shifted to how best to address this serious problem.

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Justifying the procedure

Rates of coronary artery bypass grafting (CABG) are easier to define than are ideal rates. For example, in "Coronary artery bypass grafting in Canada: What is its rate of use? Which rate is right?" (*Can Med Assoc J* 1992; 146: 851-859) Dr. C. David Naylor and colleagues document the extension of CABG to the elderly, but the supplied references provide scant support for the use of CABG in this group.

Unfortunately, the information justifying these procedures seems to be arriving less quickly than changes in the disease itself. Strains on our health care system arise from the gradual extension of validated procedures into areas of less certain benefit, a process that leads inevitably to utilizations clearly inappropriate compared with other demands on the societal purse.

However, the core problem is far deeper. The authors "do not know whether high CABG rates are associated with low rates of death from coronary artery disease." Either CABG and other aggressive coronary interventions prolong life or they don't. If they do, then consideration must be given (and has not been) to a risk-benefit analysis of the intervention in those people who otherwise would have died as their heart disease progressed or other conditions both more debilitating and more costly (cancer or dementia, for example) developed.

The relative weighting of values that would be necessary to conduct this analysis has not been made explicit. It is now estimated that the complete eradication of ischemic heart disease, the most frequent cause of death in North America, would prolong life expectancy from birth by only 3.0 years for women and 3.5 years for men.[1] If this is true a risk-benefit analysis is essential, especially for elderly people, whose death is closer.

On the other hand, if CABG does not prolong life, then we may well ask how the quality of life in the elderly compares with education, environmental protection or welfare. No accepted scale of relative weighting will arise from a consensus of practising physicians.

Because of its prevalence heart disease cannot be studied in isolation. Diverting very large sums toward one disease will inevitably produce wide-reaching consequences, and the decision to do so is ultimately political. Given the uncertainty that surrounds the issue I am unmoved by the admonition that regional variation in CABG should be discouraged. It is disappointing that variations are not better studied, but that they are not is largely because they are uncontrolled. It seems anomalous that a society whose well-being stems largely from the scientific method should spend so little effort in validating the results of political decisions or in acquiring, through the political process, the information needed to spend public resources intelligently. I suggest that some efforts be devoted to developing a field of "legislative epidemiology."

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[The authors respond:]

We thank Dr. Turnbull for his interest. We share his frustration with haphazard approaches to health care policy making. We would recast his core argument as follows:

1. The incremental benefits of CABG over medical therapy for symptomatic coronary disease in the elderly have not been rigorously evaluated in a clinical trial.

2. If CABG does prolong life for the elderly, matters are nevertheless more complicated than in, for example, middle-aged people. This is because the elderly may be briefly spared death from coronary disease only to meet a more protracted demise from cancer or dementia.

3. If CABG works primarily to improve the quality of life among older people, then we need to consider competing investments in other measures that might improve quality of life, either for the elderly or for society in general.

4. Such broader evaluations — be they of "quality of