## Kudos for *CMAJ*'s new look

How pleased I was to see the many changes in the format of the Jan. 1, 1997, issue of *CMAJ*. I appreciate the change in the print; it is darker, better spaced and larger. I also appreciate the more favourable spacing of paragraphs and advertisements and the general improvement of the layout. Perhaps my complaints about the old style bore some fruit. Again, thank you for a most interesting and informative journal.

**Leonard I. Levine, MD**
Former Editor
*Hologram*
Canadian Holistic Medical Association
Former Editor
*Dalhousie Medical Journal*
Ottawa, Ont.

Congratulations on the new and improved format of *CMAJ*. It is most interesting and enjoyable.

**Claude L. LeBlanc, MD**
Calgary, Alta.

I like the new clean look of *CMAJ*. I also like the "at a glance" cover. All the best for 1997.

**Peter Vaughan, MA, MD**
MPH Program
Johns Hopkins University
Baltimore, Md.
Received via e-mail

The new *CMAJ* is very snazzy indeed. I even think that there are changes of substance as well as of form.

**A. Mark Clarfield, MD**
Ministry of Health
Jerusalem, Israel
Sir Mortimer B. Davis–Jewish General Hospital
Montreal, Que.
Received via e-mail

Congratulations on a great redesign! You and your team deserve lots of credit for the new look.

**Stewart Cameron, MD**
Assistant Professor
Department of Family Medicine
Dalhousie University
Halifax, NS
Received via e-mail

I have pored over perhaps a dozen redesigns of *CMAJ* in the past decades, but the new cover and internal design of *CMAJ* has far excelled them all in harmonizing graphic and textual elements, while offering plenty of uncluttered white space. Congratulations.

**Peter Morgan, MD, DPH**
Former Editor-in-Chief
*CMAJ*
Lanark, Ont.

## Lax record keeping

To the tips for keeping good medical records given in the article "Physicians who keep lax records put careers in danger, college course warns" (*Can Med Assoc J* 1996;155: 1469-72), by Dee Kramer, I would like to add consideration of transcribed records. After my internship in 1981, I would have been one of those with very poor writing and difficulties in time management, and I would have easily succumbed to poor record keeping. However, I had joined a clinic in which the records were dictated and transcribed. There is an obvious overhead cost associated with dictation; however, in terms of the clarity of the records, the ability to be succinct and the ability to dictate a referral note or significant other record immediately (avoiding the necessity of pulling charts later or having charts pile up on your desk) there is a distinct advantage. The ongoing typed record also provides a good organization tool that allows the temporal sequence of care to be easily documented. Effective dictating may also reduce the time-frame for making records from the suggested 5 minutes to only 1 or 2 minutes; furthermore, records can be made immediately after the patient is seen, while the visit is still fresh in the physician's mind.

Cost aside, with the time saving and the ability to organize the files easily and to provide documentation of the good work and the amount of work done, there are potential benefits to transcribing records.

In the future, as computer voice-recognition systems become more effective, they may also allow for cost-effective transcription.

**Patrick J. Potter, MD**
Chief
Physical Medicine and Rehabilitation
University of Western Ontario
London, Ont.

## Keeping an eye on the eye bank

I read with interest the 2 articles "Dr. James MacCallum: patron and friend of Canada's Group of Seven" (*Can Med Assoc J* 1996;155: 1333-5), by Roger Burford Mason, and "First cornea transplants meant blind WW I veterans saw first sights in 40 years" (*Can Med Assoc J* 1996;155:1325-6), by Peter Wilton. Both articles are linked to the University of Toronto Department of Ophthalmology, yet made little reference to this institution.

The article on James MacCallum, who practised ophthalmology in Toronto for 50 years, stated that he encouraged members of the Group

← For prescribing information see page 727

of Seven to pursue their art and exhibits. In fact, in his time he was considered the most outstanding ophthalmologist in Ontario. His first position at the university was as lecturer in pharmacology and therapeutics, and he also assisted the professor of gynecology. He then did postgraduate ophthalmic study in London, England, before returning to work at the Toronto General Hospital and the Hospital for Sick Children. He was professor of ophthalmology at the University of Toronto from 1914 to 1929, published widely on ophthalmologic conditions and represented the university on the council of the College of Physicians and Surgeons of Ontario.[1] His patronage of the Group of Seven was without a doubt his major legacy.

Wilton's article on corneal transplants alludes to the university but neglects the important role it played in establishing the Eye Bank of Canada (Ontario Division) in conjunction with the Canadian National Institute for the Blind (CNIB). The concept of a Toronto eye bank arose during a discussion between Col. E.A. Baker and Professor A.J. Elliot in May 1950.

The CNIB contributed $500 to the university's Department of Ophthalmology to help establish the eye bank. Its first medical director was Dr. Hugh Ormsby, who obtained funding from the federal health department in 1955 and established research programs in corneal transplantation under Elliot. In 1959 Elliot appointed Dr. P.K. Basu Stapells director of ophthalmic research. Anne Wolfe, who managed the eye bank and built up the donor system, eventually handed management responsibility to Dr. Marilyn Schneider, and Fides Coloma succeeded Schneider in 1996. Dr. David Rootman has been responsible for directing the bank since 1991, and Professor William Dixon, the senior medical adviser, maintains close links between the bank and the CNIB. Since 1966 the eye bank has been funded by a Ministry of Health contract grant and an operational grant from the CNIB. It is the only transplantation program housed on site at the University of Toronto.

The ophthalmology department is proud of its historical links to the Group of Seven and its continuing links, via the Eye Bank of Canada, with the CNIB and the provincial government.

**Graham E. Trope, MB**
Professor and Head
University of Toronto
Ophthalmologist-in-Chief
The Toronto Hospital
Toronto, Ont.

**Reference**

1. Roy P, Basu P, Trope G. Ophthalmology in Toronto from 1887 to 1946: a historical review. *Can J Ophthalmol* 1996;31:171-4.

## The other side of the great divide

After reading "MD crosses great divide when moving between practices in Canada, US" (*Can Med Assoc J* 1996;155:1599-600), by Charlotte Gray, I feel obliged to respond. The article dealt with a plastic surgeon who practises on both sides of the Canada–US border. For the past 5 years, I have practised on both sides as a general practitioner.

In the winter I work part time for a nonprofit corporation that operates community clinics in 3 counties in South Central Florida. They provide care to low-income Americans. In the summer I do part-time work as a locum in my former practice in Ontario, where I spent 35 years in general practice.

In Florida, medical care is excellent if you can afford it. The community clinics have excellent providers, including board-certified specialists, general practitioners and nurse practitioners. Although primary assessments are reasonably complete, progression to more sophisticated studies such as echocardiograms, contrast studies of the gastrointestinal tract and endoscopic examinations require a cash outlay that most patients cannot afford. Even recipients of Medicaid, which provides care for destitute Americans, encounter difficulty, since specialists often refuse to accept these patients. For emergencies, hospitals make all modalities, such as MRI and CT, available.

For the patient population I serve in Florida, my treatment decisions are almost always severely restricted by the patients' poverty. Although great publicity is given to campaigns encouraging women to have an annual mammogram after age 50, for most of our patients the fee of $60 or more is a real financial strain.

When I see patients in Canada, I know they will be seen by a specialist regardless of their income. A mammogram can be ordered without cost. In Ontario, patients are required to wait for bypass surgery due to overburdened facilities. In the US this procedure can be done promptly, but I have treated patients whose delay in having the surgery was due to their inability to pay. Meanwhile, they remained cardiac cripples. As a Canadian physician, I cherish the freedom to treat patients without concern for their ability to pay.

As a provider and a user, my plea is that the beleaguered Canadian health care system does not become Americanized into a two-tier system.

**Donald H. Aikenhead, MD**
Avon Park, Fla.

## Revisiting Rick: more bad news on the HMO front

Last year, during one of my periodic visits to Los Angeles, my friend Rick (as I have been calling him), a primary care physician, recounted some of the difficulties he ex-