

RD et al: A study to develop clinical decision rules for the use of radiography in acute ankle injuries. *Ann Emerg Med* 1992; 21: 384-390

2. Stiell IG, Greenberg GH, McKnight RD et al: Decision rules for the use of radiography in acute ankle injuries: refinement and prospective validation. *JAMA* 1993; 269: 1127-1132

## Savings at what cost?

The headline of the report "Ontario's move to limit out-of-province health care spending pays off in a big way," by Milan Korcok (*Can Med Assoc J* 1993; 148: 425-426), should have been expanded to read "pays off in a big way for government but hurts many consumers."

After reading the report I was left extremely angry, for a number of reasons. First, the patients I am most aware of who have been significantly hurt by this change are young women suffering from eating disorders and those with severely abusive backgrounds who suffer from dissociative states. At present there are extremely long waiting lists for the specialized treatment centres for eating disorders in Ontario, and there are no such comprehensive centres for patients suffering from dissociative states. Patients wait months for the limited treatment resources available locally. This past week two patients who had been waiting for 3 months were admitted to a general hospital on an emergency basis, one because of an overdose and one because of extreme emaciation. In both cases the threat to life could have been avoided if adequate treatment resources had been available.

I am angry at myself for not having realized that by permitting these waits to occur and not referring patients for out-of-province treatment I have allowed the administrators of the Ontario Health Insurance Plan (OHIP) to feel that

their savings were, indeed, not hurting anyone. I have started to refer for OHIP out-of-province consideration all my patients who are on a waiting list, and I encourage all my colleagues who have similar waiting lists to do the same immediately.

I do not see this as a long-term solution, however; indeed, such a lack of coordination and communication between the different bureaucracies in the health care system is the second reason why I was angered. At a time when the Ontario health care economy needs monies to preserve jobs and when it is clear that high-quality health care needs to be comprehensive and close to the patient's community, to send the patient out of the province for treatment when the necessary expertise could be willingly and readily developed in Ontario makes no sense. Some of the patients whom I have treated in the past year have had treatment in the United States. Some of this treatment was, indeed, valuable; however, without adequate resources for follow-up, relapse has often occurred. The severe forms of these disorders require long-term treatment, preferably on an outpatient basis, by multidisciplinary teams, which are just not available in adequate numbers.

Dr. Robert MacMillan, executive director of OHIP, may not be aware of the long waiting lists and limited access to appropriate treatment services. It is critical that some of OHIP's savings be redirected with all speed to develop a small number of specialized, comprehensive treatment centres and teams for patients with these disorders. Moreover, I am convinced that not only will the quality of care increase greatly but also the province will continue to make significant savings.

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## Hemophilia and HIV infection

The article "HIV [human immunodeficiency virus] and Canada's hemophiliacs: Looking back at a tragedy" (*Can Med Assoc J* 1993; 148: 609-612), by Kate Dunn, correctly states that I deny statements made by some HIV-positive people with hemophilia who said that I discouraged them from launching lawsuits. The policy of the Canadian Hemophilia Society (CHS) on this question has remained constant since 1988: the CHS neither encourages nor discourages people from undertaking legal action over HIV infection. Our organization has consistently recommended that its members seek their own legal advice should they have reason to believe that their rights need protection. Also, the CHS has freely provided information from its archives to any person pursuing litigation.

As well, the late-1980s decision "to put all . . . efforts into negotiating government compensation . . . instead of publicly crying scandal" was not made by me alone (I was vice-president at the time) but, rather, by the CHS Board of Directors, which represents all 10 provincial chapters. That decision resulted in the federal government's Extraordinary Assistance Program, which the CHS hopes to complete in 1993 through negotiations with the provincial governments, the key players in the now-defunct Canadian Blood Committee. We still believe in a collective solution to the financial problems brought on by HIV infection acquired through government-approved blood and blood products.

As for "crying scandal," the preferred approach of the CHS has been and continues to be the mustering of accurate information about the Canadian blood delivery system and the use of this