gent to be a nurse. It is that kind of misunderstanding that leads to the ill-feeling that pervades our health care system. It is important to me to have positive working relationships with other health care professionals. If more people felt this way, maybe physicians and nurses could reach some common ground. Respect must be earned, not demanded. I am doing my best to start off that way, and I hope that others in my profession and yours will do the same.

Samantha Imrie, RN
Halifax, NS

RULES FOR EDITORIALS
AND PLATFORM ARTICLES

I felt depressed after reading “Information on editorials and platform articles” (Can Med Assoc J 1994; 151: 1573–1574), by Drs. Bruce P. Squires and Patricia Huston. It seemed to me to present only more irksome rules for we who toil in the vineyard of medical journalism.

But I was relieved to read the Platform article that immediately followed, “Barriers to interprovincial physician mobility” (Can Med Assoc J 1994; 151: 1579–1580). Its authors, Drs. Dennis A. Kendel and W. Dale Dauphinee, apparently have a cheerful disregard for CMAJ regulations. The article’s title is not entirely descriptive, there is no summary, and the article has no introduction (the first three paragraphs are irrelevant). It does not seem to have an exposition, and its conclusion, which is a little vague, could best be summarized as “Barriers to interprovincial migration of physicians are contrary to market forces and should be abolished.”

There is a lot of talk these days about freedom of speech. Do your rules and regulations interfere with this freedom? Maybe editors should confine their efforts to making sure that grammar, syntax and spelling are correct.

I hope that CMAJ editors will treat the rest of us as gently as they treated Kendel and Dauphinee!

W. Robert Harris, MD, FRCSC
Toronto, Ont.

(The editors respond:)

Dr. Harris states that he felt depressed about our “irksome rules,” although our authors have a “cheerful disregard” for them, and suggests that our role as medical editors should be limited to correcting authors’ English or French. Misconceptions about our role are not uncommon.

Our goal is to improve the quality of the content and the clarity of scientific communications, and our recommendations allow for more leeway than Harris assumes. Contrary to his analysis, we think that the Platform article to which he refers did have a clear introduction, exposition and conclusion. The summary was translated into French, our practice at that time (we now provide bilingual summaries).

To recommend that professional opinions be presented in a succinct, logical fashion, supported by evidence, is simply a way to promote academic rigour, not to cramp academic freedom.

Patricia Huston, MD, MPH
Associate editor-in-chief
Bruce P. Squires, MD, PhD
Editor-in-chief

MEDICAL-MANAGEMENT GUIDELINES WORTH WHILE

Milan Korcok’s article “Medical-management guidelines being developed with a vengeance in US” (Can Med Assoc J 1994; 151: 1625–1627) is timely. It prompts me to comment from the perspective my 30 years of psychiatric practice in the United States, including peer review for the American Psychiatric Association, review for the Social Security Disability Program and consultation for a large, private health insurer.

In returning to full-time practice in Canada, I was at first surprised at the apparent absence of guidelines and quality assurance, then reminded that a host of factors (not just the profit motive, as in the United States) affects clinical judgement, patients’ length of hospital stay and intensity of workup. For instance, in the United States, we discovered that psychiatric hospital stay was longer on the east coast than in the west — apparently only as a result of local custom. In psychiatry and general medicine, certain patients have dependency needs and a potential to manipulate, which can prolong hospital stay if they go unmanaged. I have seen that happen in Canada as well, in psychiatric units that have a “reasonable” average length of stay. The appropriate use of guidelines in such a case could improve care rather than erode it, quite apart from cost considerations.

In consulting for the private insurer, I was involved in developing guidelines for psychiatric care and supervising the application of such guidelines by psychiatric nurses. I also worked with practitioners in situations that lacked clarity or did not appear to be well served by the guidelines, which were modified as we learned. This leads me to the point that accepting — or buying — someone else’s guidelines, especially those developed in the world of managed care, makes it too easy to leave out the factor of clinical responsibility and just “go by the book.” This could lead to realization of the worst fears of practitioners; the US medical press is full of war stories about such situations. It would be much better to develop our own guidelines and be active in their application.