agreement, and any money lost in this way did not rightly belong to the emergency group in the first case.

The AFA will be particularly attractive to ED groups that already act cohesively and where the premium over FFS is considered worthwhile. It is least attractive to sites where individuals traditionally function as autonomous practitioners and wish to stay that way. It is certainly not for everybody, but gives Ontario physicians a choice they previously did not have. It is not perfect, but 65 EDs thought it was better than the status quo. If they are at any time disappointed in the terms or effect of the AFA they can withdraw with 90 days notice. It is very hard to ascribe a hidden government agenda for this program; the motive appears obvious: to stabilize physician staffing in order to improve public service and keep EDs out of the headlines. That is a motive we can all support.

Jonathan Dreyer, MD, CM
Chair
Howard Ovens, MD
Vice-Chair
Andrew Affleck, MD
Past-Chair
OMA Section of Emergency Medicine

[The author responds:]

Caution and judgement must be exercised whenever a body of power offers something. In the matter of alternate funding plans, it is ludicrous to say our government does not have a hidden agenda. The agenda is to control costs; at whose expense is hidden.

Dreyer and colleagues state that alternate funding plans (AFPs) are intended to exceed the current FFS pool, but I ask: When was the last time a government lined up to give doctors a raise and does this take into account the large clawbacks that some EDs on AFP have seen?

AFPs are based on numbers seen (CTAS data), and if physicians are less than diligent in the administrative task of "shadow billing," it will appear that our productivity has fallen, and this will translate into more cutbacks. Dreyer and colleagues suggest there are neither standards nor external monitoring of individual or group productivity, yet all organizations need monitoring and managers to function, and the government will develop systems to monitor individual and group productivity — information that will not be used to give doctors raises.

Many centres with AFPs have opened "walk-in" clinics, allowing them to practise FFS for low-acuity patients and AFP for sicker patients. This drives ED numbers down and, as a result, the AFP pool shrinks. In an AFP, emergency physicians will become lackeys of the government — motivated to please their employer rather than their patients.

The authors suggest that "cohesive groups" will find AFPs attractive, but I believe the converse is true: groups will be more cohesive if emergency physicians work independently. The more that individuals become aware of each other's workload, productivity and income, the more likely problems are to arise. Our system is in crisis not because of supply and demand economics (i.e., FFS), but because government has exercised too much control over the "supply side" of medicine. AFPs are just more of the same. Let's not jump on the bandwagon that promises nirvana.

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An apology to Dr. Nijssen-Jordan

The National Working Group on Triage would like to recognize Dr. Cheri Nijssen-Jordan as one of the contributing members involved in the development and publication of the Canadian Paediatric Triage and Acuity Scale (PaedCTAS) guidelines.[1] Dr Nijssen-Jordan has been a valued contributor to the development of the CTAS guidelines from the inception of the National Working Group.

We apologize for the error we made in inadvertantly excluding her from the list of members in the supplement.

Michael J. Murray, MD
Chair
National Working Group on Triage

Reference

1. Warren D, Jarvis A, Leblanc L, and the National Triage Task Force members. Canadian Paediatric Triage and Acuity Scale: implementation guidelines for emergency departments. CJEM 2001;3 (4 Suppl):S1-27.

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