was an extremely sad woman who had no one to really listen to the expression of her emotions; we only listened to the physical expression of her symptoms. She gave gifts to her physicians and to the coroner and no doubt would have hoped that someone would have given her the gift of listening and trying to understand what her problem really was.

While reading and thinking about Amy, who was indeed a good teacher, I could not help remembering Balint's book, *The Doctor, His Patient and the Illness*.[1]

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Reference

1. Balint M. *The doctor, his patient and the illness*. New York: International United Press; 1957.

[The author responds:]

I thank my colleagues for their comments, but I think they have missed the point about how different this woman was. Perhaps it is easier to conclude that this was a traditional situation of a mentally ill person who was not really listened to than to admit that we do not have the ability to "fix" every patient we see. I find it illuminating that most people who knew this woman superficially, whether from reading about her or after a single consultation, felt that she was mentally ill. By contrast, those who came to know her well over time, who had established a relationship with her, were convinced she was eccentric but competent.

A few facts: this woman was listened to from the outset, and it is a disservice to her caregivers to suggest that they failed to use the "third ear." She was offered numerous opportunities for support and therapy, all of which she refused. (She went to the hematologist 3 times not of her own initiative but at the insistence of her physicians. Her choice of suicide site and time was designed to ensure that she would not be seen, but she was foiled when she was delayed until dawn by sleeping in.) There was no need to commit her involuntarily. She agreed to admission, where she spent several days under careful professional observation. Several options to suicide were presented to her, and again she made it clear that she was not to be dissuaded. The second psychiatrist who saw her considered all of the matters mentioned in the letters, and he disagreed with Dr. Watler's opinion.

I reject Watler's assertion that anyone refusing treatment with a "high therapeutic index" must be mentally ill. Such a statement neglects the critical importance of patient context and belief systems. People who refuse blood transfusions for religious reasons are not mentally ill, even when their decision does not seem rational when measured against our values. The right of individuals to determine their own choices, even if they seem to be bad ones, is well enshrined in law and ethics.

Yes, as many as 90% of suicidal patients have treatable psychiatric disorders. However, I believe Watler makes a mistake when he concludes that all suicidal people are therefore mentally ill. It is not that simple, and that is why I wrote Amy's story. I believe this woman did not follow the general rule: she was truly exceptional in the literal sense.

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Another look at those OECD numbers

Many variables affect the percentage of gross domestic product (GDP) that a nation spends on health care. It is useful that *CMAJ* published the most recent comparative data from the Organization for Economic Cooperation and Development (OECD) ("Where do we stand in the OECD?," *Can Med Assoc J* 1997;156:464, by Lynda Buske), since these are often used in discussions. However, the variations may depend on a country's priorities and on factors such as levels of remuneration of physicians, nurses and hospital administrators.

It seems valid to compare the broad political approach to the organization of health care. From the data provided, it is apparent that countries with a greater ratio of public to private expenditure also have a lower total expenditure as a percentage of GDP. This supports the National Forum on Health's recommendation of a universal drug program and its belief that this will reduce overall costs.

It does not make sense for the author to relate the variation in health care expenditure between Canada and the United Kingdom to the mistaken belief that physicians in the UK bill 10% of their revenue privately or that Canadian legislation outlaws private insurance. According to the CMA's own research, published in *Canadian Health Care in the Global Village* (August 1995), this is incorrect.

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Debate over dexfenfluramine

In her letter "Weighing benefits and risks of drug to treat obesity" (*Can Med Assoc J* 1997;156:768-9), Sana R. Sukkari reiterates the risk of primary pulmonary hypertension (PPH) that may result from long-term use of appetite suppressant drugs, reported in the epidemiologic study by Abenhaim and associates.[1]