



to their own specialty. This is equivalent to having a flat CMPA fee for Ontario specialists, whether they realize it or not.

I am not aware of the situation in the other provinces, but if the uniform flat fee were adopted in Ontario it would only be fair to go back to square one — to calculate and remove the extra percentages that were allocated to specific specialties in the past and redistribute the “extra” evenly to all physicians in the province. Failure to make the necessary fee-schedule corrections would punish family physicians twice, first when the schedule was tilted to give a greater percentage to specialties facing high CMPA fees, and then again if uniform CMPA fees were adopted.

Maybe we should take Justice Charles Dubin’s theory one step further — “in the spirit of collegiality and in the interests of ensuring the continued provision of high-quality health care both for the sake of the profession and for the sake of all Canadians” we should have a uniform-fee structure not only for the expense side of the equation, but also for the income side.

Chris Stefanovich, MD
Queen Elizabeth Hospital
Toronto, Ont.

In this article, Justice Charles Dubin suggests that “in the spirit of collegiality, physicians should equally share the responsibility of the cost of professional insurance.” I suggest that, in the spirit of reality, we keep our malpractice insurance regulated by actuaries and based on group risk.

There are many inequities in this world, but it is not for the people at the bottom of the decision-making ladder to have to smooth them over. Government, which ultimately pays physicians in this country, and medical associations and registration bodies, which are involved in the regulation of the fee structure, need to

ensure that physicians in high-risk groups receive more money to be able to afford their malpractice coverage.

We cannot allow the legal system and litigants to remove huge sums of money from the medical establishment in the form of claims settlements without realizing that we will have to pay more into the system. If we practised under a private fee schedule, patients requiring the services of a physician in a high-risk category would have to pay more for that service because of the insurance costs involved. The answer appears simple. Pay the high-risk physicians more so that they may insure themselves adequately.

Finally, I assume no one needs reminding that we already have a differential fee structure. As the pay differentials are adjusted over time, the cost of insurance should be taken into account.

Christopher J. Galanos, MB, BCH
Radville, Sask.

Sleep statement for adults only

Iwould like to congratulate the Standards Committees of the Canadian Sleep Society and the Canadian Thoracic Society for the article “Standards for polysomnography in Canada” (*Can Med Assoc J* 1996;155:1673-8). It is an excellent summary of factors to be considered in adults with sleep disorders. Those who prepared it have considerable expertise in understanding, investigating and managing sleep disorders. However, the article seems to deal only with adults, although this is not stated in the title or the text.

Following the lead of these societies, the Respiratory Section of the Canadian Paediatric Society will prepare a similar document for children.

I recommend that all groups

preparing standards state explicitly in their published statements which populations are targeted.

Ian Mitchell, MB
Chair
Respiratory Section
Canadian Paediatric Society
Calgary, Alta.

Radical mastectomy now outdated

The articles “Patterns of initial management of node-negative breast cancer in two Canadian provinces” (*Can Med Assoc J* 1997; 156:25-35), by Dr. Vivek Goel and associates, and “A surgical subculture: the use of mastectomy to treat breast cancer” (*Can Med Assoc J* 1997; 156:43-5), by Dr. Adalei Starreveld, make fascinating reading. Not only is it remarkable that the patterns of practice differ so much between Ontario and British Columbia, but one is left wondering why outdated radical mastectomy procedures are still being performed in such large numbers, especially in older women and women in rural areas in BC. Is this largely a function of how recently the surgeon has been trained and his or her academic affiliation, or a more general reluctance to keep up-to-date with current scientific evidence?

It has been evident for at least 10 years that breast-conserving surgery, followed by timely radiation therapy, is equivalent to mastectomy in terms of outcome. Adjuvant chemotherapy with such agents as tamoxifen should be part of the program, to lower the rate of recurrence.

In BC an additional factor is the shortage of radiation machines. Although such therapeutic equipment is available in Vancouver and Victoria, the existing machines in Victoria are inadequate to deal with the demand, and proposals to upgrade and expand equipment have recently been



shelved by the Ministry of Health. It appears that funds are available for the questionable screening mammography of asymptomatic women 40 to 49 years of age, but not for timely radiation therapy for all of the women with breast cancer who could benefit from it.

The larger question remains: What are the best ways to incorporate recommendations based on new scientific knowledge into medical practice?

Timothy Johnstone, MB, BS
Victoria, BC

[The authors respond:]

We agree with Dr. Johnstone that randomized trials have shown that breast-conserving surgery (BCS) followed by timely radiation therapy (RT) is equivalent to total mastectomy for most patients with early-stage breast cancer. BCS alone, however, results in higher rates of local recurrence¹⁻⁵ and higher rates of distant metastatic cancer.¹⁻³

As described in our article and in a more detailed investigation of variation in the use of BCS within British Columbia,⁶ access to RT services was one of several factors influencing the rate of BCS. Women living more than a 2-hour drive from an RT facility had lower rates of BCS in both BC and Ontario. In 1991, the period of the study, 30% of patients in BC lived more than a 2-hour drive from an RT facility, whereas only 6% of patients in Ontario lived this far from an RT facility. Only 4% of patients were treated with BCS alone in BC, as compared with 17% in Ontario. This finding reflects the closer compliance with international⁷ and provincial cancer treatment guidelines in BC. To improve access to RT in BC, a new cancer centre with 4 machines opened in the Fraser valley in 1991, another is under construction in Kelowna, 2 new machines are

being commissioned in Vancouver and the capacity in Victoria is being doubled.

There was also a strong surgeon effect influencing BCS use in BC. This could not be explained by the surgeon's sex, volume of patients treated, academic affiliation or year of graduation from medical school.⁶ Our study could not determine whether women faced with the need to travel for RT were not offered or did not choose BCS.

It has been shown that patients who participate in the choice of treatment, independent of the choice selected, have less long-term anxiety and depression than women directed to either mastectomy or BCS.⁸ Women should be informed of the equivalence of BCS plus RT and total mastectomy in a nonjudgemental way, be assisted to obtain additional information about the advantages and disadvantages of each option and given the time and respect to make the decision for themselves.

The issue of resource allocation among treatment, prevention and screening programs is important and must be addressed by society as a whole. Studies such as ours can describe the distribution of resources but cannot answer the question of how to allocate available resources most appropriately. Such questions require evaluation of the efficacy, effectiveness and costs of different interventions and the preferences of individuals and society toward different outcomes.

Ivo A. Olivotto, MD
T. Gregory Hislop, MD, CM
Andrew Coldman, PhD
British Columbia Cancer Agency
Vancouver, BC
Vivek Goel, MD, CM
Carol Sawka, MD
University of Toronto
Toronto, Ont.

References

1. Fisher B, Anderson S, Redmond CK, Wolmark N, Wickerham DL, Cronin

WM. Reanalysis and results after 12 years of follow-up in a randomized clinical trial comparing total mastectomy with lumpectomy with or without irradiation in the treatment of breast cancer. *N Engl J Med* 1995;333:1456-61.

2. Clark RM, Whelan T, Levine M, et al. Randomized clinical trial of breast irradiation following lumpectomy and axillary dissection for node-negative breast cancer: an update. *J Natl Cancer Inst* 1996;88:1659-64.
3. Forrest AP, Stewart HJ, Everington D, et al. Randomised controlled trial of conservation therapy for breast cancer: 6-year analysis of the Scottish trial. *Lancet* 1996; 348:708-13.
4. Veronesi U, Luini A, Del Vecchio M, et al. Radiotherapy after breast-preserving surgery in women with localized cancer of the breast. *N Engl J Med* 1993;328:1587-91.
5. Liljegren G, Holmberg L, Adami H-O, et al. Sector resection with or without post-operative radiotherapy for stage I breast cancer: five-year results of a randomized trial. *J Natl Cancer Inst* 1994;86:717-22.
6. Hislop TG, Olivotto IA, Coldman AJ, et al. Variations in breast conservation surgery for women with axillary node negative breast cancer in British Columbia. *Can J Public Health* 1996;87:390-4.
7. Treatment of early-stage breast cancer: National Institute of Health Consensus Development Conference. *JAMA* 1991; 265:391-5.
8. Fallowfield LH, Hall A, Maguire GP, et al. Psychological outcomes of different treatment policies in women with early breast cancer outside a clinical trial. *BMJ* 1990;301:575-80.

Introducing students to community health

In the article "Creating community agency placements for undergraduate medical education: a program description" (*Can Med Assoc J* 1997;156:379-83), Drs. Donald Wasylenki and Carole Cohen and Ms. Barbara McRobb describe how it is possible to provide medical students with relevant experience in community agencies by choosing agencies carefully and maintaining good working relationships. We recognize the formidable logistics they overcame in offering 354 students stimulating learning experiences, including allowing students to observe health care in the community, to appreciate the concepts of barriers to health and to