

and catapulted out of life-patterns that had endured for thousands of years.”⁶

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A worthy Web site

I recently underwent a set of screening, then diagnostic, mammograms, followed by 2 ultrasounds and a biopsy. I found trying to gather reliable and comprehensive information about breast health issues by phone, in person and online to be an exercise in sleuthing and perseverance — until I came across the *CMAJ* Web site (www.cma.ca/cmaj), which is offered at no subscription cost. It provided a clear, concise and complete guide to all of the questions to which I needed answers in order to be informed at each stage of the screening and diagnosis process.

Thank you for providing an informative and helpful online resource to both health care practitioners and lay people.

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Anticoagulant prophylaxis against stroke

Jaime Caro and colleagues are to be congratulated for their study confirming the beneficial effect of anticoagulants to prevent stroke in atrial fibrillation.¹

In the same issue Stuart Connolly asks why so many eligible patients are not receiving anticoagulant therapy.² I would suggest the following possible reasons.

First, patients may be reluctant to go to a testing laboratory on a regular basis. They may also be concerned about the restrictions the use of blood thinners may impose on their lifestyle.

Second, there is the issue of informed consent. Using the results of the study by Caro and colleagues, a diligent physician might explain to a patient that the risk of stroke in individuals taking warfarin is 2.3 per 100 person-years as opposed to 6.7 per 100 person-years in the no-treatment group and that the hazard rate from bleeding is 3.4 per 100 person-years in the warfarin group versus 1.9 per 100 person-years in the no-treatment group. The patient might assume that taking warfarin would mean going from the frying pan into the fire.

The third reason is physician reluctance. Connolly makes no mention of the increased workload anticoagulant therapy places on the treating physician and his or her staff. Whenever a patient goes for a blood test, the international normalized ratio (INR) results are typically phoned into the physician's office. The physician must then modify the dose as required and notify the patient of any changes. This requires several phone calls and can be a major source of anxiety (and possible medicolegal liability) when, for whatever reason, the doctor's office is unable to reach the patient to make the required medication changes. Admittedly, in BC physicians do get paid the princely sum of \$2.73 for providing this service.

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Reference-based pricing

We found the articles by Lutchmie Narine and colleagues¹ and Chantal Bourgault and associates² to be of particular interest, as we have been involved in the development of the Reference Drug Program in BC from its inception. The program has received both criticism and accolades since it was launched in the fall of 1995. Criticism has come primarily from the pharmaceutical industry, as any savings that governments achieve from the application of the policy are also reduced profits for the drug companies. Indeed, it has been stated that one gauge of any policy's effectiveness is the vigour of the industry response.³ Accolades have come from those who recognize the importance of a sustainable drug program for the long term.

Narine and colleagues¹ attempt to draw correlations between the reference pricing policies in Europe and those in BC. Although there may be some similarities, there are significant differences. The primary focus of the policy in BC is the baseline prescribing habits of physicians. The policy is designed to ensure that the most cost-effective agent within a drug class is used initially. If there are particular patient circumstances that would justify the use of a more costly agent, such as an adverse reaction or lack of therapeutic effect, the alternative agent is funded fully. In addition, the Reference Drug Program in BC does not target generic equivalents as stated in the article, but rather it targets competing drugs in a class.

Bourgault and associates² review the utilization of a select group of angiotensin-converting-enzyme (ACE) inhibitors, as well as hospital admissions and physician visits. Although the authors speculate that there are therapeutic differences among the ACE inhibitors, they present little evidence to support this assertion.

We agree with the critical comments by editorialists Paul Grootendorst and Anne Holbrook.⁴ There are many plausible explanations for the differences in health services utilization rates ob-