CAM and conventional therapies; rather, there are only therapies that either work or don’t work. The reality is that scientifically oriented physicians accept a lower standard of evidence for adopting a therapy they consider scientifically plausible.

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References

CMAJ on the Web

The article on diagnosing and treating diabetic ketoacidosis and the hyperglycemic hyperosmolar state was very informative. I especially appreciate the fact that neither a subscription nor membership in the Canadian Medical Association is required to download articles from the CMAJ Web site. This is helpful to those of us who are unable to subscribe to the journal.

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Reference

[The authors respond:]

We disagree with Maurice McGregor’s suggestion that the real cause of the uncontrolled growth in expenditures of the Ontario Drug Benefits Program (ODB) is the belief on the part of the program’s administrators that their resources will not be limited. McGregor’s letter indicates confusion between the case of unlimited resources and the case in which resources are allowed to grow. In a world with unlimited resources, there is no scarcity and thus choices need not be made between different programs (i.e., there are no opportunity costs). In this situation, maximizing total health improvements requires only information on effectiveness; no information about costs is needed. In contrast, in the situation where program resources (such as those for the ODBP), even if scarce, are allowed to increase, choices will be needed: the additional resources must be taken from elsewhere, and those resources are insufficient to support all new interventions. Contrary to McGregor’s claim, the information provided by the incremental cost-effectiveness ratio (ICER) is insufficient to identify the efficient use of additional resources (see Appendix 1 to our commentary). Only by considering opportunity costs can the “best value for those resources” be determined.

McGregor’s assessment that ODBP administrators believe that resources “will, in fact, not be limited” is not supported by evidence. In his description of the decision-making process of the ODBP, Laupacis stated, “Given that resources for health care are limited, it seems sensible . . . that cost-effectiveness is the main criterion used to determine which drugs are reimbursed from the public purse.” Administrators were led to believe that selecting programs on the basis of ICER values would maximize total health improvements from whatever resources were made available. Decision-
Relative risks or odds ratios?

I was surprised that in an article concerning risks of waiting for cardiac catheterization, written by specialists in clinical epidemiology, the same results are reported as relative risks (in the abstract and the Results section of the paper) and as odds ratios (in Table 5). Given that these data were generated by multivariate analysis, I suppose that the values are odds ratios, as stated in Table 5. However, with regard to the results of the univariate analysis, which are presented only in Table 5, I'm uncertain what the numbers represent. They might be odds ratios, as stated; however, because the report describes a cohort study, relative risks should have been given.

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References

[Two of the authors respond:]

Cristian Baicus is correct in pointing out the inconsistency in terms in our article. We intended to refer to relative risks in all instances. The type of analysis (univariate or multivariate) would not determine the type of value generated.

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Correction

Letters

Pharmacia
Arthrotec
1/3 page, 4clr.

Repeat of April 29, 2003, page 1143