jury pattern (after resuscitation from a ventricular fibrillation arrest) has a much higher risk of mortality than a patient with an average inferior myocardial infarction of the type reported in the Fibrinolytic Therapy Trialists' overview, i.e., at least 17.4% on the basis of a simple risk index calculation derived from the InTIME II substudy.[5] Thus, the benefits in this case clearly outweigh the risks.

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Risk factors for cardiovascular disease

Most patients do not show any of the conventional risk factors for cardiovascular disease.[1] In a recent *CMAJ* article, Jean-Pierre Després and colleagues emphasized the need to look beyond traditional risk factors, such as the plasma level of low-density lipoprotein cholesterol, as they might not provide enough predictive power for accurate risk stratification.[2] The authors focused on a cluster of factors characterizing the "metabolic syndrome" and especially on the novel measurement of the ratio of total cholesterol to high-density lipoprotein cholesterol.

In a recent study in which we evaluated the cardiovascular risk profile of elderly male patients, we confirmed the limited significance of traditional risk factors, such as total cholesterol or low-density lipoprotein cholesterol levels, and we observed a striking relationship between cardiovascular disease and the ratio of total cholesterol to high-density lipoprotein cholesterol.[3] However, we also noted that the high levels of lipoprotein(a) and homocysteine in these patients may have contributed to the development of cardiovascular complications in our clinical setting. These 2 factors, along with an elevated ratio of total cholesterol to high-density lipoprotein cholesterol, were highly predictive for cardiovascular disease. Therefore we agree with Després and colleagues on the need to look beyond low-density lipoprotein cholesterol and we further suggest that lipoprotein(a) and homocysteine measurements be included when assessing cardiovascular risk.

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Waiting times for cancer surgery

I enjoyed reading the article by Marko Simunovic and colleagues on waiting times for cancer surgery.[1] I was particularly intrigued by the fact that there were no age-related differences in median waiting times from referral to surgery. This is somewhat surprising, given the growing body of literature suggesting that older adults with cancer receive less aggressive diagnostic workups and treatments than younger adults.[2–7]

The investigators analyzed all tumour types together for patients aged 50 years or less, 51 to 65 years and 66 years or more. Given that they demonstrated differences in waiting times across cancer types, and given that some cancers are more common than others in different age groups, this analysis may mask true age-related differences in waiting times. Did the authors examine age-related waiting times separately for each tumour type?

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[One of the authors responds:]

Our group, like Shabbir Alibhai, was surprised at the lack of a significant difference in waiting times to cancer surgery among our selected age groups.[1] We did examine the relationship between age and time to surgery for each of the 6 cancer types included in the study; there were still no significant variations. We again caution read-

ers that all surgeons involved in our study were affiliated with regional cancer centres, and thus waits among their patients may not be representative of waiting times for all patients across Ontario.

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Bedside rationing

To implement bedside rationing as described in Peter Ubel's *Pricing Life: Why It's Time for Health Care Rationing*[1] would most certainly set medical ethics back 2500 years by ignoring the issue of patient trust, which gave rise to the traditional Hippocratic oath. The fundamental unit of health care is the physician–patient relationship. For physicians to knowingly withhold beneficial services from patients to promote the financial interests of others (or of themselves) would introduce suspicion into that relationship, further subjectivize the practice of medicine, and increase the power disparity between physician and patient. What patient wouldn't question the physician's commitment under such circumstances?

Should rationing ultimately become necessary, then bureaucrats must impose it broadly, at the system level, for the sake of maintaining consistency across the population and of minimizing physician conflict of interest. Patients must also have the option of obtaining services privately. Before Hippocrates, the sick could never be certain of their physicians' motives or competing interests, but generations since have enjoyed the peace of mind that comes from the physician's pledge to do no harm. Bedside rationing would undermine this precious gift that has protected us all.

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Reporting the clinical importance of randomized controlled trials

Karen Chan and colleagues address how well reports of randomized controlled trials discuss the issue of clinical importance.[1] We agree with these authors and others[2,3] that clinical importance needs to be discussed in the report of any randomized controlled trial.

Chan and colleagues defined clinical importance using 10 dimensions, such as an explicit statement of the primary outcome. We are surprised that they state early in their article that the CONSORT statement "failed to recommend specifically that authors discuss the clinical importance of their results." Perhaps they have not completely read the CONSORT statement[4] and its accompanying explanation and elaboration paper,[5] which definitely draw attention to this important issue. For example, item 6 of the CONSORT checklist explicitly recommends that authors of randomized controlled trials report "clearly defined primary and secondary outcome measures."[4] Moreover, the explanatory paper is clear about the relevance of clinical importance: "The difference between statistical significance and clinical importance should always be borne in mind. Authors should particularly avoid the common error of interpreting a nonsignificant result as indicating equivalence of interventions. The confidence interval (item 17 of the checklist) provides valuable insight into whether the trial result is compatible with a clinically important effect, regardless of the *P* value."[5]

The CONSORT statement is an