

We agree that the transfusion of 3 units of packed red blood cells in this case was most likely unnecessary and deviated from the published Red Blood Cell Transfusion Guidelines. Our patient, who did not speak English or French, was sent to the hospital after an on-call family physician was notified by the community laboratory of critical results. Hospital consultant physicians were faced with a newcomer to the Canadian health system, an Arabic-speaking patient without prior Canadian health records. We suspect communication challenges contributed to their aggressive management approach.

The literature is full of examples of ethnic minorities receiving suboptimal health care because of various challenges associated with communication, unfamiliar disease patterns, physician practice patterns, and disempowered or underinformed patients.^{1,2} We also would like to highlight the need for well coordinated health services for migrant patients,³ with which we continue to struggle. We hope our case study and the ensuing discussion will raise awareness of these issues and contribute to improved care for migrant patients.

Intestinal helminths play an important role in mild-to-moderate anemia in the developing world and are often found in corresponding immigrant subgroups.⁴ As part of our preventive care program for arriving refugees, we screen all patients for ova and parasites; this patient's stool test results were negative. We thank Dr Moore for highlighting this important omission.

—Kevin Pottie, MD, MCLSC, CCFP, FCFP

—Patricia Topp, RN(EC), MSCN

—Frances Kilbertus, MD, CCFP, FCFP

Ottawa, Ont

by e-mail

References

1. Mayberry RM, Mili F, Ofili E. Racial and ethnic differences in access to medical care. *Med Care Res Rev* 2000;57(Suppl 1):108-45.
2. Smedley BD, Stith AY, Nelson AR, editors. *Unequal treatment: confronting racial and ethnic disparities in health care*. Washington, DC: National Academies Press; 2003.
3. DuPlessis HM, Cora-Bramble D; American Academy of Pediatrics Committee on Community Health Services. Providing care for immigrant, homeless, and migrant children. *Pediatrics* 2005;115:1095-100.
4. Stauffer WM, Kamat D, Walker PF. Screening of international immigrants, refugees, and adoptees. *Prim Care* 2002;29:879-905.

Whose pen is in your pocket?

I whole-heartedly concur with the sentiment of Dr C. Sikora's article, "Whose pen is in your pocket?" in the March 2006 *Canadian Family Physician*.¹ Dr Sikora refers to the Canadian Medical Association guidelines for our interactions with the pharmaceutical industry. These guidelines allow physicians to judge for themselves the accuracy of information provided to them by the industry.

How well do family doctors adhere to these guidelines? Are the guidelines specific or strict enough? Dr Sikora refers to a common interaction where perhaps we don't do well enough: talking to pharmaceutical representatives in our offices. We let these salespeople wine us and dine

us. Until recently we would get the odd golf game out of them or maybe even a weekend away with the family. We let them leave behind various promotional items, barely disguised as patient-education tools. And all the while we claim to maintain our objectivity. But do we?

It seems to me that the pharmaceutical industry spends millions on us for one reason; it works. It sells their product. A "drug rep" visiting you is responsible ultimately to the shareholders of their company, not to the health of your patients. We are as likely to receive objective information from these people as to have a Toyota salesperson recommend a Honda! So why do we subject ourselves to this? And what would our patients say to this influence on our prescribing practices?

Why don't we have the fortitude as a profession to admit that listening to these salespeople is not in the best interest of our patients?

—Dale Cole, MD, CCFP, FCFP

Calgary, Alta

by e-mail

Reference

1. Sikora C. Whose pen is in your pocket? *Can Fam Physician* 2006;52:394.

I was heartened to read Dr Sikora's Residents' Page¹ about the detrimental effects of pharmaceutical advertising on "...the basic tools of our trade,"¹ including pens and notepaper, on the patient-physician relationship.

This resident's opinion stands in stark contrast to the recent developments at the Medical Society of Nova Scotia (Doctors Nova Scotia). The Society announced in the February 2006 issue of its magazine² that the pharmaceutical company "AstraZeneca has become the educational sponsor of the Doctors Nova Scotia electronic bookshelf. The sponsorship agreement is valued at \$125000 for a 1-year term."² The article continues, "The electronic bookshelf, on doctorsNS.com, is the most accessed feature on the website." In return for the funding, the electronic bookshelf will carry the AstraZeneca logo. Dr Sikora's patient would have even greater justification for being suspicious of the advice doctors give if she became aware of this development.

It is ironic that our residents can clearly identify conflicts of interest while the establishment chooses to ignore the dangers of intimacy with the pharmaceutical industry.

—Jyothi Jayaraman, MD, CCFP

St Margaret's Bay, NS

by e-mail

References

1. Sikora C. Whose pen is in your pocket? *Can Fam Physician* 2006;52:394.
2. Doctors Nova Scotia. AstraZeneca becomes educational sponsor of electronic bookshelf. *Doctors NS* 2006;4:5.

The burden of paperwork

Time required for paperwork has been increasing to the detriment of other aspects of physicians' work.¹

Physicians' satisfaction is inversely related to this burden.² In this era of electronic medical records (EMRs), paperwork is being supplanted by electronic "document handling." We have been unable to find articles in the literature that quantify this aspect of Canadian family doctors' workload and, therefore, we analyzed document handling in our practice.

We began implementing an office EMR system for our rural family practice in 2002. All correspondence and laboratory, imaging, and consultant reports are entered into patients' electronic records. Prescriptions are generated electronically.

Electronic documents handled by physicians in our office during a 3-year period (2003-2005, inclusive) were identified and counted. During this time clinic progress notes were still handwritten; we estimated 1 for each office visit.

There were 30213 visits in the EMR appointment book over the 3 years. We electronically signed 28304 pages of received correspondence and 21774 pages of laboratory results (each with an average of 11 test results). The physicians wrote 17874 prescriptions, with an average of 2 medications per prescription. The practice generated and sent 6109 pages of correspondence. One handwritten note per visit adds 30213 progress note entries.

Every week, on average, each physician saw 97 patients and handled 335 pages of documents (including 91 pages of received correspondence, 70 pages of laboratory results, 57 prescriptions, 20 pages of outgoing correspondence, and 97 progress notes).

These numbers underestimate our overall document handling workload and paperwork burden. We have not included estimates for handwritten requisitions (laboratory and imaging), notes to patients, immunization cards, additional progress note entries related to patient phone calls, or follow-up of results. Much of the document workload generated at the local nursing home is not included. We have also not included a count of the many third-party or government forms (eg, drug plan limited-use forms, travel grant applications) that are not entered into the EMR. Paperwork related to billing, office administration, practice audit, quality assurance, continuing education, teaching, research, or coroner duties are not included in this analysis.

We believe that our experience of each handling well over 17000 pages yearly will be similar for other family doctors who provide a range of clinical services. Our numbers for laboratory results are similar to those reported for American primary care physicians by Poon and colleagues in 2003.³ The document burden, however, could be much greater in practices with higher rates of patient referral to specialists or private health insurance coverage.

While an EMR might not reduce physician time needed for document handling, it does allow for quantification of this component of physicians' work. Canadian

physicians were already spending 5.4 hours weekly on "indirect patient care" in 2002.⁴ Increasing time needed for this will exacerbate physician shortages and contribute to longer wait times.

Modern clinical practice demands high-quality documentation. Electronic medical records are powerful tools to improve quality of care; however, increased need for documentation will require increased physician manpower. Medical software vendors must strive to find ways to streamline EMR interfaces. Administrators, government agencies, and third parties must be encouraged to prioritize, simplify, and reduce documentation requests from physicians.

Efforts to reduce the burdens of paperwork and document handling must become a priority to help reduce physician burnout and frustration and to contribute to solving the problems of doctor shortages and long waiting lists.

—Shelagh McRae, MD, CCFP, FCFP

—Robert Hamilton, MD

Gore Bay, Ont

by e-mail

References

1. Excessive paperwork detracts from patient care, professional mentoring, and research. *Oncology (Williston Park)* 2001;15(7):834.
2. Grant P. Physician job satisfaction in New Zealand versus the United Kingdom. *N Z Med J* 2004;117(1204):U1123.
3. Poon EG, Wang SJ, Gandhi TK, Bates DW, Kuperman GJ. Design and implementation of a comprehensive outpatient Results Manager. *J Biomed Inform* 2003;36:80-91.
4. Martin S. More hours, more tired, more to do: results from the CMA's 2002 Physician Resource Questionnaire. *CMAJ* 2002;167:521-2.

Make your views known!

Contact us by e-mail at letters.editor@cfpc.ca, on the College's website at www.cfpc.ca, by fax to the Scientific Editor at 905 629-0893, or by mail.

Canadian Family Physician
College of Family Physicians of Canada
2630 Skymark Ave, Mississauga, ON L4W 5A4

...

Faites-vous entendre!

Communiquez avec nous par courriel : letters.editor@cfpc.ca, au site web du Collège : www.cfpc.ca, par télécopieur au Rédacteur scientifique à 905 629-0893, ou par la poste.

Le Médecin de famille canadien
Collège des médecins de famille du Canada
2630 avenue Skymark, Mississauga, ON L4W 5A4