

With regard to the second question, in the study by Caro and colleagues² the largest absolute difference in non-persistence was between thiazides and angiotensin-converting-enzyme inhibitors: 9% at 6 months and 13% at 4.5 years. Would this small difference in compliance lead to a difference in morbidity and mortality? We believe it is highly unlikely, and randomized controlled trials would be required to answer this question. It is important that doctors not be fooled into thinking that observational studies measuring compliance are a substitute for randomized controlled trials that are designed to be generalizable and to measure clinically important outcomes.

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Why aren't we falling for anticoagulant therapy?

In his editorial regarding the reasons why so many eligible patients with atrial fibrillation are not receiving anticoagulant therapy,¹ Stuart Connolly suggests that anticoagulant therapy is contraindicated in elderly patients with a history of falling. A recent study² demonstrated that for the risks of anticoagulation to outweigh its benefits, the average elderly person must fall approximately 300 times in 1 year; the study concluded that the risk of falling is not an important factor in the decision about whether to offer antithrombotic therapy to elderly people with atrial fibrillation.

Connolly focuses on patient factors involved in the lack of appropriate use

of anticoagulants, but physician factors may be just as important. Treatment of patients with warfarin is a time-consuming, poorly remunerated aspect of clinical care, requiring multiple phone calls from the laboratory and contacts with the patient to explain dose adjustments. This may help to explain why physicians seek reasons (including a predisposition to falling) not to offer warfarin therapy to eligible patients. Before this care gap can be closed, both patient and physician factors need to be addressed.

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[The author responds:]

Malcolm Man-Son-Hing draws attention to 2 interesting factors related to underuse of anticoagulant

therapy in patients with atrial fibrillation. Anticoagulant therapy is inconvenient both for physicians and for patients. To my knowledge, there is little information about the factors that influence physician decisions to prescribe (or not prescribe) anticoagulant therapy for atrial fibrillation. Large anticoagulation services are available in many urban centres, and many of these accept referrals from physicians. This reduces the burden of caring for these patients. It would be interesting to know whether anticoagulant therapy is more readily prescribed in such areas. Would the wider availability of such a service increase anticoagulant use in atrial fibrillation?

Man-Son-Hing also draws attention to his recent analysis of the relation be-

tween anticoagulant therapy for atrial fibrillation and risk of falling among elderly people. His Markov decision analytic model suggests that the benefit-risk ratio favours using anticoagulant therapy even in elderly patients who are at high risk for falling. The reliability of decision modelling (based on literature review) is only modest. In the absence of randomized trial data pertaining to this issue, I would remain cautious about prescribing anticoagulant therapy in elderly patients with a history of repetitive falling.

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Fear and loathing of tuition fees

I applaud Brian Cummings for identifying some of the most important issues surrounding resident tuition fees.¹ Although I understand that universities are experiencing chronic underfunding, this is no justification for the attempt at a cash grab from the newest members of the medical profession.

What will the universities offer us in exchange for this monetary outlay? Will they pay the interest on our student loans? Can they even guarantee that repayment or interest on those loans will be deferred (given our status as students)? Are they prepared to reimburse us fairly for the teaching that we do?