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Editor's preface

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> Habit is habit, and not to be flung out of the window by any man, but coaxed downstairs a step at a time.
>
> Mark Twain, *Pudd'nhead Wilson*

Can physicians' habits be changed? Should they be? In this issue Finlay McAlister and colleagues review the records of 969 patients in Edmonton who were treated for newly diagnosed hypertension (page 23). Their aim was to determine whether physicians are following the published guidelines of the Canadian Hypertension Society. What they found is remarkable. A substantial number of physicians did not order recommended laboratory tests (24% of patients had no serum creatinine level recorded) or ordered tests that are not recommended (23% of patients had a chest radiogram). First-line agents (beta blockers or thiazide diuretics) were given for only 30% of patients who were started on antihypertensive medication. Interestingly, family physicians were found to be much more likely than internists to prescribe the recommended drugs, even when other clinical factors were considered.

In a perceptive editorial, Nuala Kenny comments on these practice variations and reflects on how scientific evidence is applied in clinical contexts (page 33). Evidence alone cannot be expected to guide clinical decision-making; physicians will always need to make judgements about the applicability of trial results to particular patients. At the same time, we need to minimize unacceptable practice variations by fostering continuing education and professional collegiality and rethinking our attitudes toward physician authority.

Terfenadine has been removed from the market in some European countries, has been reclassified from nonprescription to prescription status in the UK, and is in the process of being taken off the market in the US. In Canada it remains available without a prescription. Robert Rangno points out that over 125 deaths have been linked to terfenadine in the US alone (page 37). Terfenadine can precipitate life-threatening cardiac arrhythmias, particularly in people with one of a number of predisposing factors. Unfortunately, these factors may go unrecognized until a serious adverse reaction occurs. Rangno recommends a return to basics in the treatment of hay fever and proposes new dosing schedules for our old friend, chlorpheniramine.

New payment mechanisms will almost certainly be population based, at least for primary care physicians. Truls Østbye and Steinar Hunskaar report on the experience in Norway, where large-scale experiments in rostering have been conducted over the past several years (page 45). As David Mowat points out, although capitation and rostering may be effective in some countries, we need to carefully explore the up side and the down side of population-based funding systems in the Canadian context (page 43).

With this issue we welcome Drs. Kenneth Flegel and Thomas Elmslie as Associate Editors and say goodbye to Dr. Patricia Huston, Associate Editor-in-Chief of *CMAJ* since 1993. Ken, former Chief of the Division of General Internal Medicine at McGill University, is a practising internist and clinical researcher at McGill. Tom, a family physician, is Chair of the Research Committee in Family Medicine at the University of Ottawa. We know that the journal will benefit from their enthusiasm and clinical insight. — JH