2. It is absolutely unsafe to return to play while symptomatic in any way following a concussion. Dr Hickey mentions Second Impact Syndrome,[1] but this is extremely rare. Symptomatic people are far more likely to be concussed again, however, to be concussed more easily, and to have postconcussion symptoms that are more severe and long-lasting. This is a very common reason for patients I see to have a prolonged postconcussion course.
3. Return to play should follow a stepwise progression. Athletes should rest until asymptomatic, then start with very light aerobic activity, and progress gradually toward participation if asymptomatic. This progression will vary depending on the duration of postconcussion symptoms and the type of sport (eg, contact vs noncontact).
4. I add this point: prevention. Family physicians are in an ideal position to advocate for safe participation in sport (eg, use of helmets when snowboarding and in-line skating).

Physicians who follow these guidelines would be doing their patients a great service and would greatly decrease their risk. Physicians will likely be called upon more often to "clear" athletes for return to play after concussion; for example, the Greater Toronto Hockey League now requires a doctor's certificate in this regard. It is, therefore, critical that physicians are up-to-date with the most recent information in this field.

*—James Kissick, MD, CCFP, DIP SPORT MED*
*Palladium Sport Medicine Centre*
*Ottawa, Ont*
*by e-mail*

**References**

1. Hickey J. Concussion [Just The Berries]. *Can Fam Physician* 2004;50:231-3.
2. Aubry M, Cantu R, Dvorak J, Graf-Baumann T, Johnston KM, Kelly J, et al. Summary and agreement statement of the 1st International Symposium on Concussion in Sport, Vienna 2001. *Clin J Sport Med* 2002;12:6-11.

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I was glad to see an article[1] on concussion management in the February 2004 issue of *Canadian Family Physician*. I regret to inform you, however, that the article contains serious errors of omission. I am surprised that, in such a rapidly evolving field as concussion, the author and peer reviewers entirely missed the new guidelines[2] that have altered management of concussion worldwide. In addition, none of the author's references were from the Concussion in Sport theme issue published in the *Clinical Journal of Sport Medicine*, volume 11, number 3, in July 2001. Many of the issues raised in these new guidelines are not included in Dr Hickey's article.

To say that "Nevertheless, these are the tools we have to use at present" is just an error, when alluding to guidelines using level IV evidence that have now been abandoned by Canadian concussion experts. We must inform Canadian family physicians that use of concussion grading systems is no longer advocated for return-to-play decisions. In addition, physicians are now being asked to give written permission for hockey players in some communities to return to play after a concussion. This puts physicians who make the wrong decision at risk of legal action, especially if they use obsolete guidelines. Members of the Concussion Committee of the Canadian Academy of Sport Medicine and the Concussion Education Committee of the ThinkFirst-SportSmart group have been searching for the best method to relay these new concussion management guidelines to Canadian physicians. We request that you assist us in conveying the most current concussion management guidelines through a full article in your journal at your earliest opportunity.

*—James D. Carson, MD, CCFP, DIP SPORT MED*
*Chair, Sport Safety Committee*
*Canadian Academy of Sport Medicine*
*Unionville, Ont*
*by e-mail*

**References**

1. Hickey J. Concussion [Just The Berries]. *Can Fam Physician* 2004;50:231-3.
2. Aubry M, Cantu R, Dvorak J, Graf-Baumann T, Johnston KM, Kelly J, et al. Summary and agreement statement of the 1st International Symposium on Concussion in Sport, Vienna 2001. *Clin J Sport Med* 2002;12:6-11.

## Debating the values of family medicine

The College of Family Physicians of Canada's Committee on Ethics has done all family physicians, and indeed the discipline of family medicine,

a great service with publication of their paper *Family Practice Concepts and Values: Benchmarks for Health Reform* (found under Family Medicine Ethics in the Education section of the College's website at **www.cfpc.ca**).

This document was written in response to the changes we are likely to be challenged to address. We should be taking the lead as a result of the many initiatives to reform our health care system. The paper has been written partly "to initiate professional and public debate" about the values of our discipline.

While many family doctors might scoff at the suggestion that we need to debate our values and core concepts, the lack of debate is doing our discipline great harm. The reality is that our role in the health care system is changing. Some of this change is driven by our own actions in leaving hospital practice in the larger centres and withdrawing from maternity care. Other influences on this change include the type of funding agreements our medical associations negotiate with provincial governments on our behalf, the decisions of regional health authorities, advances in information technology, changing roles of our health care providers (eg, advanced practice nurses and midwives), and specific health reform initiatives that are designed to bring about these changes. If we do not take the time to engage in this debate, we run the risk of allowing the system to evolve in a way that is inconsistent with our values and core concepts.

The Committee on Ethics has defined and expanded on 10 concepts and values. They have even cleverly suggested that these should be used to score reform proposals in the form of an "Ethical Apgar Score."[1] Each of the 10 values will be scored as to whether the proposed change would have a negative effect, no change, some enhancement, or major enhancement. So we could decide on the effect of a proposed change on our values as a group (the total score) and presumably approve or disapprove of the proposed initiative based on this score.

Publication of this scoring system does not, in my view, enhance the proposed debate of these values. By developing the "Ethical Apgar Score," the authors have canonized their suggested values and stifled the very debate they seek to promote. Furthermore, their scoring system misses a critical issue: the relative importance of each of these values and concepts. They have indicated in their text that they regard some of the listed values to be more central to our role than others but have not allowed for this prioritization in their scoring system.

The solution to this flaw would be to weight the values in the scoring system in relation to their importance. This would allow a value at the heart of family medicine, such as trust, to be assigned a greater weight in the final score than a less important value. To develop this weighting system, we would need to engage in the debate necessary to assign the appropriate importance to each value. How much more important is trust than privacy and confidentiality? When two values are placed in conflict by a proposed system reform, we need to be able to resolve this conflict. How much of one value are we prepared to sacrifice to maintain another? Can we compromise patient confidentiality in our attempts to improve quality of care?

The College's Committee on Ethics has initiated an exciting and vital debate. Let us join the discussion, whether it be in the pages of *Canadian Family Physician*, through debate at the Chapter level, or during informal discussions with our colleagues wherever we might meet.

*—Alan Katz, MD, CCFP, FCFP*
*Winnipeg, Man*
*by e-mail*

**Reference**

1. Malus M, on behalf of the CFPC Committee on Ethics. User's guide to health care reform [FP Watch]. *Can Fam Physician* 2004;50:275-7.

## Casting doubt on impartiality

I am writing to protest the new format of *Canadian Family Physician*.

A peer-reviewed journal that purports to be offering legitimate educational information to its readership should not have advertisements for