Canada's family doctors and obstetricians. In fact, our Board has recognized both ALSO and ALARM as being worthy of equivalent continuing medical education credits, including those for Maintenance of Certification (MAINPRO-C). Our informal discussions with our colleagues at the SOGC suggest that we share the objective of trying to bring our two programs together. We look forward to our continuing deliberations addressing this possibility.

Until we are able to achieve this goal, however, we will continue to distribute the Canadian version of ALSO for family doctors and others providing maternity care in Canada. We continue to receive very strong support for the Canadian ALSO program that we have developed—people like it. They support the content and, in particular, we receive positive feedback with respect to the empowering aspect of taking a course developed and run by family doctors.

We did not "buy" the ALSO program, and it is not funded through membership fees. It is managed as a financially self-supporting initiative. The fee structure, however, does allow course directors to offer lower fees to CFPC members.

The CFPC's relationships extend to our international colleagues in family medicine, including a strong and beneficial ongoing interaction with our friends in the AAFP. Over the past few years, we have exchanged many ideas and programs that have proven to be of great benefit to family doctors and patients on both sides of the border. While we are committed to enhancing the collaborative relationship we enjoy with our obstetric colleagues across Canada, we are pleased that the feedback from most of our members who have participated in ALSO supports the approach we have taken to date.

*—Duncan Etches, MD, CCFP, FCFP*
*Chair, CFPC ALSO Sub-committee*
*—Michael Klein, MD, CCFP, FCFP*
*Chair, CFPC Maternity Care Committee*
*—Richard Handfield-Jones, MD, CCFP, FCFP*
*Director of Continuing Medical Education, CFPC*

# Is testing always necessary?

I am writing in regard to the Practice Tips[1] in the October 1998 issue on breast cyst aspiration. I agree that this procedure can quickly reassure patients and physicians that the lesion is indeed cystic. However, I was surprised that the advice in the article was to discard the fluid if it was not bloody. I would have thought that the safer course would be to send the fluid to the laboratory for cytologic examination. Certainly you should not do the aspiration unless you have the correct container for sending the fluid to the laboratory if it turns out to be bloody. The cytology can provide either extra reassurance when results are normal, or if results are positive, can provide extra ammunition to fast-track patients through the inevitable delays in the system.

*—C.F. Wallace, MD*
*Abbotsford, BC*

**Reference**

1. Mahoney L, Heisey R, Watson B. Breast cyst aspiration [Practice Tips]. *Can Fam Physician* 1998;44:2093.

# *Response*

I share Dr Wallace's concern. In general, it is important to ensure that material obtained from a procedure is sent for appropriate diagnostic tests. However, when there is conclusive evidence that a specific test does not add to the diagnostic yield, it is just as important that we not request it.

Ciatto et al[1] examined the results of cytologic examination of 6782 consecutive breast cyst fluids. In the 6747 nonbloody specimens, they found no suspect cells. They concluded that cytology should be used only when bloody fluid is obtained, as indiscriminate application to all cyst fluids does not affect the rate of detection of intracystic lesions.

Further work by Hamed et al[2] supports this claim and also gives evidence to support sending the fluid to cytology if the cyst does not completely disappear or if it recurs.

My own experience is corroboratory. Of many thousands of aspirations performed, I have encountered only four in which the cyst was associated with a cancer (papillary cystadenocarcinoma of the breast). In all four the diagnosis was obvious immediately. The cyst only partially disappeared on aspiration, and a residual mass was easily palpable. The cystic component recurred within 2 days in every case.

I hope this helps to clarify the issue.

*—Leo Mahoney, MD, MS, FRCSC, FACS*
*Toronto, Ont*

**References**

1. Ciatto S, Cariaggi P, Bulgaresi P. The value of routine cytological examination of breast cyst fluids. *Acta Cytol* 1987;31:301-4.
2. Hamed H, Coady A, Chaudry MA, Fentiman IS. Follow-up of patients with aspirated breast cysts is necessary. *Arch Surg* 1989;124:253-5.

# Solutions needed to control environmental illness

I appreciated the articles in the July 1998 issue of *Canadian Family Physician* on physicians' experiences with environmental health problems. Most physicians worry about the effect of environmental pollutants on their patients (whether they be dioxins, depleted ozone, or air pollution), but it is important to remember that the real answer to the problem of environmental illness is to prevent the pollution in the first place.

Currently our government policy forces taxpayers to foot the bill for a company's pollution in "clean-up" costs and health care, not to mention the human cost of illness the pollution causes. As long as industry is allowed to reap the profits and is not forced through legislation to pay the true costs of its activities, it will continue to pollute. Green taxes as proposed by

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the Green Party provide monetary disincentives to polluting.

Green taxes involve heavily taxing companies that pollute and that deplete resources, and lightly taxing or even subsidizing those that practise sustainably and without polluting. As industry always follows the path of least taxation and therefore maximum profit, being accountable for all stages of production and disposal of waste will force it to be more environmentally friendly.

We can, as consumers, try to buy and live in a more sustainable manner, but to protect the environment and truly prevent environmental illnesses through eliminating pollution, we must vote for governments that enforce green taxes. We must "make the polluters pay instead of paying the polluters." Until then we will continue to see more environmental illness in our offices and hospitals, as well as continued degradation of the environment upon which we rely for survival.

*—Cathy Vakil, MD, CCFP*
*Kingston, Ont*

# Family physicians and acute care

In response to Francine Lemire's article[1] on the role of family physicians in hospitals, the Calgary Regional Health Authority in Alberta recently completed a task force study on the role of the family physician in the acute care sector. The task force was originally convened to address the issue of care for unattached patients presenting to emergency departments and requiring admission. For a copy of the report, telephone Dr June Bergman at (403) 219-6132.

Currently, just over 200 of the 800 family physicians in Calgary have hospital privileges. These doctors do 50% of all medical admissions, do approximately 50% of the 6000 deliveries in the region, and play a substantial role in geriatric and palliative consultation and care services.

*—Pat Heard, MD, CCFP*
*Calgary, Alta*

**Reference**

1. Lemire F. Role of the family doctor in hospital [letter]. *Can Fam Physician* 1998;44:2369 (Eng), 2369-71 (Fr).

# Threats to the health care system

Dr Mulligan[1] is quite accurate in her perception of the evolution of our health care system, but she does not give us any suggestions on how to deal with the most important problems that threaten the system: the conspiracy of certain interested groups against the system; the disguised self-serving views of some practitioners; the unlimited, unrealistic consumer demands (cultural factor); and the population's sense of entitlement (cultural factor).

*—Juan E. Munoz, MD, PHD, CCFP*
*London, Ont*

**Reference**

1. Mulligan PK. Americanization of our health care [editorial]. *Can Fam Physician* 1998;44:2351-3 (Eng), 2363-5 (Fr).

# *Response*

I am not as sure as Dr Munoz that the principal threats to our system stem from unnamed conspirators, irresponsible practitioners, or the public's sense of entitlement. In Ontario, the greatest threat comes from the government,which sees health care as a nuisance to be shunned, rather than a responsibility to be accepted.

The creation of capitation-funded IDSs with expanded private sector roles in managing and delivering vital public services will relieve the government of the financial risks and management responsibilities associated with providing appropriate health care. Such changes invite the introduction of a US-style, market-driven system, with all the inequities and dissatisfaction it is known to entail. Our system might need improvement, but it does not need a replacement "born in the USA."

*—Pamela K. Mulligan, PHD*
*Grimsby, Ont*

# More should be less

There was an error in the update of the Canadian clinical practice guidelines[1] for treating diabetes in the November 1998 issue.

On page 2466 it read "... those with high-density lipoprotein cholesterol of 0.9 mmol/L or more..." are at risk and need to be tested more frequently. This is contrary to our understanding of the benefits of HDL and contrary to the guidelines found in the supplement[2] to the *Canadian Medical Association Journal* regarding this risk factor, which states "less than or equal to 0.9" as being a risk factor.

*—Ryan Hunt, MD, CCFP*
*Montreal, Que*
*—Robert Piche, MD, CCFP*
*Longuguil, Que*

**References**

1. Harris SB, Macaulay AC. Diabetes management: new evidence-based recommendations. Highlights of the 1998 Canadian clinical practice guidelines. *Can Fam Physician* 1998;44:2465-72 (Eng), 2473-9(Fr).
2. 1998 clinical practice guidelines for the management of diabetes in Canada. *Can Med Assoc J* 1998;159(8 Suppl):S1-S29.

# Correction

Two errors occurred in the article "Diabetes management: new evidence-based recommendations. Highlights of the 1998 Canadian clinical practice guidelines" (*Can Fam Physician* 1998;44:2465-72 [Eng], 2473-9 [Fr]). On page 2466, under the second bullet point in the section on screening for type 2 diabetes, it should read "those with high-density lipoprotein cholesterol less than or equal to 0.9 mmol/L...."

In Table 6, page 2471, the fourth column heading is incorrect. The correct version of the table is printed below.

*Canadian Family Physician* apologizes for any inconvenience or embarrassment this error might have caused the authors, Drs Harris and Macaulay.

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