Letters

Correspondance

A burning issue

The new series in *CMAJ* on the environment[1] is long overdue. With respect to the issue of medical-waste incineration, 2 years ago I set the year 2000 as the target date for shutting down our hospital incinerator. Given the current rate of progress, I am thinking of re-establishing that date as the year 3000.

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Reference

1. McCally M. Environment and health: an overview [commentary]. *CMAJ* 2000;163(5): 533-5.

Anticoagulation therapy for patients with atrial fibrillation

Robert Hart makes several astute observations in his recent letter[1] and in general I agree that warfarin therapy is not well used in atrial fibrillation; it is overused among low-risk patients and underused among high-risk patients. Perhaps the problem is more with the treatment itself than with the physician using it. Adjusted-dose warfarin treatment is a complex therapy that requires assiduous and ongoing monitoring to achieve good results, with a narrow therapeutic window. It ties patients to the medical system, interferes with travel and complicates use of alcohol and of many common medications. Although a decade has passed since we learned that warfarin is beneficial in atrial fibrillation, many patients with atrial fibrillation who are at a high risk for stroke are not receiving adequate prophylaxis. With new antithrombin agents on the horizon and more effective antiplatelet agents (alone and in combination) already available, perhaps our efforts should be directed toward discovering effective antithrombotic control for atrial fibrillation that is safer than warfarin therapy and easier to manage.

Stuart J. Connolly
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Reference

1. Hart RG. Anticoagulation therapy for patients with atrial fibrillation [letter]. *CMAJ* 2000;163(8):956-7.

Validity of utilization review tools

We agree with Norman Kalant and colleagues that it is important to validate the use of utilization review tools in Canada,[1] but we feel that the methodology they used for their study does not reflect the manner in which the tools are implemented and cannot adequately support their conclusions.

Whereas actual utilization review activity uses current criteria, the researchers chose criteria that are now 4 years old. Utilization review at the 2 largest Vancouver hospitals has shown that approximately 10% of inpatient days meet criteria for subacute care, yet the researchers failed to use the subacute care criteria.

In addition, the sample size was very limited, both in number and scope (i.e., 75 charts were reviewed for cardiology only). Generalization as to the validity of the entire tool is thus suspect.

Finally, implementation in our health region includes a secondary review process that improves upon tool validity as well as inter-rater reliability tests for the reviewers. Kalant and colleagues did not include a secondary review process in their study and they questioned its usefulness given "the frequent divergence of clinical opinion among individual physicians."[1] How valid is it to use 3 cardiologists as a "gold standard"?

Although utilization review is not a perfect science, it is one of many important strategies that we can employ to determine how best to improve our health system.

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Reference

1. Kalant N, Berlinguet M, Diodati JG, Dragatakis L, Marcotte F. How valid are utilization review tools in assessing appropriate use of acute care beds? *CMAJ* 2000;162(13):1809-13.

The conclusion reached by Norman Kalant and colleagues that utilization review tools "have only a low level of validity when compared with a panel of experts, which raises serious doubts about their usefulness for utilization review"[1] is not well supported by the data in this very limited study involving 75 patients in a single diagnostic group.

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