concerns whether abortion is a medically necessary operation.

What happens, by and large, if a woman who has an unwanted pregnancy is denied an abortion? Her attitude changes dramatically from disappointment, perhaps desperation, to acceptance and often to love. It is no wonder many people question the provision of abortion on demand or without good medical reasons, and that others question it for moral reasons.

Abortion is both a moral and a medical issue, and we should not be surprised if people do not regard it as a necessary procedure in the same way they view other operations.

**Patrick G. Coffey**
Surgeon (retired)
Newcastle, Ont.

**Reference**

1. Eggertson L. Abortion services in Canada: a patchwork quilt with many holes. *CMAJ* 2001;164(6):847-9.

Your homey analogy of abortion as a patchwork quilt — a warm, comforting and maternal object if ever there was one — furthers the dishonourable tradition of euphemizing the medicalized killing of small human beings.[1] Most appealing, this is a quilt with holes — patching, perhaps before the fire with a kettle on for tea, is needed. Not easily would the reader suspect that an oppressive abortion-rights orthodoxy, with a paranoid determination to avoid straight talk about what abortion really is, seeks to stifle even the few pathetic remnants of resistance to this national tragedy.

CMA members remain deeply divided on these issues. An even-handed editorial and reporting style would show respect for this diversity of opinion.

**Will Johnston**
Secretary-Treasurer
Canadian Physicians for Life
Vancouver, BC

**Reference**

1. Eggertson L. Abortion services in Canada: a patchwork quilt with many holes. *CMAJ* 2001;164(6):847-9.

## No more eyeball jugglers, please

The art on the cover of the April 17, 2001, issue of *CMAJ* is distasteful. A collage purports to show a white man in a doctor's jacket juggling eyeballs and clocks. This is supposed to refer to an article concerning the Manitoba Cataract Waiting List Program.[1] This article does not mention anything about the technical aspects of cataract surgery. As far as I know, cataract surgery does not involve enucleation of the eye.

Rather than simple "art" showing dismembered body parts, I would prefer photographs of Canadian nature scenes, or a white cover with the table

of contents on it, à la *New England Journal of Medicine* or *The Lancet*.

**Robert Shepherd**
Family physician
Gatineau, Que.

**Reference**

1. Bellan L, Mathen M. The Manitoba Cataract Waiting List Program. *CMAJ* 2001;164(8): 1177-80.

## The stethoscope as a postural aid

I read with interest and amusement the paper by William Hanley and Anthony Hanley[1] and the subsequent comments by David Leak[2] and John Campbell[3] regarding the wearing of the stethoscope. My stethoscope has a rather heavy head end and when I carried it in the traditional (T, or U) manner I found it to exert undue pressure against one or other (or both) carotid sinus(es) when it slipped on my neck. Rather than wearing it draped around my neck in the cool (C) position, I carry it draped over my left shoulder, which I shall now call the S position. Benefits of this style are that it is seen from behind as well as from the front and it helps one maintain an erect posture.

**Edward A. Petrie**
Anesthesiologist
Fredericton, NB

**References**

1. Hanley WB, Hanley AJG. The efficacy of stethoscope placement when not in use: traditional versus "cool." *CMAJ* 2000;163(12):1562-3.
2. Leak D. The stethoscope at ease [letter]. *CMAJ* 2001;164(6):747-8.
3. Campbell JD. The stethoscope at ease [letter]. *CMAJ* 2001;164(6):748-9.

## Improving the quality of discharge summaries

In 1995, Carl van Walraven and Anthony Weinberg reported in *CMAJ* on the assessment of quality in a discharge summary system.[1] In a further report they noted that the quality of the reporting decreased as the length of the discharge summary increased.[2] We evaluated the discharge summaries of 1712 sequential patients discharged from the respiratory division of Tsukuba University Hospital between April 1992 and December 2000.

Chief complaints, medical history, hospital course and discharge diagnosis were documented in all of the discharge summaries. However, physical examinations were not completely documented in 10.5% of the summaries, significant laboratory tests in 9.9% of the summaries and discharge medications in 3.4% of the summaries. The discharge summaries of the 171 patients who died in hospital were less likely to be complete than those of patients discharged alive in the categories of physical examination (83.0% v. 90.3%, $p$ = 0.003) and significant laboratory tests (84.8% v. 90.7%, $p$ = 0.014). However, the discharge summaries of the patients who died in hospital were not shorter than those of the patients discharged alive (1.48 v. 1.43 pages, $p$ = 0.44).

For the records of patients who survived to discharge, summary length correlated significantly with completeness of reporting. The mean length of discharge summaries with complete reporting was 1.48 pages compared with 1.12 pages for summaries with incomplete reporting ($p < 0.001$).

We believe that discharge summaries should be routinely audited. This will ensure that problems with documentation are addressed and may improve completeness. It will also reinforce the importance of discharge summaries to physicians in training.

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**References**

1. van Walraven C, Weinberg AL. Quality assessment of a discharge summary system. *CMAJ* 1995;152(9):1437-42.
2. van Walraven C, Rokosh E. What is necessary for high-quality discharge summaries? *Am J Med Qual* 1999;14:160-9.

## Dysfunctional title

The report by Evangelos Michelakis and colleagues on erectile dysfunction was misnamed.[1] The title should have been "Sildenafil: from the bench to the bedroom"; I have never seen a case of acute or chronic erectile failure in a hospital.

**N.B. Hershfield**
Clinical Professor of Medicine
University of Calgary
Calgary, Alta.

**Reference**

1. Michelakis E, Tymchak W, Archer S. Sildenafil: from the bench to the bedside. *CMAJ* 2000; 163(9):1171-5.

## A missing candidate

A news item in *CMAJ* gave the names of physicians who sought a Commons seat in the Nov. 27, 2000, federal election,[1] but mine was missing from the list.

I was a candidate for the Progressive Conservative Party in the riding of Edmonton Southwest; I did not win the seat.

**Joseph T. Fernando**
General practitioner
Edmonton, Alta.

**Reference**

1. Sullivan P. Eight physicians elected to Commons. *CMAJ* 2001;164(1):80.