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Dr. Chan and colleagues suggest that clearer, evidence-based guidelines, including a comprehensive strategy for implementation, are needed for spirometry.

In 1993 a task force of the College of Physicians and Surgeons of Ontario developed and promulgated clinical practice parameters and facility standards for pulmonary function studies and procedures listed in the Ontario Ministry of Health schedule of benefits and covered by Ontario's Independent Health Facilities Act (1989). The act gives the college the primary responsibility for assessing out-of-hospital facilities licensed by the Ministry of Health. Since this act excludes timed vital capacity and FV loops, clinical practice parameters for these studies were not addressed in the 1993 edition. However, the task force is now preparing clinical practice parameters and facility standards for these studies and has recommended to the ministry that they be included in the act.

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[The authors respond:]

We did not intend to suggest that FV loops are being used excessively in comparison with simple spirograms. FV loops provide physicians with a visual aid to diagnosis and are useful in the detection of high airway obstruction, an uncommon condition. Furthermore, the additional technician time needed to perform the full FV loop instead of a simple spirogram is small. Nonetheless, the usefulness of information from FV loops on small airways obstruction should be put into context. Change in flows at low lung volumes must be interpreted with caution because of measurement problems. Flows at low volumes can vary widely even in the same patient; they are also influenced by the absolute lung volume at which they were performed, which cannot be measured by spirometry. Interpretative uncertainties also exist. First, isolated reduction in flows at low lung volumes are not synonymous with but suggestive of disease in the small airways. Second, the clinical significance of an isolated reduction in an individual is unknown.

The key issue is that, although FV loops have modest benefits over simple spirograms, there is a large difference in the fees paid for them; this difference is out of proportion to the marginal benefits and cost to the provider. The fee difference, combined with the shift from spirograms to FV loops, was a key factor driving expenditure growth. If the health care system were truly interested in remunerating tests in keeping with the quality of the information they provided, we would suggest that a premium be paid for a FV test performed in a regulated facility with calibrated closed-circuit dry spirometers but not for a spirometry test performed with a hand-held model in an unregulated setting in which there is no information about the training of technical staff, no assurance of quality control and no assurance that the test will be correctly interpreted.

Clinical practice parameters for FV loop studies, such as Dr. Haddon describes, would indeed be welcome. Issues include the indications for peak expiratory flow tests, the appropriate frequency of follow-up spirometry and the use of spirometry during routine physical examinations and acute respiratory illnesses. Until these issues are clarified, we can expect the same pattern of wide variations in spirometry use to continue.

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Wife abuse: universal screening

As an emergency physician involved in the care of battered women, I found the article "Documenting wife abuse: a guide for physicians" (*Can Med Assoc J* 1997; 156:1015-22), by Dr. Lorraine E. Ferris, Margot McMain-Klein and Laura Silver, interesting and informative.

However, I would like to offer a couple of suggestions. I believe that the authors' proposals for standardizing care for and documentation of wife abuse would be more relevant to practising clinicians if the following points were addressed.

The authors suggest that physicians question women with suspicious injuries and emotional difficulties about abuse to identify victims of wife abuse. However, this approach is inadequate. Although there is little doubt that such an approach would result in higher identification rates than self-reporting, it would miss many abused women. The American Medical Association has strongly endorsed the inclusion of screening questions about violence in routine history taking: "Due to the prevalence and medical consequences of domestic violence, physicians should