race or culture of origin. As a member of a particular Aboriginal community, I may be expected to put family and community success ahead of my own personal needs, responsibilities, and rights.

When trying to effect change in my work with Aboriginal people and communities, I must be aware of the ethic of "non-interference," which Brant has defined as "a behavioural norm of North American Native tribes that promotes positive interpersonal relations by discouraging coercion of any kind, be it physical, verbal, or psychological."[1] The act of an individual community member writing a letter about a community and having it published outside of the community, while commonplace and acceptable by Western democratic standards, would violate the value system described above. The community's strong reaction against this act would be predictable.

You might have known this when you wrote your letter. I do not believe that any individual or group, Aboriginal or non-Aboriginal, can come up with the answer to "impossible circumstances" alone. I frequently find myself feeling overwhelmed. I think the solutions will need to be collaborative. Some of the questions I ask myself are: How can I work within this community to mobilize change? Who are the people in the community who have ideas about how to improve things? How can I work together with them? Am I able to recognize and respect their wisdom and inherent knowledge? And, most importantly, what would happen if discussions about Aboriginal health between Aboriginal people and communities and their health care providers were open and honest and *mutually understood*?

Thank you again for the opportunity to discuss these issues.

—Janet Smylie, MD, CCFP

Reference

1. Brant C. Native ethics and rules of behaviour. *Can J Psychiatry* 1990;35:534-9.

"Cyber" column meets a need

I really enjoy the CyberSearch column by Dr Cathy Risdon in *Canadian Family Physician*. I am a true neophyte in Web-based searching for answers to clinical questions and have been waiting for someone to make it easy and accessible enough for me to actually bother. Time is so tight that a lot of the evidence-based medicine is just not practical for me, even though I believe in the end result.

I had training in OVID and even that was too cumbersome; I have not used it once. I do have a Palm Pilot, which I use a lot, and I have UpToDate, which I find very helpful, but it was not until I read Dr Risdon's CyberSearch columns that I really found a way to get into the Internet without getting lost and hopelessly behind on other things.

I think this column is meeting a real need. I am especially interested in topics other than internal medicine, such as pediatrics, orthopedics, obstetrics, psychiatry, and the surgical specialties, from a family medicine perspective.

—Larry Willms, MD, CCFP
Sioux Lookout, Ont
by e-mail

Response

Thank you for your comments on CyberSearch. I am happy to hear the column is increasing your ability to navigate the World Wide Web in a way that makes sense for your practice.

Thank you for your request about favourite sites. What a great topic for a future column! I will take up the challenge to find a good general surgery site and let you know what happens.

As well, in the next several months I will be introducing a tool for storing favourite sites that will allow users to be at home on any computer with an Internet connection. I think some of the sites I have been accumulating will be helpful to you. Stay tuned….

—Cathy Risdon, MD

Remuneration: looking for a better way

It was interesting to read the tug-of-war between Rosser and Kasperski[1] and Pamela Mulligan.[2] The problem is that each ignores the facts.

The facts are that Rosser and Kasperski's vision of a blended funding model is not that of the Ontario Family Health Networks. There is no "sessional fee" or any other incentive for taking care of complex illnesses, although this would be desirable. There is no fee-for-service component for after-hours emergency call that is specifically *included* in the global coverage. To be fair, there is fee-for-service payment for obstetrics and visits by non-enrolled patients, although it is capped.

On the other hand, Mulligan makes no argument to deal with the current intolerable situation of walk-in clinics "skimming" the easiest problems, and of committed family physicians being rewarded only for the high-volume component of their practices.

No one has yet proposed that the fee-for-service model could be modified to provide just the incentives necessary for comprehensive care. As a matter of fact, the current fee schedule in Ontario actively discourages comprehensive care by limiting the number of counseling sessions to three per patient per year no matter how many problems a patient has. In my opinion, the "relative value–based" fee schedule currently in preparation in Ontario will not provide the right incentives either.

I agree with Mulligan that capitation puts us in a position of conflict of interest: providing fewer services increases our hourly wage. Fee-for-service puts us in conflict, too: we must balance volume and quality. There is no perfect way.

Overall, I think Rosser and Kasperski's proposals are the best compromise, but this model is not being implemented in the real world, and so those of us looking for a better

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way must wait and continue to speak out. Surely in a time of serious shortage of family physicians we can cut a better deal that serves not only the profession but also our patients.

—Bob Bernstein, PHD, MDCM, CCFP, FCFP
Ottawa, Ont
by e-mail

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1. Rosser WW, Kasperski J. Argument for blended funding [editorial]. *Can Fam Physician* 2002;48:236-7 (Eng), 247-9 (Fr).
2. Mulligan PK. Capitation: the wrong direction for primary care reform [editorial]. *Can Fam Physician* 2002;48:233-5 (Eng), 244-7 (Fr).

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Having read the two editorials in the February issue by Pamela Mulligan[1] and Walter Rosser with Jan Kasperski,[2] I cannot help but think that changes to the existing fee schedule could be a much simpler answer to keeping family physicians doing comprehensive care than any combination of capitation or complicated blended payment schemes.

If one of the problems to be solved by primary care reform and capitation is the overuse of very expensive emergency departments by patients who either cannot or will not see their family physicians at hours that are mutually convenient, then why not offer a premium for after-hours work by family doctors in their offices? I am sure it would lead to abuses with patients being booked in regular "premium" time slots, but I am also sure these patients would be happier and less likely to use emergency departments. Also, the money saved by not having emergency departments overloaded would more than pay for any extra expense engendered by the after-hours premium fee. There are lots of after-hours premiums already paid for various in-hospital visits and procedures as well as housecalls and nursing home visits, so why not physicians' offices?

The same principle of using the fee schedule to influence how doctors practise could easily pertain to complicated patient counseling (ie, patients with multisystem disease) or in-hospital care. I have been in practice for more than 20 years, but 2 years ago, I gave up my obstetrics privileges, and unfortunately soon I will be resigning my inpatient privileges. I say unfortunately because this is not good for the hospital, not good for my patients, and not good for my education. But it will be good for me financially, as inpatient care pays so poorly, and my time will be more financially productive in my office where I have more patients than I can handle.

I am certain that, if the fee schedule were altered to improve pay for after-hours work, obstetrics, and in-hospital care, I and many of my colleagues would continue to provide these services. The fee schedule is quite capable of influencing practice patterns. I believe it is not necessary to re-invent the wheel with capitation or blended payment schemes to achieve the goals of maintaining comprehensive care when the solutions can be so much simpler.

—David J. Barker, MD, CCFP
Oshawa, Ont
by e-mail

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1. Mulligan PK. Capitation: the wrong direction for primary care reform [editorial]. *Can Fam Physician* 2002;48:233-5 (Eng), 244-7 (Fr).
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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Having read the recent articles[1,2] on remuneration of Canadian family physicians, it seems there are some facts not generally understood by many. Over the past 50 years that I have been practising medicine, I have been remunerated by fee-for-service in Canada and by capitation and straight salary in the United Kingdom. I think, therefore, that I have some idea as to the problems involved.

First, the problems involved depend on who is paying the piper. Fee-for-service might be the best way when patients are paying, because there is control right from the