

Journal. Moreover, if large Western medical journals were to begin better representing the global burden of disease in the articles they publish, researchers in smaller countries might become more interested in submitting their work to, or serving as reviewers for, these journals.

In the interim, we encourage researchers in smaller countries to continue to publish peer-reviewed studies relevant to local experience of disease in both smaller, local journals such as the *Croatian Medical Journal* and larger Western medical journals.

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Reference

1. Rochon PA, Mashari A, Cohen A, Misra A, Laxer D, Streiner DL, et al. Relation between randomized controlled trials published in leading general medical journals and the global burden of disease. *CMAJ* 2004;170(11):1673-7.

DOI:10.1503/cmaj.1050023

Case summaries: another method

The article by Ahmed Bayoumi and Peter Kopplin¹ presents an alternative to traditional case presentations. The authors emphasize presentations that produce “logical flow,” “present the most salient information early” and do not “impede effective diagnosis.” I agree with this approach and present yet another option.

The usual purpose of oral “morning report” case presentations is to review data (including context) to support diagnosis and management. These data can be delineated by listing problems, beginning with the reason for admission. With each problem (e.g., pneumonia), the supporting findings from the history (e.g., cough, fever), examination (crackles) and tests (leukocytosis, infiltrate) are presented. To avoid premature conclusions before a firm diagnosis has been established, it is appropriate to present symptoms along with

their differential diagnosis. For example, cough, fever and hemoptysis should be presented as symptoms until their cause is elucidated. Next, the patient’s allergies and medications are reported to identify drug–drug and drug–disease interactions, unnecessary medications and deviations from established protocols. The medication and problem listings should be reconciled. A brief checklist is used to ensure that such items as “code” status, prophylaxis for pressure ulcers and deep vein thrombosis, and pneumococcal vaccination have been addressed. Key situation-dependent parameters are defined and presented, and these almost always include vital signs, weight and renal function. Finally, “experiential text” adds patient and physician perspective.

As such oral presentations are made, I transcribe them (using a laptop computer and a preformatted word-processing document, with one page for each patient) to form the basis for my faculty chart notes. Problem and medication lists for a patient remain reasonably stable and are readily updated as new information accumulates. Key parameters can be compiled in a table, where a week’s worth of data are readily visible. With sections for completed and pending test results and daily narratives, an easily updated cumulative note is produced.

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Reference

1. Bayoumi AM, Kopplin PA. The storied case report. *CMAJ* 2004;171(6):569-70.

DOI:10.1503/cmaj.1041620

[The authors respond:]

Gary Fox describes a systematic and thorough method for recording clinical data in an electronic form. His system is concordant with our approach¹ of grouping together logically linked information to “tell a story.” We are heartened that he also includes space for experiential text as an essential component of the case history.

Indeed, Fox's letter is a cogent reminder that the introduction of the electronic medical record (EMR), which holds great promise for standardizing data collection, archiving important information and facilitating the sharing of patient records among physicians and institutions, may nevertheless enforce the tendency to divorce the data from the patient. This concern is particularly prominent if the focus of an EMR is on collecting information that can be coded and categorized. In contrast, if electronic systems adopt the approach of explicitly reminding practitioners to record daily narratives, the EMR could increase the use of narrative medicine principles. Perhaps we should encourage technologically inclined house staff to "blog" rather than to "chart" information for their patients!

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Reference

1. Bayoumi AM, Kopplin PA. The storied case report. *CMAJ* 2004;171(6):569-70.

DOI:10.1503/cmaj.1050017

More arithmetic of health care

Contrary to the claims of Janice MacKinnon,¹ the most recent data from the Organisation for Economic Co-operation and Development (OECD), for 2002, show that Canada ranked sixth, not third, in terms of health care spending as a percentage of gross domestic product (GDP) (data available through OECD Web site at www.oecd.org/home/).

Furthermore, Canada is the only OECD country where health spending as a percentage of GDP actually declined over the past decade (from 10% in 1992 to 9.6% in 2002). By contrast, health spending as a percentage of GDP in the United States (with its multitude

of user pay schemes) increased from 13% in 1992 to 14.6% in 2002.

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Reference

1. MacKinnon JC. The arithmetic of health care [editorial]. *CMAJ* 2004;171(6):603-4.

DOI:10.1503/cmaj.1041622

Janice MacKinnon's health care arithmetic is incorrect.¹ She uses a figure of 8% as the annual rate of growth of health care costs in Ontario, but this value is based on current dollars and therefore does not take into account inflation or growth of the population.

The correct calculation should be based on per capita spending of constant dollars. The Canadian Institute for Health Information gives the following figures for annual rate of growth in these terms: 2.6% from 1974 to 1991, -0.03% from 1991 to 1996, and 4.4% from 1995 to 2003.² It is highly probable that the negative rate of growth for 1991 to 1996 corresponds to the decrease in health care transfers that occurred during the early 1990s; the subsequent increase in rate of growth is due to the replacement of part of those funds.

Furthermore, MacKinnon's reference to the increasing percentage of provincial budgets devoted to health care¹ is almost irrelevant, since the percentage depends on revenues as well as on expenditures. The provincial governments have decreased their revenues by cutting income taxes but have then implied that the increased percentage spent on health care is due to an increase in expenditures.

Finally, all the figures quoted so far have been for total health care expenditures, but what we should be debating are expenditures for the public health care system (and the services provided). The cost of our medicare system is the amount spent by the provincial governments, equivalent to 63.8% of total health care costs.²

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