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

death" (point 2) or "quality of life" (point 3) — cannot be made on clinical grounds by consensus panels but instead require broad societal input.

We agree with these arguments but not with some other points in Turnbull's letter.

The references we gave were not intended to justify the use of CABG in elderly patients. On the contrary, we highlighted the fact that the rates of death and disability associated with the procedure are higher in the elderly. There is also a high prevalence of symptomatic coronary disease in such people, with triple-vessel stenosis or left-mainstem stenosis or both. These are anatomic patterns of coronary disease for which the life-prolonging benefits of revascularization are well established; the relief of symptoms is surely a legitimate goal of treatment for any age group. The issue is whether, for the elderly, the benefits of CABG outweigh the risks. Obviously, for those patients who are subjected to surgery, clinicians believe that they do. Our own sentiments are to call not for more randomized trials but, rather, for more informed consent. We think that some elderly people would be less enthusiastic about the surgical options if they worked through a personalized decision aid that profiled the outcome states, risks and benefits of CABG.

Because of the "uncertainty that surrounds the issue" Turnbull is "unmoved" by our suggestion that rate variation in CABG is undesirable. This implies, without any evidence, that rate variation is entirely attributable to practitioner and patient uncertainty. Turnbull also says that the reason variations are not better studied is largely because they are uncontrolled. We argue the opposite. Supply-side management measures can never "control" practice variations without assessing first why those variations exist and second what utilization patterns are justifiable on the basis of evidence, economic factors and patients' preferences.

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## Canadian medicare: view from Utopia

In his reply (*Can Med Assoc J* 1992; 146: 674, 676) to Drs. Malcolm G. Munro and Howard L. Tanenbaum (*ibid:* 674) Dr. Bruce P. Squires unfortunately fails to answer the question that most people are asking: What is the use of so-called universal insurance if the coverage so obtained cannot purchase good medical care?

Some might say that the money was spent on new roads, countless committees, large salaries for bureaucrats and politicians and endless royal commissions to find out why our medical services have deteriorated so rapidly and so tragically. This is all true, but the real reason is that what are now called "collusive interest groups" have ordained the expenditure of money that should only have been spent according to the decisions of patients and their physicians.

As to the claim by some government statisticians that Canadians pay less than Americans for health care, one would indeed hope so given the kind of care that Canadians get a lot of the time.

The raw statistics on longevity and infant death rates do not provide a true comparison between the United States and Canada, because such factors as racial mix, climatic conditions and the pace of life have never been allowed for.

One thing is certain: Britain and Europe are finding that the adaptability and responsiveness of the free enterprise system is encouraging them to progressively abandon various socialized schemes in medicine.

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The loyalty of Drs. Munro and Tanenbaum to the US health care system is alarmingly blinkered. They appear not to have heard or read of anti-Canadian propaganda in the media and national press. There are considerably more negative sentiments about the Canadian health care system by US physicians, the American Medical Association and leading politicians and journalists than there are anti-US criticisms.

In his campaign for the presidential election President Bush made adverse comments about the Canadian health care system and stated that British Columbia had a long waiting list for coronary artery bypass surgery. This is true, but several medical experts on the Feb. 6, 1992, *Nightline* television program about the health crisis in the United States said that there were more deaths among US patients who had had coronary artery bypass surgery than among the Canadian patients who were awaiting surgery in British Columbia.

The Democratic presidential contender Paul Tsongas remarked that "if I had been in Canada when I got cancer, I might not be here today, because the research that was being done, very experimental, was here" (*Toronto Star*,