centage of today's physicians are involved in child rearing, which could reduce the number of hours they practise. They also failed to point out that the number of subspecialties has increased and this could contribute to the shortage as well.

They were correct to observe that doctors are increasingly concerned about lifestyle issues, which may mean a reduction in practice hours, but they did not question whether this trend is due to the type of students we now select to enter medicine. In the past, medicine was considered a vocation: the physician dedicated his life to medicine and had few outside interests. Today, medicine is a profession like any other.

Increasing medical school enrolment is important, but it is also important to select students who are going to dedicate most of their time to the practice of medicine and less time to other pursuits.

J.J.P. Patil
Physical medicine specialist
Halifax, NS

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Improving management of depression

We wish to report the follow-up results of a previously described randomized controlled trial[1] to evaluate an educational strategy to improve family physicians' use of clinical practice guidelines for the detection and management of depression. We measured depression using the Centre for Epidemiologic Studies Depression (CES-D) scale.[2] The primary outcome was the "gain" score (the difference between the first and last CES-D scores).

At 6 months, the mean gains for patients in the intervention and control groups were 17.9 and 16.5 respectively ($p = 0.04$) (Table 1). One year later, 18 months after the intervention, the corresponding gain scores were 17.9 and 13.4 ($p = 0.09$) (Table 1). There was an apparent, but not significant, deterioration of CES-D scores in the control group over the 12-month interval; the scores of the intervention group remained stable.

The numbers of patients available for follow-up dropped from 85 to 65 between 6 and 18 months; despite a greater difference in mean gain score at 18 months, the result is not statistically significant.

We also examined whether patients who saw a physician of their own gender did better than those who saw a doctor of the other gender. Interestingly, gender-matched physician–patient dyads showed higher mean gain scores (21.26 [SD 14.90]) than gender-unmatched dyads (16.40 [SD 13.91]) but, again, the sample was too small and the variance was too great for this difference to approach statistical significance ($p = 0.18$).

Although the loss of patients to follow-up in our study means that the results should be cautiously interpreted, and despite the various factors affecting retention, it is encouraging that the modest benefits that we detected at 6 months in our study appeared to be maintained at 18 months. The long-term effects of this and other medical education strategies require further investigation.

Table 1. Self-reported depressive symptoms at 6- and 18-month follow-up assessments

	CES-D scores					
	O mo		6 mo		18 mo	
Group	Mean (SD)	*n*	Mean (SD)	*n*	Mean (SD)	*n*
Intervention	37.3 (8.95)	91	19.4 (13.55)	57	19.4 (12.73)	40
Control	38.7 (8.11)	56	22.2 (11.73)*	28	25.3† (12.70)	25

*Gain = 16.5.
†Gain = 13.4

Graham Worrall
Frank J. Elgar
Megan Robbins
Centre for Rural Health Studies
Whitbourne, Nfld.

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The move away from fee-for-service care

A recent *CMAJ* article asked if fee-for-service is on the way out in Ontario.[1] The answer is uncertain but probably should be Yes. The detailed arguments appear in the 50-page document that the article cited (www.cfpc.ca/ocfp), which is easy to download but more difficult to read.

A couple of points can be stressed. Income based on capitation provides financial security, and the move away from fee-for-service payments removes disincentives to collaborative care involving nonphysicians. As well, rostering of patients promotes continuity of care.

However, 2 statements in the *CMAJ* article disturbed me. One was that "patients register with a single family practice that has from 7 to 30 physicians." Presumably these larger practices mean that a doctor may be on call only once a month. Although this may seem a wonderful prospect for some overstressed physicians, it makes nonsense of the notion of true continuity of care outside the office setting.

The article also stated that "physicians would be expected to see large numbers of people for very short periods (6 to 10 per hour)." How is this different from the high-volume walk-in clinics that we so rightly criticize? True patient-centred care should be reflective and thoughtful, and it can be in the