

the 1996 Panel on Cost-effectiveness in Health and Medicine endorsed its use.⁴ Reporting “outcomes in natural units,” as McGregor suggests, detracts from the goal of developing an ideal measure incorporating both quantity and quality of life.

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References

1. McGregor M. Cost-utility analysis: use QALYs only with great caution [editorial]. *CMAJ* 2003; 168(4):433-4.
2. Gold MR, Siegel JE, Russell LB, Weinstein MC, editors. *Cost-effectiveness in health and medicine*. Oxford: Oxford University Press; 1996.
3. Sackett DL, Straus S, Richardson S, Rosenberg W, Haynes RB. *Evidence-based medicine: how to practice and teach EBM*. 2nd ed. London: Churchill Livingstone; 2000.
4. Weinstein MC, Siegel JE, Gold MR, Kamlet MS, Russell LB. Recommendations of the Panel on Cost-effectiveness in Health and Medicine. *JAMA* 1996;276:1253-8.

[The author responds:]

I regret that I cannot accept Christopher Chong's “challenge,” which is based on a misinterpretation of my commentary.¹ Nowhere did I argue that “because the quality-adjusted life-year (QALY) has ‘severe limitations’ it is not useful for cost-utility analyses.” Of course it is useful. My argument is rather that those severe limitations must be well understood by any decision-makers who would use the QALY in making health policy decisions.

There is no dispute that estimates of utility vary according to how and from what viewpoint they are made. My point is that if such estimates are to be used in health policy decisions, this variability must be understood by the decision-makers. Most decision-makers would probably be astonished to learn that utility is not a constant unit of measurement and that it can only validly be used to compare one health option with another when the health preferences have been estimated by the same method and from the same viewpoint.

As for there being no difference between comparing cost-effectiveness ratios and “using league tables based on number-needed-to-treat to evaluate the clinical effectiveness of interventions,” the issue is again the extent to which the decision-makers understand the units of measurement they are employing. I suspect that clinicians understand the index number-needed-to-treat far better than health care administrators understand utilities and QALYs.

And of course I agree that we should continue to try to develop “an ideal measure incorporating both quantity and quality of life.” But if the imperfect measurements that we have developed up to this time are used in health policy decisions, the imperfections must be acknowledged and understood by the users.

Maurice McGregor
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Reference

1. McGregor M. Cost-utility analysis: use QALYs only with great caution [editorial]. *CMAJ* 2003; 168(4):433-4.

Why choose ophthalmology?

In a “Pulse” article earlier this year,¹ Patrick Sullivan hypothesized that “Because the number of call hours can seriously hamper family and other activities, it is probably no coincidence that specialties with less onerous call schedules, such as dermatology and ophthalmology, tend to be oversubscribed in annual residency matches.” However, he presented no statistical information to justify this theory.

In the CMA's annual Physician Resource Questionnaire for 2002,² only 40 ophthalmologists were surveyed. Of these, approximately 20% had more than 180 hours of call per month;² this is only slightly less than the 25% of surgical specialists with this level of call reported by Sullivan.¹

According to statistics from the

Canadian Resident Matching Service, the ratio of the number of applicants whose first choice of specialty was ophthalmology to the number of spaces available was approximately 2:1 for 1998 to 2002.³ Cardiac surgery, diagnostic radiology, emergency medicine, plastic surgery and dermatology had similar ratios over the same period. Yet the on-call duties of the first 4 specialties in this list are also onerous, at least from what we have observed in our centres. The “oversubscription” Sullivan describes is therefore more likely a result of the number of residency positions in the smaller specialties being too low in relation to societal needs.

We suspect that the popularity of ophthalmology is determined by a variety of factors, such as interest in the specialty, advances in treatment, and perceived benefit to patients and society, rather than on-call duties.

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References

1. Sullivan P. On-call duties total over 7.5 days a month for 25% of surgeons. *CMAJ* 2003;168(1):80.
2. Martin S. More hours, more tired, more to do: results from the CMA's 2002 Physician Resource Questionnaire. *CMAJ* 2002;167(5):521-2. Tabular data available: www.cmaj.ca/cgi/content/full/167/5/521/DC1 (accessed 2003 Apr 29).
3. *CaRMS Statistics: archives of match statistics*. In: Canadian Resident Matching Service Web site [Internet]. Ottawa: The Service; 2002 Apr 25. Available: www.carms.ca/stats/stats_index.htm (accessed 2003 Apr 30).

Correction

Dr. Douglas Cram¹ of London, Ont., was predeceased by his wife, Madeline. Because of an editing error, incorrect information appeared in a recent death notice.

Reference

1. Deaths. *CMAJ* 2003;168(9):1223.