It is possible to relieve a substantial part of the pain and suffering caused by terminal illnesses with palliative care techniques. However, many patients continue to suffer in their last days, with no hope of ever achieving a quality of life they would consider worthwhile. To refuse them the assistance of a physician in taking control of their lives, and therefore deaths, would be inhumane.

I hope the College's Ethics Committee takes into account this opinion, as well as the many others I am sure you will receive, in your attempt to represent the consensus of the profession.

— *Roger Süss*, MD, CCFP
Stonewall, Man

Reference

1. Bereza E, Rainsberry P. Lobbying the lawmakers. The College and assisted death [editorial]. *Can Fam Physician* 1997;43:191-3 (Eng), 201-2 (Fr).

College to continue leading role

I offer my congratulations to the College for taking a firm stand on the thorny issues of euthanasia and physician-assisted suicide.[1] Likewise, Dr Latimer's editorial[2] is an excellent "view from the trenches," based on experience with dying patients that is far more extensive than most of us can lay claim to.

I am becoming increasingly alarmed at the number of intelligent and otherwise thoughtful physicians who are getting on the euthanasia bandwagon and proposing this drastic and simplistic "solution" to the complex problems associated with the treatment of dying patients. I trust that the College will continue to play a leading role in this field, without giving in, as Dr Latimer says, to the "temptation of a deceptively simple solution to the problem of human suffering: removing the sufferer."

— *Catherine Ferrier*, MD, CCFP
Montreal

References

1. Bereza E, Rainsberry P. Lobbying the lawmakers. The College and assisted death [editorial]. *Can Fam Physician* 1997;43:191-3 (Eng), 201-2 (Fr).
2. Latimer EJ. Euthanasia and physician-assisted suicide. The wrong issues in the care of dying people [editorial]. *Can Fam Physician* 1997;43:189-91 (Eng), 198-200 (Fr).

Testing diagnostic acumen

I was delighted to see two articles on treatment of sore throats[1,2] in the March issue.

I usually spend 6 to 8 hours a week in a walk-in clinic as well as my regular practice, and see 40 to 60 sore throats per week. I had been taught that throat cultures were the diagnostic gold standard but had always felt that, in these times of fiscal restraint, there might be a better way. I had read that doctors were supposedly poor at judging clinically whether a sore throat had a viral or bacterial cause, but I always thought I could do better. Therefore I decided to test myself. My plan was to do throat cultures on 100 patients presenting with sore throats as the only symptom. I predicted the results of cultures, wrote my prediction down, and treated patients based on my "guess." I then compared the swab results with my predictions and adjusted therapy if necessary.

The results were as expected. I had to abandon the experiment after 40 patients because I could not justify doing 60 more swabs. My predictions were almost 90% accurate. Of the 40 I tested, only five were Group A streptococcus, and three of these were listed as scant growth. I had missed two of them, for a false-negative rate of 5%, and had unnecessarily treated three of the "normal floras" for a false-positive rate of 8.6%.

I do not pretend that this sample has any scientific or statistical validity, but taken together with the two articles by McIsaac et al, it offers food for

Canadian Family Physician

We welcome readers' comments.

Make your views known!

You can contact us:

by mail at
Canadian Family Physician,
College of Family Physicians
of Canada, 2630 Skymark Ave,
Mississauga, ON L4W 5A4
by fax at (905) 629-0893
by email via internet:
jgibbs@cfpc.ca

We welcome comments for publication, queries and concerns, and suggestions for articles.

Le Médecin de famille canadien

Nous encourageons nos lecteurs à nous transmettre leurs commentaires.

Faites-vous entendre!

Vous pouvez communiquer avec nous

par la poste:
Le Médecin de famille canadien,
Collège des médecins de famille
du Canada, 2630 avenue Skymark,
Mississauga, ON L4W 5A4
par télécopieur: (905) 629-0893
par courier électronique:
jgibbs@cfpc.ca

Nous recevrons vos commentaires pour publication, vos questions ou préoccupations et suggestions d'articles.

← FOR PRESCRIBING INFORMATION SEE PAGE 991

thought. I had not used any specific criteria other than 20 years of experience to decide on viral versus bacterial, but I realize now I was using the same criteria as the authors, only informally.

My main purpose in doing this test was to see if there was a way to save a few dollars from the shrinking health care pie wastefully spent on thousands of normal throat swabs. In British Columbia, each negative swab costs about $14, and each positive with sensitivities about $27 (more than the physician's fee). This research and my small "front line" confirmation should reassure us insecure doctors that we can clinically diagnose a sore throat, save a few dollars, and treat our patients better without relying on laboratory tests.

I have one question for the authors of these studies. Given the 10% to 15% prevalence of Group A streptococcus in asymptomatic, healthy individuals, how significant is a throat swab positive for Group A streptococcus in a patient who meets one or none of their criteria? In other words, does the mere presence of Group A streptococcus establish a causal relationship to sore throats?

I would be happy to accept large research grants to investigate this topic further!

— *M.T. Marshall,* MD
North Vancouver

Reference

1. McIsaac WJ, Goel V, Slaughter PM, Parsons GW, Woolnough KV, Weir PT, et al. Reconsidering sore throats. Part 1: Problems with current clinical practice. *Can Fam Physician* 1997;43:485-93.
2. McIsaac WJ, Goel V, Slaughter PM, Parsons GW, Woolnough KV, Weir PT, et al. Reconsidering sore throats. Part 2: Alternative approach and practical office tool. *Can Fam Physician* 1997;43:495-500.

Response

Dr Marshall's experiment aptly illustrates the view of many family physicians. It is difficult to justify throat cultures for all patients when experience suggests physicians can differentiate viral and Group A streptococcal (GAS) infection using clinical judgment. In a survey we did of some Ontario family physicians, 47% felt confident in their ability to tell clinically the difference between common colds and GAS infections.[1]

A problem for most of us is that clinical judgment leads us to prescribe more antibiotics than are needed. The best guess is between 50% and 70% of patients walk out of their doctors' offices with antibiotic prescriptions when they have a sore throat or cold. It is interesting that the prevalence of GAS infection in Dr Marshall's experiment was 12.5% (5/40), which agrees nicely with the 10% to 16% prevalence shown in our **Table 5** for general practice settings.[2] Clearly, the number of infections requiring antibiotics is much lower than the number receiving antibiotics.

The last 40 years has focused attention on the need to accurately identify GAS infection (sensitivity of clinical judgment); we must now focus on the problem of antibiotic resistance and reducing unnecessary antibiotic prescribing. This requires greater accuracy in identifying infections that are not GAS (specificity of clinical judgment). I calculate the false-negative rate in Dr Marshall's experiment to be 40% (2/5) and the false-positive rate to be 8.6% (3/35). As is often the case, specificity can be improved only at the expense of sensitivity.

If, like Dr Marshall, we do not wish to use throat swabs in every case, we need to challenge our assumptions about standard clinical judgment and current methods of incorporating signs and symptoms (informal clinical judgment). The research we have summarized suggests that standard clinical judgment can be enhanced and unnecessary antibiotic prescribing minimized by systematically combining the most useful signs and symptoms, while disregarding clinical information that is redundant (formal clinical judgment).

The answer to Dr Marshall's specific question about the importance of a throat culture positive for GAS in those with a score of 0 or 1 is: probably not much. These adults are usually 30 or older, which is a group at low risk for rheumatic fever. It is also clear that, because we currently do not request cultures for everyone, and not everyone with a sore throat bothers to come to the doctor, there have always been many people with GAS who do not receive antibiotics. The score approach is not any worse in this regard.

While not wanting to dampen Dr Marshall's enthusiasm for doing research, we did not have any research grant to do this work, much less a large one! He should also know that, unlike US grants, grants in Canada do not allow money to be paid to support the researcher. Other than that, family medicine research is a great career choice!

— *Warren J. McIsaac,* MD, MSC, CCFP
North York, Ont

References

1. McIsaac WJ, Goel V. Sore throat management practices of Canadian family physicians. *Fam Pract* 1997;14(1):34-9.
2. McIsaac WJ, Goel V, Slaughter PM, Parsons GW, Woolnough KV, Weir PT, et al. Reconsidering sore throats. Part 1. Problems with current clinical practice. *Can Fam Physician* 1997;43:485-93.

Sugar Group not part of CDA

In reference to your News article[1] on diabetes and indigenous peoples published in the September 1995 issue, I wish to clarify that the Strategies for Undermining Glucose in Aboriginal Races (Sugar) Group is not a member of the Canadian Diabetes Association (CDA). The Sugar Group was founded by the Aboriginal Women of Manitoba, Inc, a local women's group. Although we have done work with the CDA, we were not connected with them in any way.

FOR PRESCRIBING INFORMATION SEE PAGE 1003