drawal practices in a situation that should not have been initiated and supported in the first place. The publication of an article such as this one, upholstered with a sufficiency of the elegant though irrelevant algebra that so delights editors, may still do some good if it leads to action against bad medical practice and waste. Is nobody minding the shop?

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I commend Lucie Baillargeon and colleagues[1] for conducting their important and challenging study on discontinuation of benzodiazepine therapy in elderly patients. However, I have concerns about the control group, as described in the report. The physicians of patients whose benzodiazepines were gradually withdrawn in the control group "were not permitted to give advice on nonpharmacological treatments of insomnia."[1] Given the effectiveness of such interventions for chronic insomnia in older people,[2,3] it is not surprising that cognitive–behavioural therapy combined with drug tapering was found to be superior to benzodiazepine withdrawal alone. What this study does not establish is whether cognitive–behavioural therapy is better than standard care, which would include, at a minimum, advice on sleep hygiene.[2]

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Cat naps

Sheldon Singh and associates[1] conclude that their patient's symptoms of presyncope "may have been due to the weight of her cat on her right carotid sinus." However, they report that multiple pauses of 3–4 seconds' duration, associated with vomiting and syncope, were observed while the patient was in the emergency department, without the cat.[1]

Hypersensitive carotid sinus syndrome (as diagnosed in this patient) and severe sick sinus syndrome commonly occur together. The superiority of dual-chamber, atrially based pacing of these patients has been demonstrated in VVI (ventricular demand pacing) to DDD (fully automatic pacing) crossover studies.[2] In addition, the British Pacing and Electrophysiology Group has recommended selecting a pacing mode with as many features of normal sinus rhythm as possible,[3] and Moller and colleagues[4] demonstrated that prescribing relatively contraindicated[3] products for older patients represented a false economy.

In the case reported by Singh and associates,[1] a single-lead (ventricular) pacemaker was inserted. Thus, the patient would be wise to keep the cat off her neck in future because she has been given an inferior device, activation of which can sometimes be severely vasodepressive in patients with retrograde conduction. The statement by Singh and colleagues[1] that "cardiac pacing is … not [helpful] for those [patients] with vasodepressor response" relates primarily to use of ventricular pacing; in contrast, many patients with severe hypotensive syndromes can be rendered more or less asymptomatic if they are given a device with high-rate, dual-chamber pacing response to the associated sudden drops in heart rate.[5]

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Sustainability of health care in Canada

Morris Barer and colleagues[1] set out to "ascertain whether there is more than just rhetoric" behind claims that the Canadian health care system is unsustainable. Although their interpretation does not specifically confront this stated objective, they imply that the system is sustainable. I do not believe their data support this conclusion.

The authors' statement that "the combined effects of population growth, aging and general inflation . . . were virtually identical to the overall increase in physician expenditures"[1] is misleading. Physician fees declined by 9.4% in real terms during the years studied,[1] and fees were the only inflation-sensitive measure of the study. The increase in expenditures was therefore not an "effect" of inflation; rather, the effects of increased utilization were compensated for by the decline in real value of physician fees. Putting aside the important issue of whether this situation is equitable, it clearly is not sustainable:

physician fees cannot decline in real terms indefinitely.

More important, the authors' data do not penetrate the effects of financial restraint on quality of care, a fact that they themselves point out.[1] But this issue is the very crux of the perceived health care crisis. What happened to waiting lists for referrals, surgery and diagnostic tests? How were health outcomes affected? Is it appropriate to assume that age- and population-adjusted fee expenditures *should* remain the same (in real dollars) over this time period? Moreover, physician fees account for only 24% of health care spending in British Columbia;[2] if there is a funding crisis, physician fees are only a small part of a larger problem.

A sustainable system must both control costs and provide appropriate health care. Barer and colleagues establish that the government of British Columbia controlled costs, but they do not establish that it did so in a sustainable manner.

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[Three of the authors respond:]

We strongly support Mark Fruitman's point that "[a] sustainable system must both control costs and provide appropriate health care." Our purpose[1] was to identify the key components in physician billings as a means of isolating both what was and what was not happening. The observation of major changes in the patterns of contact between patients and general practitioners is, we think, quite new: we found that GPs are increasingly sharing their patients, yet the net impact on costs is minimal. It appears that neither patients nor physicians are abusing the system or, if they are, that abuse has not been increasing. This situation might raise concerns about continuity of care, but such concerns take us beyond these data.

In contrast, the care of elderly patients after they pass the GP "gatekeeper" and enter the specialty system is much more expensive. As Fruitman points out, our data cannot say whether these dramatic increases in cost are appropriate. But if one is truly concerned about both the appropriateness and the cost of care, these sectors and this patient group would seem obvious places for further scrutiny.

Fruitman suggests that our conclusion regarding sustainability had its basis in costs for physicians, whose real fees declined over the period in question. But even if fees had increased at the rate of inflation, the average annual increase in expenditures would have been 6.8% rather than 5.8%, hardly enough difference to support claims of "unsustainability." Furthermore, this calculation presumes that the change in (age-specific) utilization per capita would have been the same, irrespective of the change in real fees. It seems conceivable that faster growth in fees would instead have been associated with slower growth in utilization — the fact that the increase in use almost precisely offset the decline in fees may be more than coincidence. In any case, physician fees in British Columbia have been the highest, or among the highest, in the country for decades.

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Reducing adverse events

Further to the landmark work of Alan Forster and coauthors[1] at the Ottawa Hospital–Civic Campus in identifying levels of adverse events at discharge and revealing the extent of the gap in continuity of care, particularly drug management, I wish to point out measures that have been taken in this region to diminish the problem.

In 1995 a group of Ottawa-area health care professionals — hospital and community pharmacists, physicians and a nurse — gathered to promote solutions to the gaps in seamless care.[2] We recommended 2 major innovations: pocket drug profiles to be used by community pharmacists for patients receiving long-term medication, as well as formal discharge communications from the hospital to the family physician and the community pharmacist. The latter recommendation was instituted the next year at the Ottawa General Hospital (now the Ottawa Hospital–General Campus) in a form called "Prescription and Discharge Notes," which provided complete information on discontinued medications, medication incidents and recommendations for ongoing care. A pilot project was instituted on a surgical floor, and a chart review followed. The review indicated that on average half of each patient's medications were changed before discharge and that potentially 61% of the discharge forms reported drug-related problems, only half of which were resolved before discharge.[3] A later study on a medical floor showed an even greater number of changes and potential drug-related problems.[4]

This form has now been updated and its use extended to the Civic Campus and to other institutions. A further study showed that use of the form on the medical ward of a Montreal hospital increased the accuracy of patient profiles maintained by community pharmacists.[5] It would be interesting to determine if this form makes a difference in the negative outcomes that Forster and coauthors[1] so clearly identified.