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## FAREWELL TO "BARTS" IS PREMATURE

I read Caroline Richmond's premature obituary for St. Bartholomew's Hospital, London, England, (*Can Med Assoc J* 1995; 152: 1129-1130) with some annoyance at its insensitivity and inaccuracy. Such inaccuracy is disconcerting, especially when the writer lives in England and is in touch with the pulse of the press and people.

"St. Bart's" is the oldest on-site hospital in the world. It was founded in 1123 and failed to close during the peasant revolution, the fire of London or the Blitz, when the whole city was ablaze. In fact, during the great fire of London in 1660, the city was nearly destroyed and St. Bartholomew's had been given up, but the wind turned just as the flames licked the walls of the hospital, and the fire was blown away. A small statue stands at the site where the flames were repelled.

The present attempt at closure is being spearheaded by the British minister of health, Virginia Bottomley, who was savaged in the House of Commons for her proposal, based on yet another government report.

It is true that the emergency de-

partment has been closed and its gates padlocked. (The government leaves little to chance.) With the horrendous traffic in London at rush hour, a person having a heart attack would die of old age before reaching one of the peripheral hospitals. The closure also removes emergency protection should a terrorist attack occur at one of the many world-class functions and ceremonies held in the city.

However, I am optimistic that Richmond's grim prognosis is incorrect, for several reasons. Even if Bottomley is not shuffled to a less medically destructive ministry, the results of local elections will indicate that the government is about to change, and the socialist government has pledged to keep this hospital, which has always provided universal care to pauper and prince alike, alive.

Any physicians who feel strongly about the proposed closing of St. Bart's may contact me at the address below.

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## PRESCRIBING FOR ELDERLY PEOPLE IN NB: WHERE DO THE FIGURES POINT?

Dr. Warren Davidson and his associates ("Physician characteristics and prescribing for elderly people in New Brunswick: relation to patient outcomes," *Can Med Assoc J* 1995; 152: 1227-1234) claim that general practitioners in New Brunswick whose patients had high rates of mortality, morbidity or hip fracture also prescribed more drugs, were more likely to be male, had larger practices, saw more patients per day, billed more and tended to be younger than physicians whose patients had lower rates of these outcomes. They infer a causal link between these factors and the outcomes for their patients.

Davidson and associates divided physicians who had written more than 200 prescriptions annually for elderly people into quartiles and compared their performance and practice characteristics.

Their statement that those with the highest rates of morbidity, mortality and hip fracture among their patients prescribed the most drugs appears to be true, although the difference is not very striking, and it is

not surprising that physicians treating sicker people needed to prescribe more drugs. If we compare the behaviour patterns of the physicians, the authors' conclusions apply only when the upper three quartiles are compared with the lowest quartile. Among the 75% of physicians in the top three quartiles of patient mortality, morbidity and hip fracture there is remarkably little difference.

Table 1 summarizes the practice characteristics for physicians in these quartiles. In many cases, the practice characteristics do not have the highest values among physicians in the

highest quartile, as one would expect, but among those in the second or third quartiles.

The differences among the top three quartiles are so small that one wonders whether the low quartile is abnormal in some way. We are told that every physician who wrote more than 200 prescriptions for elderly people was included. However, 200 prescriptions is a very low number, suggesting that some of the physicians included in this study saw very few elderly people. It is possible that the lowest quartile is not a comparable group.

Therefore, the figures presented

in this article do not support the claims of the authors.

Barry R. Wheeler, MD  
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**[The authors respond:]**

In our study results we claim that there is a relation between health outcomes and physicians' characteristics and prescribing habits. We suggest as possible explanations for this relation that sicker patients are aggregated in the same practices or that physicians' prescribing practices make their patients sicker.

Dr. Wheeler disagrees with the proposed mechanisms to explain this relation. He criticizes our inference of a possible causal link between health outcomes and physicians' characteristics and prescribing habits, contained in our statement that "our results most probably reflect a combination of patient and physician variables." He then infers that the relation we demonstrated is explained by the fact "that physicians treating sicker people needed to prescribe more drugs." As we suggested in another response to Wheeler (*Can Med Assoc J* 1994; 151: 142,144), if these physicians were seeing much sicker patients, we would expect them to take more time to examine their patients and develop a therapeutic plan, therefore resulting in a lower number of visits per day. This pattern never emerges, and we are left to speculate that these sicker patients do not get the attention they need or that they are aggregated in the lower quartile (which is obviously not the case).

We are not the first researchers to suggest that elderly people are subject to inappropriate prescribing. The literature is also clear about the problem posed to elderly people by such inappropriate prescribing.

We are puzzled by what Wheeler means by saying that the relation between health outcomes and the num-

**Table 1: Practice characteristics of general practitioners in New Brunswick who wrote more than 200 prescriptions for elderly people**

Physician practice characteristic; health outcome on which quartiles are based	Physician quartile by rate of health outcome			
	First	Second	Third	Fourth
<b>Mean no. of patients in practice</b>				
Mortality	1862	2587	2318	2130
Morbidity	2175	2319	2274	2143
Hip fracture	1833	2434	2522	2123
<b>Mean no. of practice days per year</b>				
Mortality	200.8	208.8	200.9	210.2
Morbidity	202.0	211.1	203.6	204.6
Hip fracture	186.9	216.8	209.5	207.5
<b>Mean no. of visits per day</b>				
Mortality	21.9	25.9	25.1	26.0
Morbidity	23.8	25.1	25.6	24.3
Hip fracture	22.3	26.0	25.3	25.1
<b>Mean no. of services per day</b>				
Mortality	31.3	37.6	37.9	35.6
Morbidity	32.7	36.9	37.0	36.8
Hip fracture	32.2	36.1	38.7	37.3
<b>Mean no. of visits per year</b>				
Mortality	4772	5768	5263	5671
Morbidity	5311	5632	5403	5163
Hip fracture	4634	6051	5505	5289
<b>Mean billings per patient, \$</b>				
Mortality	65.9	64.2	68.3	73.9
Morbidity	65.1	64.6	65.9	76.6
Hip fracture	68.1	67.1	65.8	71.2
<b>Mean billings per year, \$</b>				
Mortality	117 930	160 001	152 045	153 989
Morbidity	130 061	150 559	148 638	155 301
Hip fracture	120 086	160 529	155 944	147 885