Specialists really do need family physicians

I have been practising and teaching neurology for 25 years. Recently, I was talking to a new graduate from one of your programs who works in a small town in Nova Scotia. I was extremely impressed with her workup of a patient and her excellent care and knowledge of the problem and the patient as a whole. It heartens me to know that, in Canada, we are producing such graduates.

I think family physicians sometimes feel that specialists do not care what they do, but for many of us this is simply not true. I work with some wonderful colleagues in family medicine and just wanted to make these comments. We really do need to do more to praise family physicians more for their hard work on behalf of “our” patients.

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Charting made easier and faster

In response to the letter1 “Food for thought” in the January issue, we share Dr Kwiatkowski’s concerns. In recent years, the Medical Review Committee (MRC) in Ontario and similar committees in other provinces have been auditing physicians’ charts with severe financial implications for physicians if record-keeping for annual health examinations did not meet MRC criteria. Although many components of a complete physical examination might be important in establishing and maintaining physician-patient relationships and in satisfying the MRC, they have not been shown to be effective screening maneuvers for detecting asymptomatic disease.2

Readers are encouraged to visit the Coalition of Family Physicians website at http://www.cofp.com/bulletins/aug23_02.asp to view the MRC “scorecard” currently used in Ontario by the MRC to audit the annual health examination.

In response to media attention received by MRC audits in Ontario, we (a group of family medicine residents) elected to audit our own practices. Our goal was to develop a user-friendly periodic health examination form that satisfies both current preventive medicine guidelines and the MRC criteria in the event of an audit. Reminder tools, when constructed to improve screening, have been shown in several trials to be successful in improving physician performance.3 We audited charts in our practices to see how they would meet the current standard of care according to the MRC. Our results showed there was substantial room for improvement in our audit scores. We found that, in a busy medical practice, it is difficult to meet the strict documentation criteria required by the MRC scoring tool. Practices that used pre-printed annual physical examination forms were far more likely to receive passing scores than practices that did not. In particular, specific information targeted on the form corresponded well with high scores in the respective MRC categories. We predict that this is due to the ease of documentation provided by pre-printed forms. With this in mind, we developed annual health examination forms for both men and women that encompass both the information required by the MRC (in bold) and pertinent information regarding current preventive medicine guidelines. This form can easily be modified according to practice preference and can be updated when new preventive maneuvers are recommended.

Our hope was to make charting easier, faster, and congruent with MRC billing standards while strengthening our practice of preventive medicine.
With this in mind, we recognize the irony of integrating a highly evidence-based guideline reference with the MRC scoring criteria that lack this support. Please feel free to download our male and female periodic examination forms from http://67.69.12.117:8080/oscarResource/forms/CPXforMale and http://67.69.12.117:8080/oscarResource/forms/CPXforFemale.

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New guidelines on concussion management overlooked

Concussion is a serious problem that is often underappreciated and poorly managed by physicians. I was, therefore, pleased to see an article on management of concussion in the February issue of Canadian Family Physician. The article does not reflect what is currently considered to be optimal concussion management, however, and fails to reference the most important and comprehensive statement on this subject: "The summary and agreement statement of the First International Conference on Concussion in Sport, Vienna 2001." This statement was prepared by an international group of concussion experts (The Concussion in Sport Group) following a conference sponsored by the International Ice Hockey Federation, FIFA (International Soccer), and the International Olympic Committee Medical Commission. For those of us who look after athletes with concussions, it is the definitive current reference and was considered so important that it was simultaneously published in the Clinical Journal of Sport Medicine, British Journal of Sports Medicine, and Physician and Sportsmedicine. It is unfortunate that this publication was missed by the author and peer reviewers.

Concussion grading systems are all anecdotal, with no hard scientific evidence. Return-to-play times accompanying these guidelines are similarly the personal estimates of the author. They are, therefore, not recommended by the Concussion in Sport Group and are not used by those of us dealing with concussion.

A summary of the key current concepts in concussion management follows.

1. Concussion can have multiple symptoms and signs that evolve over time, including physical (eg, headache, nausea, imbalance), cognitive (eg, memory, concentration alteration), and emotional (eg, mood changes) manifestations. You do not have to lose consciousness to have a concussion! This is perhaps the biggest misconception and mistake made in diagnosis of concussion.

References

Summarizing ordinal data. What is appropriate?

In the article by Midmer et al, Table 3, “Women’s ratings of the ALPHA form by type of form” used a scale that ranged from 1—very much to 5—not at all. It appears as though the variables are ordered, ie, that there is some order among the categories ranging from 1 (very much) to 5 (not at all). Ordinal data are characterized by the presence of order among the categories and by the fact that the difference between two categories is not the same throughout the scale. For this reason, the most appropriate descriptive statistical ways of summarizing ordinal data are through proportions and percentages and estimates of the median value.

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Reference