witness the failure of their patients' "natural network" to support them adequately through difficult times. Family physicians are in better positions than specialists to assist their patients by helping them reconnect to their significant others who can, and do, contribute to their healing.

We would like to emphasize the importance of Dr McWhinney's contribution to the development of family medicine; nevertheless, we believe that some of his perspectives put undue burden on family physicians' shoulders.

— Marie-Thérèse Lussier, MD, MSC and Claude Richard, MA
Montreal

References

1. McWhinney IR. The importance of being different. Part 1: The marginal status of family medicine [editorial]. *Can Fam Physician* 1997;43:193-5 (Eng), 203-5 (Fr).
2. McWhinney IR. The importance of being different. Part 2: Transcending the mind-body fault line [editorial]. *Can Fam Physician* 1997;43:404-6 (Eng), 414-7 (Fr).

Drugs and herbal preparations: how safe are they?

I appreciate the concern expressed about the safety of herbal products.[1] However, very few hospitalizations were reported to be caused by herbal preparations. Ms Kozyrskyj discussed a large number of herbs, but the list of adverse effects is quite short, and most of the effects were not severe.

On the other hand, surveys have estimated the proportion of hospitalizations caused by prescriptions to be approximately 25% of the total number of hospitalizations. Any casual reader of the *Compendium of Pharmaceuticals and Specialties* (*CPS*) will be familiar with the large number of adverse effects associated with most drugs listed there, and many of the effects could be severe.

If we hold the drugs we prescribe to the same standards to which we would like to hold herbal products, we might well revise our assessment of them. Articles that depict herbs as dangerous should also acknowledge the dangers of drugs.

— Michael Vesselago, MD
Associate, Psychotherapy Institute
Toronto

Reference

1. Kozyrskyj A. Herbal products in Canada. How safe are they? *Can Fam Physician* 1997;43:697-702.

Rebuttal

I would like to thank Dr Vesselago for his comments on my article.

Most health professionals are aware of potential side effects associated with use of drugs and their contribution to morbidity and mortality.[1] As Dr Vesselago noted in his letter, one only needs to consult the *CPS* to be acquainted with all possible side effects of a drug. But that is precisely the point I was trying to make in my overview of herbal product regulation in Canada. Data in the *CPS* on the side effects of drugs is accumulated from premarket and postmarket drug surveillance studies.[2] No such medium exists for herbal products, and they are not registered with the Health Protection Branch. Moreover, the *CPS* also lists inactive ingredients found in drugs, ingredients that pose risks to some patients. Again, this kind of data is not available for most herbal products. If health professionals are going to practise evidence-based medicine, then herbal products should be subjected to the same scrutiny as conventional drugs, with respect to efficacy and safety. Registration of herbal products will promote the availability of data on herbal product efficacy and safety.

The objective of the overview was to familiarize family physicians with these issues, provide guidance regarding available references on herbal products, and include suggestions on their use in the absence of existing data. I also pointed out the purported benefits of alternative therapies. In this respect, I believe I presented a balanced view of herbal product use. Only when health professionals are familiar with the issues surrounding herbal therapies can they help their patients make informed choices and correct misconceptions about herbal products, which are often promoted as harmless.

— Anita Kozyrskyj, BSCPHM, MSC
Winnipeg

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1. Johnson JA, Bootman JL. Drug-related morbidity and mortality: a cost-of-illness model. *Arch Intern Med* 1995;155:1949-56.
2. Somers E, Carmen-Kasparek M, Pound J. Drug regulation—the Canadian approach. *Regul Toxicol Pharmacol* 1990;12:214-23.

Accessing primary care services

In the article "Distribution of physicians in Ontario,"[1] Dr Coyte and associates draw attention to the real difficulties faced by many Ontario residents in accessing needed primary care services. His paper uses an approach that avoids many of the shortcomings of the "head count" method favoured by the government and used recently to determine areas in the province in which newly entered physicians should be subjected to medical fee discounts.

The findings by Coyte and coworkers show that many residents in southern Ontario are comparatively undersupplied with primary care services provided by general practitioners and family physicians. Unfortunately, too much attention was paid to the inability of the methodology to attach statistical significance to difficulties in accessing primary care services in some northern regions. This is a function, in large measure, of relying on a county-level analysis. The findings of Coyte and colleagues are

consistent with our own. However, the results should not be used—and we do not believe it was their intent—to minimize the extreme difficulties many people in northern communities have in accessing primary care services.

The Ontario Medical Association (OMA) believes that the method used by Coyte and associates offers promise as the basis of a much-improved approach to determining comparative oversupply and undersupply of general practitioners and family physicians in the province. However, we believe it must be applied to smaller catchment areas to realize its full potential.

— Darrel J. Weinkauf
Executive Director, Economics, OMA
Toronto

Reference

1. Coyte PC, Catz M, Stricker M. Distribution of physicians in Ontario. Where are there too few or too many family physicians and general practitioners? *Can Fam Physician* 1997;43:677-83,733.

Practice intensity: urban vs rural

I must express my concerns about the conclusions reached in the article[1] by Coyte et al in the April issue of *Canadian Family Physician*. In particular, I question the validity of the statement, "No evidence supported the contention that patients in remote regions were seriously underserved," and the title of a press release issued by the authors "Ontario's north not under served by physicians."

The researchers have attempted to produce "adjusted GP densities" by looking at physician fee service claims in various counties and modifying them by incorporating data on physicians' age and sex, and the age-sex composition of the population. This resulted in a rather complex statistical analysis, which only academics could hope to appreciate.

However, as is often the case in research such as this, the practicalities facing rural residents and physicians are completely ignored. The figures seemed to suggest that three physicians are sufficient to look after a population of 3000 people or less. However, patients in urban areas are looked after by a combination of family doctors and specialists, always with the assistance of a fully staffed emergency department. In rural areas, a limited number of doctors provide both primary- and secondary-level medical services (both in and out of hospital), obstetrical services, and of course 24-hour emergency service. I think the comments of those three overworked and underpaid rural physicians would be a most interesting addition to the discussion in this paper!

I also question the validity of attempting to use OHIP fee service claims to develop a "practice intensity equivalent index" because practice styles in urban and rural areas are different. For example, rural doctors tend to spend more time away from their offices, providing complex, time-consuming services in hospitals, nursing homes, and patients' homes. Unfortunately, the fee codes are often the same as those used by physicians who work only in their offices, in walk-in clinics, or in patients' homes during housecalls. The reality of just how "intense" a rural practice can be is completely missed.

Indeed the question of how many physicians are needed in a particular rural area is a major stumbling block in addressing the issues of recruitment and retention of rural doctors. The hopelessly outdated Underserviced Area Program definitions, with their rigid limits, are still being used by the government in an effort to establish direct and group contracts; this is severely hampering efforts to improve the working conditions of rural doctors. It is unfortunate that this study simply compared counties instead of including a detailed analysis of rural versus urban needs.

The revelation that areas of southern Ontario are underserviced is hardly news. The OMA Section on Rural Practice has argued, during recent negotiations with the government, for appointing a Community Relations Officer to address this very issue.

Finally, I must seriously question the decision of the researchers to provide a press release with such a sensational and potentially damaging title before publication of the article and before allowing others the opportunity to debate these conclusions.

— C.R.S. Dawes, MD
Chair, OMA Section on Rural Practice
Barry's Bay, Ont

Reference

1. Coyte PC, Catz M, Stricker M. Distribution of physicians in Ontario. Where are there too few or too many family physicians and general practitioners? *Can Fam Physician* 1997;43:677-83,733.

Response

Mr Weinkauf highlights the methodologic contribution of our research. He suggests that our methodology might be used in physician supply management policies, and agrees that our empirical findings are consistent with those of the OMA.

Mr Weinkauf and Dr Dawes share two further observations. First, they both agree that too much emphasis was placed on our inability to detect a statistically significant shortfall of physicians in some northern regions of Ontario. Second, they recommend that the methodology be modified so that it is applicable to catchment areas that are smaller than counties and that our measure of physician supply be combined with other pertinent information.

We agree with the points raised by Mr Weinkauf and Dr Dawes, which we believe support the general thrust of our paper. We do, however, maintain our conclusion that, because almost 90% of all inhabitants in areas found to have significantly lower