was a more reliable reflection of the true intravascular diastolic pressure as determined by invasive techniques, and other data favouring the phase V sound.

There is little doubt that the Korotkoff phase IV sound is subject to greater interobserver and intraobserver variability than the phase V sound,[5] but the latter may occasionally be falsely low.[6] Although diastolic pressure measurements as determined by the phase IV sound may be 5 to 8 mm higher than those determined by the phase V sound,[5] the difference is reduced in hypertensive states of pregnancy.[7]

Faced with a lack of reliable data to support adopting either the phase IV or the phase V sound, the members of the consensus group felt that the phase IV sound, by virtue of its being slightly higher than the phase V sound, might offer a wider margin of safety in initiating surveillance for the possible complications of hypertensive disorders of pregnancy. Most societies and interest groups, as well as many leading authorities in the study of hypertension, have recommended using the phase IV sound to determine diastole in pregnancy.

Recommending that clinicians record both sounds is not an original idea. The American National High Blood Pressure Education Program Working Group on High Blood Pressure in Pregnancy[8] recommended that both sounds be recorded.

Canadian research in this area is urgently needed. Our recommendations will be revisited in the future, especially when more evidence becomes available.

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Resource allocation and the Code of Ethics

In the article "Bioethics for clinicians: 13. Resource allocation" (*Can Med Assoc J* 1997;157[2]:163-7), Dr. Martin McKneally and colleagues state "The clinician's goal is to provide optimal care within the limits imposed by the allocation of resources to health care generally and to the institution, program and specific situation in which an individual patient is treated." Any physician who follows this advice would violate the CMA's Code of Ethics, the first canon of which is "Consider first the well-being of the patient."

The concept of resource allocation also raises the question of the fundamental nature of medicare in Canada. If we have state medical care, then despite the Code of Ethics one could possibly support McKneally's thesis. However, if we have medical care insurance, then the thesis is unsupported. Furthermore, in Saskatchewan we know that the coverage for physician services is insurance and not state medicine. A judicial ruling has said so.

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[One of the authors responds:]

Dr. Baltzan raises the central issue in resource allocation that troubles every caregiver. Does the physician's fiduciary obligation, expressed in the CMA canon discussed by Baltzan, require us to "do everything that may benefit each patient without regard to costs or other societal considerations"?[1] Can we simultaneously ignore the potential harm to other patients, including some we ourselves will be forced to treat suboptimally because of our earlier expenditure of finite resources? Our answer to both questions is No.

"Consider first the well-being of the patient" is a prima facie principle, one that provides sufficient moral guidance *at first view*, unless it is refuted or modified by other relevant facts, principles or contextual features. Just as we reluctantly harm patients when we perform a venipuncture to achieve a necessary benefit, we must reluctantly limit the allocation of resources to our individual named patients because the overall good of the community requires us to participate justly in the allocation of its resources. Morreim[2] has argued persuasively that physicians can generously dispense what is theirs to control and to give: their knowledge, care, skill and diligence. However, they must turn to society for dispensation of technological and other costly resources. Physicians are not members of a special class that has the right to allocate resources that they do not own and

that are beyond their control.

The vision of the physician–patient relationship unrestrained by considerations of cost or the needs of others has not been the traditional view of prudent medical practitioners over the centuries. It is an aberration of the North American economic expansion following World War II, when relatively less expensive but increasingly effective treatments developed in an economy that could afford to distribute them liberally (Dr. Laurenc B. McCullough, Baylor College of Medicine, Houston: personal communication, 1997). The economic, social and technological characteristics of that era no longer apply, and we intensify the moral distress of physicians unwisely when we imply that patient care can now be viewed as unconstrained by finite national, provincial or institutional resources.

The second issue raised is whether the nature of the reimbursement system changes the way physicians should approach the allocation of health care resources. It does not. Insurance coalitions, however they are constructed, create a pool of fiscal resources to help defray the cost of various misfortunes, including illness. Because of the continuing expansion of expensive and effective treatment technologies, and the increasing age and needs of the beneficiaries, no system of payment for health care can accumulate sufficient wealth to eliminate the need for physicians to manage resources prudently. Physicians' participation in the moral analysis and just resolution of the allocation of finite health care resources is inevitably required — and entirely appropriate. Our thesis, clarified by Baltzan's challenge, stands.

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A less conventional approach to re-entry training

From the article "Shortage of re-entry positions tackled on East Coast" (*Can Med Assoc J* 1997;157 [10]:1338), it seems clear that the number of re-entry positions available through conventional routes to physicians already in practice is not going to meet the demand for additional training. Fortunately there are less conventional ways of doing things, as a growing number of physicians and communities are discovering.

It is now relatively common for community hospitals to provide financial support to family physicians who wish to upgrade their skills or even complete specialist training in return for guarantees of service. I suspect it will not be long before communities offer to fund residency positions as a means of attracting physicians with needed skills and appropriate qualifications. There might even be some competition among medical schools to attract such additional sources of trainees and dollars.

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Annual visits to GPs by elderly patients

In the article "The health of Canada's elderly population: current status and future implications" (*Can Med Assoc J* 1997;157[8]:1025-32), Drs. Mark W. Rosenberg and Eric G. Moore use data from the National Population Health Survey (NPHS) to explore the health of Canada's elderly population. They performed a logistic regression analysis to model the influence of chronic conditions on the likelihood of an individual visiting a GP more than once a year. I don't think that this is the best way to investigate utilization, because it is not necessary to use a dichotomous model to analyse frequency of visits. In any event, the authors must have made an error in their computations, because Table 5 shows negative values for the odds ratios. The odds ratio, $p/(1-p)$, where p is the probability of any particular event, can never be negative, because p can never be greater than 1.

I used a generalized linear model to investigate the frequency of visits to an academic family medicine clinic in 1993.[1] I found that the mean annual number of visits was greater for older patients, that women made more visits than men and that the presence of a chronic condition (such as back pain or hypertension, both of which appear in Table 5 of the article by Rosenberg and Moore) was associated with a higher frequency of visits. More complicated models than the one used by Rosenberg and Moore are needed to capture the complexity of health care utilization.

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Drs. Rosenberg and Moore set out to address the health status of Canada's elderly population and its