Tanenbaum that my response to Mr. Woods' letter was, perhaps, overly sarcastic. I was not referring to the quality of the care that Woods would receive if he became ill but, rather, to the cost. I do not doubt that the best of US health care is excellent, and I am not about to get into a sparring match with anyone about which ranks first, the Canadian or the US system. But Canadians are universally insured and pay less for their health care; they also live longer and have lower infant death rates. Why else would US policymakers be looking so carefully at the Canadian scene?

Bruce P. Squires, MD, PhD
Editor-in-chief

Hepatitis leaves Halifax surgeon an operating room outcast

I sympathize with Dr. Reginald Yabsley concerning the unfortunate consequences of his infection with hepatitis B virus (HBV) that were described in Deborah Jones' article (*Can Med Assoc J* 1991; 145: 1345, 1346, 1348). Yabsley's case is a good example of what happens when we neglect the serious issues that surround the risk of transmission of HBV or human immunodeficiency virus from health care worker to patient.

However, I would like to point out a few inaccuracies in this article. The author mistakenly states that the US Centers for Disease Control (CDC) recommends that physicians infected with HBV stop performing invasive procedures. In reality CDC recommends that physicians who are carriers of hepatitis B surface antigen and of hepatitis B e antigen should not perform certain "exposure-prone" procedures unless advised otherwise by a committee of experts.[1] Although the CDC has not yet ruled on the nature of these procedures such a committee could doubtless have examined the matter with Yabsley, allowing him to continue to practise medicine while eliminating certain high-risk procedures from his daily work.

It is not true, as the article appears to imply, that all health care workers have the same risk of transmitting bloodborne pathogens in a health care setting. Many elements must be considered in the assessment of this risk, the most important of which is the type of contact between the infectious source and the patient. A worker whose task does not involve any risk of contact between his or her blood and the patient's blood would not constitute a risk.

Another major concern is the conclusion the article reaches about testing. Testing is not an end in itself: a solution must be proposed concerning those who are infected. There are many objections to mandatory testing, some of which are found in the article itself; for example, Yabsley says "But what about hepatitis C and God knows what else after that?" How can testing be a panacea when there are infections transmissible through blood that cannot be detected? Yabsley mentions that patients are not always able to understand the risks to which they are exposed. If this is the case why inform them of their physician's status? So many complex questions are raised without clear answers, and a superficial treatment of them is undeserved. The issue of testing of the physician or the patient or both as a means of preventing the transmission of bloodborne pathogens in a health care setting is very complex.

As much as I feel compassion toward Yabsley I believe that he should be promoting vaccination against hepatitis B rather than mandatory testing.

Élise Roy, MD, MSc
Centre d'études sur le SIDA
Département de santé communautaire
Hôpital général de Montréal
Montréal, Qué.

Reference

1. Recommendations for preventing transmission of human immunodeficiency virus and hepatitis B virus to patients during exposure-prone invasive procedures. *MMWR* 1991; 40: RR-8

Although we may have been inattentive and missed the complete discussion of hepatitis B infection in health care workers we believe that there has been a fundamental failure of conceptualization concerning the procedures to be followed when a health care worker, such as an orthopedic surgeon, is a carrier of HBV (whether or not he or she has been proven to transmit the virus).

The answer to the issue of patient protection is not to screen all health care workers in order to apply restrictions in the case of infection, or to apply infection control measures, such as universal precautions, which have never been shown to be efficacious, effective or efficient. The simplest principle is for the patients at risk to be vaccinated against HBV. This could be done at the time of the potential exposure: if a surgeon is found to be infected with HBV the first dose of vaccine could be given either when the decision is made that surgery will be done or actually at surgery. There is ample evidence that post-exposure vaccination is efficacious.

With such a procedure the screening of health care workers who may pose a risk to patients is applied to protect the patient through immunization rather than through imposition of infection control conditions that are more stringent than usual or through restriction of the use of skills

needed by the patient. Surely this is a simple and relatively inexpensive solution that could be satisfactory to all those involved.

Richard G. Mathias, MD
Associate professor
Peter D. Riben, MD
Clinical assistant professor
Department of Health Care
and Epidemiology
University of British Columbia
Vancouver, BC

Alerting patients with artificial heart valves

Unfortunately, a mistaken impression was created by David Spurgeon's article (*Can Med Assoc J* 1991; 145: 1357-1361) "Publicity about defects in artificial heart valves caused needless panic, doctor contends."

Medic Alert Foundation International and not Canadian Medic Alert was involved in the search for patients with the Bjork-Shiley Convexo-Concave heart valves. Canadian Medic Alert, with 675 000 members, is not part of Medic Alert Foundation International.

Because it was concerned about the confidentiality of members' information the board of Canadian Medic Alert chose not to be part of this activity.

Members of Canadian Medic Alert are well protected by wearing the medical identification bracelet or necklet. Anyone who calls Canadian Medic Alert enquiring about the heart valve program is first referred to his or her own physician; the telephone number of the International Implant Registry is given if requested.

Patricia A. Hewes, CCHRA(C), MEd
Executive director
Canadian Medic Alert Foundation
Don Mills, Ont.

Unprofessional laziness

Does this sound familiar? "Forward to me such records and reports as are in your possession at your earliest convenience."

The physician is asking for my personal file on the patient. I have three choices: to ignore the request, extract information or send my entire file. If I ignore the request I may find myself in front of a disciplinary committee; at the least I appear unprofessional for ignoring a reasonable request. I am not keen on either result.

I may send my entire file and never see it again. (Future requests would then go unanswered.) The physician requesting the file must wade through pages of my writing to decipher the information, most of which will most certainly be irrelevant.

I may summarize the chart, which involves considerable time spent in reviewing it and in attempting to guess which information the physician really needs and in what detail.

My initial response is to throw the request in the garbage. However, my professionalism wins, and I retrieve it and summarize the information.

These are "shot-gun" requests. I assume that when a new patient is registered, for efficiency the secretary routinely asks for the names of all physicians seen previously and has a request signed for each and sent off.

Why not take a history and then, if further information is necessary for the management of the situation, request the specific information? This procedure has the drawback that the physician has to take a history, think and write to the correct physician. Is this too much to ask? The other method is unprofessional laziness and, to say the least, annoying.

Thomas B. MacLachlan, MD
408 Garrison Cres.
Saskatoon, Sask.

Medical training in the United States [correction]

The second paragraph of Dr. Leslie L. Citrome's letter (*Can Med Assoc J* 1992; 146: 99) stated that an H-1 visa (for entry into the United States) is a permanent resident visa. This is not the case, although holders of H-1 visas may apply for permanent residence much more easily than may holders of J-1 visas. We apologize for any confusion our error may have caused. — Ed.

Deaths [correction]

The death notice for Dr. Harold R. McKean that appeared in the Jan. 15, 1992, issue of *CMAJ* (146: 264) contained an incorrect address. Dr. McKean practised in Truro, NS, and not in Rockcliffe, Ont. We regret the error. — Ed.