ers that all surgeons involved in our study were affiliated with regional cancer centres, and thus waits among their patients may not be representative of waiting times for all patients across Ontario.

Marko Simunovic
Departments of Surgery and Clinical Epidemiology and Biostatistics
Faculty of Health Sciences
McMaster University
Hamilton, Ont.

Reference

1. Simunovic M, Gagliardi A, McCready D, Coates A, Levine M, DePetrillo D. A snapshot of waiting times for cancer surgery provided by surgeons affiliated with regional cancer centres in Ontario. *CMAJ* 2001;165(4):421-5.

Bedside rationing

To implement bedside rationing as described in Peter Ubel's *Pricing Life: Why It's Time for Health Care Rationing*[1] would most certainly set medical ethics back 2500 years by ignoring the issue of patient trust, which gave rise to the traditional Hippocratic oath. The fundamental unit of health care is the physician–patient relationship. For physicians to knowingly withhold beneficial services from patients to promote the financial interests of others (or of themselves) would introduce suspicion into that relationship, further subjectivize the practice of medicine, and increase the power disparity between physician and patient. What patient wouldn't question the physician's commitment under such circumstances?

Should rationing ultimately become necessary, then bureaucrats must impose it broadly, at the system level, for the sake of maintaining consistency across the population and of minimizing physician conflict of interest. Patients must also have the option of obtaining services privately. Before Hippocrates, the sick could never be certain of their physicians' motives or competing interests, but generations since have enjoyed the peace of mind that comes from the physician's pledge to do no harm. Bedside rationing would undermine this precious gift that has protected us all.

W. Joseph Askin
Family physician
Calgary, Alta.

Reference

1. Hurley J. Cost and effect [book review]. *CMAJ* 2001;165(8):1073-4.

Reporting the clinical importance of randomized controlled trials

Karen Chan and colleagues address how well reports of randomized controlled trials discuss the issue of clinical importance.[1] We agree with these authors and others[2,3] that clinical importance needs to be discussed in the report of any randomized controlled trial.

Chan and colleagues defined clinical importance using 10 dimensions, such as an explicit statement of the primary outcome. We are surprised that they state early in their article that the CONSORT statement "failed to recommend specifically that authors discuss the clinical importance of their results." Perhaps they have not completely read the CONSORT statement[4] and its accompanying explanation and elaboration paper,[5] which definitely draw attention to this important issue. For example, item 6 of the CONSORT checklist explicitly recommends that authors of randomized controlled trials report "clearly defined primary and secondary outcome measures."[4] Moreover, the explanatory paper is clear about the relevance of clinical importance: "The difference between statistical significance and clinical importance should always be borne in mind. Authors should particularly avoid the common error of interpreting a nonsignificant result as indicating equivalence of interventions. The confidence interval (item 17 of the checklist) provides valuable insight into whether the trial result is compatible with a clinically important effect, regardless of the *P* value."[5]

The CONSORT statement is an