achieved. It is true that as physicians we prefer "positive" trials because they leave us with a sense of a conclusive message. However, both the AFFIRM[2] and Van Gelder and associates[5] trials did yield a conclusive and important message, that for presently available approaches to atrial fibrillation therapy, rate control is not inferior overall to rhythm control. It is debatable whether larger studies that achieved a statistically significant *p* value would have provided any more practical information.

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Competing interests: None declared.

First-use risks

Eric Wooltorton[1] has written a balanced article in response to the warning on Diane-35 and the risk of venous thromboembolism issued by Health Canada.

Caution is always required in prescribing estrogen–progestin combinations, whether for contraception, postmenopausal hormone replacement or treatment of acne. However, the risk attributed to preparations containing cyproterone acetate in comparison with other preparations may have been exaggerated by not taking first-time use into account. This effect has been estimated[2] to increase the risk of venous thromboembolism 10-fold in the first year of oral contraceptive use, regardless of preparation. The research letter of Vasilakis-Scaramozza and Jick,[3] which was used by Health Canada to support the increased risk, provided adjusted odds ratios for venous thromboembolism, but no reference is made to first-time use as a potential factor. That report described a total of 128 subjects (cases and controls) who had used levonorgestrel-containing preparations and 42 subjects (cases and controls) who had used preparations containing cyproterone acetate. In the first group, only 9 (7%) had used the preparation for 6 months or less, whereas in the second group, a much larger proportion (12 or 29%) had used the drug for 6 months or less. Among patients with this short duration of use, there is a greater probability of first-time use. Thus, the proportion of women using an estrogen–progestin combination for the first time appears to have been higher in the group receiving preparations containing cyproterone acetate, which might account for some or all of the greater risk of venous thromboembolism in that group.

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Competing interests: Dr. Rowe has received speaker fees from Wyeth, Organon, and Berlex Canada.

QALYs: the best option so far

I would like to challenge Maurice McGregor's argument in a recent commentary[1] that because the quality-adjusted life-year (QALY) has "severe limitations," it is not useful for cost-utility analyses.

To support his argument that the QALY is not meaningful, McGregor quotes a seminal work emphasizing the difficulty of using a single measurement to evaluate different health outcomes.[2] However, this same text recommends the continued use of the QALY while researchers develop potentially better tools.[2]

McGregor also argues that the QALY is not valid because it "frequently violates societal concerns for fairness in the allocation of health care resources." Such ethical concerns have been expressed before, but alternatives to circumvent them are still relatively nascent, and "the conventional QALY remains the dominant approach."[2]

McGregor then contends that the QALY is not reliable because utility estimates vary with the method used. However, variability can occur in any research. Consider how frequently clinical studies yield conflicting results. A more pertinent question is whether this variability is truly fatal to interpreting cost-effectiveness analyses.

McGregor next argues that the QALY is not relevant because there is "no unanimity as to whose viewpoint should be used when making societal policy decisions." This does not make the QALY irrelevant — it merely means that research is needed to clarify the issue.

McGregor's final argument is more a general cautionary statement: "When the studies with which the cost–utility analysis in question can be compared are not identified, the cost–utility analysis should clearly not be used in health policy decisions." However, the same can be said in any field: comparators should always be identified. Furthermore, comparing one cost-effectiveness ratio with another is no different from using league tables based on number-needed-to-treat to evaluate the clinical effectiveness of interventions.[3]

Without doubt, the QALY is an imperfect outcome measure. Nonetheless, despite acknowledging its weaknesses,

the 1996 Panel on Cost-effectiveness in Health and Medicine endorsed its use.[4] Reporting "outcomes in natural units," as McGregor suggests, detracts from the goal of developing an ideal measure incorporating both quantity and quality of life.

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[The author responds:]

I regret that I cannot accept Christopher Chong's "challenge," which is based on a misinterpretation of my commentary.[1] Nowhere did I argue that "because the quality-adjusted life-year (QALY) has 'severe limitations' it is not useful for cost-utility analyses." Of course it is useful. My argument is rather that those severe limitations must be well understood by any decision-makers who would use the QALY in making health policy decisions.

There is no dispute that estimates of utility vary according to how and from what viewpoint they are made. My point is that if such estimates are to be used in health policy decisions, this variability must be understood by the decision-makers. Most decision-makers would probably be astonished to learn that utility is not a constant unit of measurement and that it can only validly be used to compare one health option with another when the health preferences have been estimated by the same method and from the same viewpoint.

As for there being no difference between comparing cost-effectiveness ratios and "using league tables based on number-needed-to-treat to evaluate the clinical effectiveness of interventions," the issue is again the extent to which the decision-makers understand the units of measurement they are employing. I suspect that clinicians understand the index number-needed-to-treat far better than health care administrators understand utilities and QALYs.

And of course I agree that we should continue to try to develop "an ideal measure incorporating both quantity and quality of life." But if the imperfect measurements that we have developed up to this time are used in health policy decisions, the imperfections must be acknowledged and understood by the users.

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Why choose ophthalmology?

In a "Pulse" article earlier this year,[1] Patrick Sullivan hypothesized that "Because the number of call hours can seriously hamper family and other activities, it is probably no coincidence that specialties with less onerous call schedules, such as dermatology and ophthalmology, tend to be oversubscribed in annual residency matches." However, he presented no statistical information to justify this theory.

In the CMA's annual Physician Resource Questionnaire for 2002,[2] only 40 ophthalmologists were surveyed. Of these, approximately 20% had more than 180 hours of call per month;[2] this is only slightly less than the 25% of surgical specialists with this level of call reported by Sullivan.[1]

According to statistics from the Canadian Resident Matching Service, the ratio of the number of applicants whose first choice of specialty was ophthalmology to the number of spaces available was approximately 2:1 for 1998 to 2002.[3] Cardiac surgery, diagnostic radiology, emergency medicine, plastic surgery and dermatology had similar ratios over the same period. Yet the on-call duties of the first 4 specialties in this list are also onerous, at least from what we have observed in our centres. The "oversubscription" Sullivan describes is therefore more likely a result of the number of residency positions in the smaller specialties being too low in relation to societal needs.

We suspect that the popularity of ophthalmology is determined by a variety of factors, such as interest in the specialty, advances in treatment, and perceived benefit to patients and society, rather than on-call duties.

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Correction

Dr. Douglas Cram[1] of London, Ont., was predeceased by his wife, Madeline. Because of an editing error, incorrect information appeared in a recent death notice.

Reference
1. Deaths. *CMAJ* 2003;168(9):1223.