Letters ❖ Correspondance

NEXUS study needs Canadian results

Drs Pulfrey and Evans address an important topic in the Critical Appraisal section of the June 2002 issue: use of radiography in blunt trauma to the cervical spine.[1] Their review of the study by the United States–based NEXUS group[2] is thorough, but their discussion of clinical implications is incomplete.

As part of their "bottom line," Drs Pulfrey and Evans assert, "Application of the five-criteria decision instrument could reduce the annual number of cervical-spine radiographs taken by about 12%."[1] This could be true in many American jurisdictions where the rate of cervical-spine radiography is generally higher than in Canada. Applying these criteria in Canada could in fact increase the number of cervical-spine x-ray examinations performed.[3]

The authors also point out that the NEXUS criteria require substantial clinical judgment in each case. The recently published Canadian Cervical-Spine Rule[3] uses clearly defined criteria that require less interpretation on the part of clinicians and yet have equal sensitivity (100% vs 99.6%) and better specificity (42.5% vs 12.9%) for identifying cervical-spine fractures than the NEXUS criteria.

We appreciate that the authors' primary task was to review the NEXUS study; however, failing to put the results into a Canadian context and omitting any mention of the Canadian Cervical-Spine Rule could leave readers with an incorrect and incomplete understanding of the available evidence concerning this important topic.

—*Merril Pauls,* CCFP(EM), MHSC
—*Mary-Lynn Watson,* CCFP(EM)
Halifax, NS
by e-mail

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Is it really malpractice?

I would like to comment on Dr Alan Kaplan's editorial[1] on inadequately controlled asthma. I found this article to be very informative. However, I object to the statement, "Not to at least give a patient with the triad of ASA allergy, asthma, and nasal polyps a trial of a leukotriene receptor antagonist would in my opinion be malpractice." Clearly, I agree with the treatment recommended. I just think it is not right to cry malpractice in an article in which the author is trying to educate, inform, and improve the delivery of health care.

I first heard this type of judgmental statement many years ago, at a conference in which the speaker said, "…in my opinion, it's malpractice to give Demerol for migraines," at a time when probably most of the audience was still using Demerol. Every conference participant got the point, but I suspect that many found the statement arrogant and insulting. From an educational point of view, this is counterproductive. Practices do change as a result of all types of information campaigns, but I think that claiming malpractice because newer strategies are still underemployed is a bit exaggerated. Dr Kaplan's article was excellent, and he did not need to make that statement.

Another more recent example would be to claim that not offering hormone replacement therapy to postmenopausal patients is malpractice….

—*Michael Taylor,* BED, MD, CCFP(EM)
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by e-mail

Reference

1. Kaplan A. Inadequately controlled asthma. Patients do not understand their treatment plans [editorial]. *Can Fam Physician* 2002;1280-2 (Eng), 1283-5 (Fr).

Response

Thank you for your comments. I am pleased to see your response; it shows that my editorial performed its purpose. I had planned for it to be informative, thoughtful, and contentious. I put in the issue of a trial of a leukotriene receptor antagonist (LTRA) in asthma triad patients on purpose to be a little controversial.

That being said, I still believe in my statement. I have seen LTRAs be lifesaving in patients allergic to acetylsalicylic acid who were mistakenly given a nonsteroidal anti-inflammatory drug. I find that most (but you are 100% correct, not all) of these patients do respond well to LTRAs. If my statement causes some physicians to rethink their prescribing patterns, then it performed its purpose.

Your analogies to my statement are insightful and accurate; however, I did say only that a *trial* of LTRAs was indicated.

Thank you for reading the article and taking the time to respond to it.

—*Alan Kaplan,* MD, CCFP(EM)

Choosing fee-for-service

I read with interest the editorials[1,2] for and against capitation in the February issue. As a Glasgow, Scotland, graduate, I had considerable experience with this system and joined the flood of GPs who fled to Canada to get away from it.

As we received a set fee per quarter for each patient on our roster and nothing for actually seeing them, we were encouraged to enrol as many patients as possible to maximize our income but were discouraged from treating them.

There was no payment for full examinations, Pap smears, and rectal examinations, so patients who we thought needed such procedures were dispatched to a local hospital with a terse note addressed to the admitting doctor of the day. Some doctors did home deliveries, but most of the ladies were attended by district nurse midwives, and the GP dropped in between housecalls, a minimum of a dozen a day and often more than 20 during cold-and-flu season.

Because there was no incentive to attract patients to doctors' offices, the offices became dismal and decrepit, usually old lock-up shops in Glasgow with not even a toilet for the doctor. In those days before dipstick testing, no blood or urine analysis was done outside the hospital.

Anybody with chest or abdominal pain seen in the evening or during the night was sent to the hospital as coronary arrest or appendicitis, respectively, in order to ensure the doctor some sleep. As a result, hospitals were full, and there was a 2-year wait to have a hernia repaired. Acute care beds were filled with geriatric patients before Canadians knew there was such a word.

I was surprised to read Dr Walter Rosser's and Ms Kasperski's editorial[2] ascribing to fee-for-service funding the problems that I have found were due to capitation in the United Kingdom. I wonder whether Professor Rosser has ever experienced the capitation system that he lauds?

In my 27 years of solo rural practice under fee-for-service, I have done full examinations, Pap smears, rectal examinations, urinalyses, and hemoglobin tests every 2 to 3 years, getting x-ray examinations and electrocardiograms done at our small hospital.

I did all my own minor surgery and obstetrics until the Canadian Medical Protective Association put the premium so high that I was paying for the privilege of losing a night's sleep. I saw 2200 discrete patients per year according to the funding agency.

However, one size does not fit all. If Dr Rosser wishes to practise under a capitation system, well and good, but I suspect most of our colleagues will opt for fee-for-service and should be allowed to.

—*Lewis Draper,* MD
Lumsden, Sask
by mail

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2. Rosser WW, Kasperski J. Argument for blended funding [editorial]. *Can Fam Physician* 2002;48:236-7 (Eng), 247-9 (Fr).

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