anything, it will be to cause medical students to eschew family practice.

During the days that this letter was percolating, Statistics Canada[2] reported that people with chronic health problems by and large are connected to family physicians; it is the young and healthy who are not. So this "consternation of late" and this "palpable anger" are a bit overstated to start with.

—Egbert H. Krikke MD CCFP
Edmonton, Alta
by Rapid Responses

References

1. Kirkwood K. Casting call. The perils of auditioning patients. *Can Fam Physician* 2008;54:831-2 (Eng), 836-7 (Fr).
2. Statistics Canada. *Canadian Community Health Survey 2007*. Ottawa, ON: Statistics Canada; 2007. Available from: **www.statcan.ca/Daily/English/080618/d080618a.htm**. Accessed 2008 Jul 11.

Response

I should begin by thanking everyone who offered their comments through e-mail and letters to the editor. In response to the 2 previous letters, I would like to clarify a number of issues.

The source of my data is from research in progress. I have had the opportunity to speak with a number of physicians and patients who shared their experiences with the "give-and-take" aspect of the patient audition process. Since the publication of the commentary, a number of physicians have discussed their use of screening mechanisms with me. These measures were motivated, for them, by a desire to facilitate the best possible doctor-patient relationships. There are justifiable reasons to not accept, or even terminate, relationships with patients, and there are unjustifiable reasons. In the process of doing this research, I've heard examples of both. Is a body mass index greater than 30 a reasonable basis upon which to accept or reject a potential patient?

I still struggle with the expansion of a patient "underclass." If some physicians are concerned about accepting patients who constitute unreasonable professional burdens, then we must ask what happens to those patients. There is a tendency to see the problem in strictly selfish terms, but ultimately the question requires a collaborative debate that should include nonphysicians.

—Ken Kirkwood PhD
London, Ont
by e-mail

Editor's note

For more reader responses on auditioning patients, visit **Rapid Responses** at **www.cfp.ca**.

Budesonide–formoterol combination inhaler

Thank you for the helpful FP Watch article "Less smoke, more fire"[1] in the May 2008 issue. I see that the authors

mention the budesonide-formoterol 400/12 µg combination inhaler for those with moderate to severe chronic obstructive pulmonary disease (COPD). I find this interesting on 3 fronts:

1. After checking with the 2008 *Compendium of Pharmaceuticals and Specialties* and AstraZeneca, I can confirm that the 400/12 µg dose is not available in Canada.
2. While I have found that many of my patients with mild to moderate COPD prefer the budesonide-formoterol combination inhaler, it is not officially indicated for the treatment of COPD in Canada.
3. Those with severe COPD are often unable to develop sufficient inspiratory pressure to use the budesonide-formoterol combination inhaler delivery device.

—Richard Beever MD CCFP CI
London, Ont
by Rapid Responses

Reference

1. Kaplan A, Hernandez P, O'Donnell D. Less smoke, more fire. What's new for you in the latest COPD guidelines? *Can Fam Physician* 2008;54:737-9.

Response

I thank Dr Beever for his response to the article on the latest chronic obstructive pulmonary disease (COPD) guidelines. He is absolutely correct that the 400/12 µg