

thetically that between 1970 and 2000 the requirements for physicians in Canada increased by 72%, whereas supply increased by 116%. However, the overwhelming experience of those of us working in the profession is that large segments of the population can no longer find a family doctor; furthermore, getting patients to specialists in a timely manner is often so difficult as to approach futility. This jarring discoordination renders the article's future projections difficult to evaluate and merits an explanation. Could the reason be increasing medical capabilities, technology or demand, or might the cause be less inhuman physician lifestyles?

Second, Denton and associates¹ report that although use of physicians' services generally increases with patient age, it declines as elderly patients become very old, except in general practice, where use continues to increase even to the oldest age group. Perhaps the explanation is that GPs caring for very elderly patients do so in relative isolation, with these patients receiving less aggressive management. If so, is this appropriate? Or does it represent an adaptation to scarce resources, not only of human resources but also things such as diagnostic equipment, operating room time, even ground transportation?

There's a thesis topic here for somebody!

Charles T. Low

Anesthesia
Brockville General Hospital
Brockville, Ont.

Reference

1. Denton FT, Gafni A, Spencer BG. Requirements for physicians in 2030: Why population aging matters less than you may think [editorial]. *CMAJ* 2003;168(12):1545-7.

The provision of and need for services for elderly patients are underestimated by Frank Denton and associates¹ in their analysis of the effect of population aging on future physician requirements. In their Fig. 1, pediatrics is identified as a separate physician category, but geriatrics is not, even though the roles of geriatricians and the Regional Geriatric Programs (RGPs) of Ontario were recognized by the province's ministry of health in 1988.²

In addition, many of the medical services provided to frail elderly patients are not captured by OHIP. Comprehensive geriatric assessments performed by geriatricians (or by team members with case conferences involving geriatricians) in the 5 RGPs are funded by alternative payment plans, not OHIP.

Of patients 75 years of age or older, 14% to 27% are frail and could benefit from a comprehensive geriatric assessment.³ However, the RGPs of Ontario saw only about 1% of this group in 2001/02. By 2030, the proportion of the population in this age group will have grown by more than 94%.^{4,5}

Unfortunately, the supply of physicians with geriatric training is not keeping up with this projected demand. For example, in Canada in 2000/01, only 7 people entered a training program in geriatric medicine,⁶ and only rarely do family physicians train in care of the elderly.

Planning by medical schools alone will not address the low numbers of physicians with geriatric training. Governments need to establish and implement policies to correct the existing and increasing shortfall of health care professionals able to assess and treat frail elderly patients.

Michael J. Borrie

William Dalziel

Rory Fisher

William Molloy

John Puxty

Program Directors

Regional Geriatric Programs of Ontario

References

1. Denton FT, Gafni A, Spencer BG. Requirements for physicians in 2030: Why population aging matters less than you may think [editorial]. *CMAJ* 2003;168(12):1545-7.
2. *Guidelines for the establishment of regional geriatric programs in teaching hospitals*. Toronto: Ontario Ministry of Health; 1988.
3. Rockwood K, Fox RA, Stolee P, Robertson D, Beattie BL. Frailty in elderly people: an evolving concept. *CMAJ* 1994;150(4):489-95.
4. *Age groups (12) and sex (3) for population, for Canada, provinces and territories, 1921 to 2001 censuses — 100% data*. Ottawa: Statistics Canada; modified 2003 Jul 3. Available: www12.statcan.ca/english/census01/products/standard/themes/ListProducts.cfm?Temporal=2001&APATH=3&THEME=37&FREE=05.

5. Population projections for 2001, 2006, 2011, 2016, 2021 and 2026, July 1 [CANSIM table 052-001 online]. Ottawa: Statistics Canada; modified 2003 Jul 9. Available: www.statcan.ca/english/Pgdb/demo23c.htm (accessed 2003 Aug 30).

6. Hogan D, Beattie B, Bergman H, Dalziel WB, Goldlist B, MacKnight C, et al. Submission of the Canadian Geriatrics Society to the Commission on the Future of Health Care in Canada. *Geriatr Today* 2002;5(1):7-12.

[The authors respond:]

There is a misunderstanding common to all 4 sets of comments. The issue we addressed is how population change will affect future requirements for physician services — that issue, and that issue alone. To that end, we abstracted from (held constant) all other factors that might affect requirements.

One of our principal findings was that “overall requirements for physicians *in consequence of population change alone* are almost certain to increase by less in the future than in the past”¹ (italics in original). We also noted that a variety of factors would affect future requirements, but to investigate the effects of population change with any precision, it is necessary to abstract from these other factors, important as they may be.

Raymond Dawes says we “postulate that because population increases are now lessening, the future need for physicians will increase to a lesser extent than in the past.” However, we did not and would not draw such a conclusion. It would be unwarranted on the sole basis of our analysis of population effects, with utilization rates held constant.

We agree with Chris MacKnight and David Hogan that fee-for-service may not be “the most appropriate way to fund physician services for aging patients with multiple problems.” However, as we noted,¹ fee-for-service practices accounted for almost all physician services in Ontario,² and the data available to us (for 1995/96) on what services were provided to patients of different ages and sexes related to such practices. MacKnight and Hogan also feel that “using historical

data to project future needs ... implies that the way we do things now is optimal." Wrong. There is no such implication in our analysis. In our calculations, we simply keep fixed the most recent utilization rates (whatever they are) and allow only population to change.

Charles Low feels that apparent shortages of both family doctors and specialists make our future projections "difficult to evaluate." Again, what we were projecting was not changes in requirements for physicians from all causes, but changes resulting *only* from population aging and growth. We make no judgement about what utilization rates *should* be but take them as they are.

Michael Borrie and associates assert that we underestimated the "provision and need for services for elderly patients" because we failed to give explicit treatment to geriatricians. We dealt with an exhaustive set of 19 categories of physicians, the maximum for which age-sex rates of utilization are available. The underlying patient utilization data were compiled from OHIP records (the only source), as provided by the Canadian Institute for Health Information (CIHI). Geriatrics is included in the CIHI category "internal medicine" (along with 10 other specialties). Given what Borrie and associates recognize as the low numbers of physicians who have been trained in geriatrics, it should be clear that any separate treatment would have had only a negligible effect on the overall projection results.

Through our analysis we found that demographic effects on overall physician requirements are likely to be smaller than might have been supposed in light of popular discussion of the "aging crisis." A helpful response to that finding would be something like the following: Good — and now that we have that out of the way, let's focus on other factors that are likely to be more important, including those mentioned by the letter writers. Population aging cannot be ignored, but it should not be at the top of the list of things to worry about in physician hu-

man resource planning at the aggregate level.

Frank T. Denton

Department of Economics

Amiram Gafni

Department of Clinical Epidemiology
and Biostatistics

Byron G. Spencer

Department of Economics

McMaster University

Hamilton, Ont.

References

1. Denton FT, Gafni A, Spencer BG. Requirements for physicians in 2030: Why population aging matters less than you may think [editorial]. *CMAJ* 2003;168(12):1545-7.
2. Denton FT, Gafni A, Spencer BG. Exploring the effects of population change on the costs of physician services. *J Health Econ* 2002;21:781-803.

The whiplash debate

In a review published in *The Left Atrium*, Walter Rosser¹ lauds as a "remarkable book" Andrew Malleon's *Whiplash and Other Useful Illnesses*.² Rosser writes that Malleon "challenges many different groups ... for their self-interest and their failure to critically assess the medical case for whiplash." Yet in Malleon's book, no study that found evidence of a valid whiplash syndrome is accurately presented, whereas those against are highly praised.

As just one example, Malleon promotes a Norwegian-Lithuanian paper that claimed that 202 drivers involved in rear-end collisions resembled control subjects at the end of 2 years.³ He writes, "Schrader and his Norwegian colleagues ... had cut too close to the quick. Like frightful Vikings from the past, they had threatened to wreak havoc with the profitable whiplash industry." This paper was evaluated by the Norwegian Centre for Health Technology Assessment, a group established by the Department of Health and Social Affairs for Norway and operating as a unit within SINTEF Unimed, a non-profit independent research organization. The expert group who wrote the Centre's report⁴ concluded that more than 4000 individuals in each group would be needed to discover with 80%

probability a statistically significant difference in the occurrence of chronic neck complaints between subjects who had and had not been involved in a collision, and the Schrader study was denied validity.

Harold Merskey

Professor Emeritus of Psychiatry

University of Western Ontario

London, Ont.

References

1. Rosser WW. Dubious diagnoses. *CMAJ* 2002;167(8):902.
2. Malleon A. *Whiplash and other useful illnesses*. Montreal and Kingston: McGill-Queen's University Press; 2002.
3. Schrader H, Obelieniene D, Bovim G, Surkiene D, Mickeviciene D, Miseviciene I, et al. Natural evolution of late whiplash syndrome outside the medicolegal context. *Lancet* 1996;347:1207-11.
4. Rø M, Borchgrevink G, Daehli B, Finset A, Lilleås F, Laake K, et al. Chapter 8. In: *SMM Report 5/2000: Whiplash injury — diagnosis and evaluation*. Oslo: Senter for Medisinsk metodevurdering [Norwegian Centre for Health Technology Assessment]; 2000. p. 44-6. Privately obtained translation from original Norwegian.

[The author responds:]

There are no studies that confirm a "valid whiplash syndrome." Perhaps what annoys Harold Merskey about my book¹ is not that I presented inaccurately the studies that do exist but that I presented them too accurately, leaving the studies, their authors and their advocates bereft of scientific credibility. Merskey cites a report of the reputable Norwegian Centre for Health Technology Assessment to condemn my book. Ironically, the authors of that report,² after commenting on the lack of science in the whiplash literature, confirm the very thesis of my book with the following conclusions:

- "There is no documented evidence supporting a causal relationship between type or grade of injury and specific symptoms or symptom constellations.
- "Evidence-based documentation has not been found to support the contention that chronic complaints following a whiplash injury mechanism are specific or are directly related to the actual injury mechanism."