital and during the last few years in a community hospital 100 km from a cancer treatment centre, treating close to 50 new cases of breast cancer yearly, I have had to radically change the way I treat breast cancer. The factors that most influence the decisions that my patients and I arrive at are never assessed in analyses of small-area variations.

Socioeconomic factors are important determinants of the variation in surgical care in my community and probably apply to most smaller communities across Canada. In my community the population is elderly, the Atlantic fishery has collapsed, and the woman may be the family breadwinner. There is no public transportation and in many cases the family does not have a car (or if they do, they would never drive to and within the city). They have rarely stayed away from home, and the prospect of 5 weeks' stay in the city for radiotherapy, which they cannot afford, is daunting. They immediately gravitate toward choosing to have a mastectomy. They want a short stay in the local hospital where they can be given all the treatment they need, at once.

The fact that women having breast-conservative treatment have a high rate of radiotherapy is natural. They would not be given conservative surgery if they had not agreed to postoperative radiation. We can and do give chemotherapy at our hospital, most often after consultation with our colleagues at the nearest cancer treatment centre.

I understand from the article that I am not providing optimal treatment for my breast cancer patients as outlined in the guidelines. However, it is optimal for my particular patients. What worries me about this type of article is that