priate mix of services and allocate their time appropriately in response to patients' needs. In either system, a measurable proportion of physicians adjust their practice patterns to suit personal and financial needs. Because of a failure to enforce the provision of the Canada Health Act that guarantees arbitrated settlements, there have been no increases in the Ontario fee-for-service schedule for 6 years. This pressures physicians to increase the number of patients they see and to reinterpret fee-schedule definitions.

In alternative payment plans such pressure would affect time commitments, leading to the well-known practices of "skimming the cream," reducing the frequency of visits to the minimum and spending the time thus freed up in other activities. Perverse incentives are not the sole property of fee-for-service medicine; rather, they are part of the human condition.

The result is a tendency for increased availability of services in fee-for-service systems and decreased availability in alternative payment plans. Forcing a massive change from one system to the other would therefore necessitate consultation with the public, who may prefer a system that errs on the side of increased service availability.

Stanley Lofsky, MD
Willowdale, Ont.

The nature and type of remuneration physicians receive are important aspects of medical care, and research and data are available. Unfortunately, Dr. Wright's commentary holds more personal opinion than facts. He assumes that high-billing physicians with numerous patients are not able to maintain practice standards. However, medicine is full of "work addicts." When the Ontario Health Insurance Plan reviewed high billers back in the 1970s (and published their names), it was found that most of these physicians were highly efficient, busy practitioners. Dr. Wright states that "[t]he personal price paid by these physicians and their families is high," but what proof is there for this assertion? Common sense dictates that physicians who are ill, depressed or otherwise disabled will in fact see far fewer patients. He speaks of abolishing the fee-for-service system but provides no data about the superiority of other methods.

It is probably time for all of us to study more closely the working patterns of some of our highly efficient, work-addicted colleagues; we might all learn something from them. I wish I had the energy to be one of them.

Robert Richards, MD
Toronto, Ont.

I am responding to Dr. Wright's outrageous proposition that the increase in use of the intermediate assessment is attributable to wilful manipulation of the system by physicians. Wright must not be a family physician, and he is avoiding the exercise of scientific investigation to pass off his own opinion as fact.

Active family physicians have witnessed the requirement to supply increasing levels of health promotion and health counselling as a standard of care. As patients age and as the number of conditions that can be diagnosed and treated increases because of technology and health promotion, the complexity of patient visits also increases — I have witnessed a significant decrease in straightforward patient visits. Even visits that could be simple are now complicated by the extensive information patients gather from various consumer publications and the Internet. If there is a concern that physicians are misusing the intermediate assessment code, then it should be substantiated with an effective primary care audit, not opinion.

My other significant concern is that *CMAJ* would publish this unsubstantiated and inflammatory opinion under the guise of an objective editorial. Last year I responded[1] to a similar article[2] advising physicians that we had it good and were greedy to advocate for ourselves. Would it not be more appropriate in these difficult times for our own journal to at least represent our profession in an objective manner?

Paul Leger, MD
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Reference

1. Leger P. Different views on privatization [letter]. *CMAJ* 1997;156(6):770-1.
2. Carver C. It's time for CMA to put the lid on privatization. *CMAJ* 1996;155:1156-7.

The best treatment may be no treatment at all

In their article "Management of common musculoskeletal problems: a survey of Ontario primary care physicians" (*CMAJ* 1998;158[8]: 1037-40), Dr. Richard H. Glazier and colleagues imply that there is an optimal way to treat a patient with an undefined shoulder problem. However, the case scenario described does not make it clear what is being treated, and no diagnosis is given. This is not surprising, as there is poor agreement on the diagnosis and the use of radiography in such cases.[1]

The optimal treatments for the problems presented in this study were determined by the consensus opinion of a multidisciplinary panel, not by a review of the relevant evidence. For the shoulder problem, undefined physiotherapy was recommended. Does this mean 6 weeks of hot packs? Ultrasound treatment? Exercise? Such a recommendation is similar to prescribing a medication without specifying the drug name, the dose or the duration of treatment.

A recent systematic review has concluded that ultrasound "does not seem to be effective in treating pa-