About those waiting lists . . .

Two recent articles in *CMAJ* have provided an interesting and positive contribution to the discussion of surgical waiting lists in Canada.[1,2] Unfortunately, these papers are flawed slightly by some unfortunate quotations, inaccuracies and statements that may affect readers' conclusions.

The authors state that "additional resources have also been found to *increase* list lengths or waiting times."[1] They point out that the volume of cataract procedures in Manitoba increased between 1992 and 1997 while the waiting lists also increased. Those changes were due to technical improvements in cataract surgery, which have had a similar effect worldwide. Because surgical outcomes have improved tremendously with newer techniques, the legitimate indications for surgery have increased considerably. Thus, if the surgical volumes in Manitoba had not increased during the period in question, the people of that province would have been grossly underserviced. The reason the volumes increased along with the waiting lists is that the supply of services was inadequate to meet a greatly increased and legitimate demand for services.

The authors state that "if long lists lever more operating room time, some practitioners will either actively build long lists or resist reallocation of their patients to those with shorter lists."[2] This misrepresents reality, for the authors seem to discount the effect of a surgeon's reputation on the length of his or her waiting list. Particularly in areas where there have been rapid changes in techniques, there may be a substantial difference in the quality of results among surgeons. It is virtually impossible to have both a high surgical volume and a long waiting list for surgery without providing fairly high standards of surgical care. The Saskatoon situation discussed in the article involves 2 high-volume surgeons who have established excellent reputations using the latest surgical techniques and have earned the trust of both patients and referring practitioners. I am simply trying to point out that there may be positive factors related to surgical waiting lists.

The authors suggest that redirection of referrals to physicians with shorter waiting lists be considered, particularly by publication of waiting lists. If the latter happens, then corresponding objective data on surgical outcomes should be published simultaneously, with appropriate cross-referencing of access so that patients and referring practitioners can make a genuinely informed decision.

The authors of these articles have made an excellent contribution to the discussion of waiting lists and managing access to surgical services.[1,2] Their key recommendations — to standardize the approach to waiting list reporting, auditing of waiting lists and prioritization of waiting lists — can be strongly supported. However, they appear to be less than fully informed about issues surrounding ophthalmology.

Harold W. Climenhaga
President
Canadian Society for Cataract
and Refractive Surgery
Edmonton, Alta.

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The article and commentary by Claudia Sanmartin and colleagues[1,2] outlining the challenges we face in deciphering the true meaning of waiting lists and their impact on patient care are important additions to the debate on the future of medicare in Canada. Physicians and their patients are often caught in a baffling waiting-list maze that results in a feeling that the health care system is dysfunctional.

The ethical underpinning of the concept of waiting lists deserves greater emphasis. In Canada, the notion of distributive justice has dominated the design of the health care system.[3,4] Lately there has been a leaning toward the ethical principle of autonomy, which has been paramount in the United States. Patients struggle with their own needs and not the needs of the general public, so it is understandable how the shift toward personal priorities can lead to the erroneous belief that private medicine can solve the public resource problem.[5,6]

It will become increasingly difficult to defend medicare when premiers like Ralph Klein and Mike Harris, as well as the leaders of the Canadian Alliance party, use their political powers to undermine the public system. They will continue to find novel ways to insert private components into the system that agree with their political beliefs. For example, young physicians who now face substantial education-related debt because of government-mandated tuition increases will be less inclined to support a publicly funded system if bet-

ter financial opportunities are available in the private realm.

Thus far, Canadians have chosen the ethical principle of distributive justice over that of autonomy as the foundation of their health care system. It will take a great deal of dedication and persistence from medicare's supporters to keep this foundation from crumbling.

A meaningful and accurate understanding of waiting lists that is transparent to physicians, patients and politicians is one important step in helping maintain our commitment to a system that has served Canadians so well for so long.

Michael Gordon
Head, Geriatrics and Internal Medicine
Baycrest Centre for Geriatric Care
North York, Ont.

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Competency of adolescents to make informed decisions

Christopher Doig and Ellen Burgess have carefully and accurately researched the rights of adolescents to accept or refuse life-sustaining treatment.[1] Pediatricians, family physicians, surgeons, nurses and paramedical staff caring for teenagers are aware of the necessity to respect the wishes of their patient, even if the patient makes decisions that are contrary to the wishes of his or her parents or the judgement of those responsible for his or her treatment.

The competency of children and adolescents to make informed decisions, if they understand the nature and consequence of that decision, has been examined by many professional bodies,[2-4] including the Canadian Paediatric Society,[5] the American Academy of Pediatrics and the Society for Adolescent Medicine.[6,7] There have also been court decisions in Canada, the United States and the United Kingdom, as cited by the authors, supporting this principle.

Where the minor's decision differs from that of parents or caregivers, ethical considerations demand compassionate counselling for decision-making but the wishes of the patient must never be overriden. I am appalled that the hospital's legal counsel ignored this minor's rights. Was he or she more concerned about the hospital's potential liability than about the child?

Martin G. Wolfish
Past-President
Canadian Paediatric Society
Past-President
Society for Adolescent Medicine
North York General Hospital
Toronto, Ont.

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β-Blockers as first-line therapy for hypertension

The 1999 Canadian recommendations for the management of hypertension[1] recommend against first-line β-blocker therapy for uncomplicated hypertension in the elderly and suggest that dihydropyridine calcium-channel blockers are preferable. β-Blockers had previously been recommended as alternative first-line agents.[2] The new recommendation is apparently based on results of the MRC,[3] STOP-Hypertension[4] and Syst-Eur[5] trials. We question whether the evidence truly supports this change.

In the MRC trial, a preplanned subgroup analysis suggested that β-blockers are ineffective. However, over 25% of subjects were lost to follow-up, a fig-

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ure exceeding the number of cardiovascular events in the trial. Furthermore, patients on β-blockers had significantly higher blood pressure than those on diuretics, raising the possibility that there were unmeasured differences between the groups or that the patients on β-blockers may have been undertreated despite guidelines for additional agents to achieve blood pressure control.

Uncertainty about β-blocker effectiveness following the STOP-Hypertension trial arose from the finding that 78% of the subjects on β-blockers required a second agent to achieve target blood pressure compared with 46% of the subjects on diuretics.[2] However, β-blocker doses were not maximized when in fact among older adults with hypertension, β-blockers at appropriate doses lowered blood pressure to an extent similar to that seen with other agents.[6–9]

Evidence supporting the use of calcium-channel blockers over β-blockers for hypertension in the elderly is not conclusive. While the Syst-Eur trial demonstrated that use of nitrendipine resulted in fewer cardiovascular events than placebo, there was no β-blocker group for comparison. Despite a small reduction in the incidence of dementia, further research is needed to determine agents of choice, particularly in light of a recently described association between dementia and older calcium-channel blockers.[10]

Finally, the STOP-Hypertension-2 trial[11] compared first-line β-blockers and diuretics with angiotensin-converting-enzyme inhibitors and calcium-channel blockers. There were no differences in cardiovascular outcomes. Efficacy for blood pressure lowering, tolerability and the need for additional agents were equivalent among all groups.

Although the case against β-blockers is weak, β-blockers at appropriate doses have yet to be compared with other first-line therapies, other than in the MRC trial. The sixth report of the United States Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure recommends an initial approach with diuretics supplemented if necessary with β-blockers.[12] Perhaps this more accurately reflects the available evidence.

George A. Heckman
Alexandra Papaioannou
Division of Geriatric Medicine
William Parkinson
Department of Rehabilitation
Christopher A. Patterson
Division of Geriatric Medicine
McMaster University
Hamilton, Ont.

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Unintended subcutaneous and intramuscular injection by drug users

There was a recent epidemic of unexplained illness and death among injection drug users in Scotland, Ireland and England. The syndrome-based case definition was soft-tissue inflammation (abscess, cellulitis, fasciitis or myositis) at an injection site and either severe systemic toxicity (sustained systolic blood pressure < 90 mm Hg despite volume replacement and total peripheral white blood cell count > 30.0×10^9 cells/L) or postmortem evidence of a diffuse toxic or infectious process including pleural effusions and soft-tissue edema and necrosis.[1] For a significant number of cases that met the case definition, there was laboratory evidence of clostridial infection, which suggests that the drugs or other materials used by the injection drug user were contaminated with soil or feces.[2] Aside from proximity in time, the common risk factor for all cases was subcutaneous or intramuscular injection rather than intravenous injection of heroin.

Public health authorities advised physicians to urgently report cases meeting the case definition and recommended that injection drug users with a serious inflammation seek medical attention rapidly. Injection drug users were cautioned to smoke rather than inject heroin; if they did inject, they were advised to avoid injecting into muscle or tissue outside a vein.

To better define the size of the population at risk in our city, we surveyed 153 injection drug users attending Montreal needle exchange programs about their injection practices. No one reported intentional subcutaneous (skin popping) or intramuscular (muscle popping) injections. However, 72 (47.1%) reported unplanned injections; of 17 554 injections in the previous month, 2308 (13.1%) were subcutaneous and 667 (3.8%) were intramuscular as a result of injection error. There was a significant association between these unintended injections and higher age ($p = 0.01$) and female sex ($p = 0.02$).

Length of injecting career and choice of drug were not associated with an inadvertent injection. These findings suggest that a significant number of injection drug users in Montreal, particularly women and older users, are at risk for toxin-mediated fatal infections if contaminated heroin enters the market, even if only intravenous injections are planned.

Because smoking is a less cost-effective route of heroin administration than injection, many users are unlikely to follow the advice to switch to smoking. Serious consideration should be given to encouraging physicians to prescribe sterile injection equipment,[4] to increasing treatment slots, to setting up injection rooms staffed by nurses who can provide advice on safe injection techniques, to conducting clinical trials of medical-quality heroin in people for whom methadone substitution has failed and to instituting strictly supervised heroin, diamorphine or buprenorphine prescription programs for long-term injectors.[5] This would reduce the risk of life-threatening infection from nonsterilized drugs, prevent overdose from heroin of unknown purity, break the link between drug use and criminal activity to acquire drugs and decrease the number of injections in public places.

Catherine Hankins
Darlene Palmer
Ravinder Singh
Montreal Regional Public Health Department
Deparment of Epidemiology and Biostatistics
McGill University
Montreal, Que.

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An author by any other name

I enjoyed the commentary describing the revised author-declaration rules in the Sept. 19th issue.[1] From the description of Attila Lorincz's contribution to the article on human papillomavirus DNA testing in the same issue,[2] I am uncertain of the justification for Lorincz's inclusion as a coauthor.

Did I overlook a key piece of information? Or were you just testing to see if your readers are paying attention?

Of course, this raises another question: Are journal editors and their staff (and peer reviewers) now going to be expected to review the authors' contributions and decide whether each of the proposed authors should be listed, or will this responsibility fall to the group of proposed authors (an honour system)?

Bart Harvey
Department of Public Health Sciences
University of Toronto
Toronto, Ont.

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[The editor of *CMAJ* responds:]

A tip of our hat to Bart Harvey — we missed that one. Attila Lorincz did in fact meet the revised authorship criteria of the Vancouver Group.[1] However, he neglected to inform us that he participated in the design and analysis of the study as well as providing a critical review of the manuscript,[2] thus qualifying him for authorship.

We will be more vigilant; editors can and should raise questions when they suspect that authorship criteria have been violated. But, as Harvey suggests, the main responsibility for ensuring that the authorship criteria are met lies with the authors.

John Hoey

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Corrections

Because of an autohyphenation problem, some readers may have been misled by a URL that appeared in a recent On the Net column.[1] The correct URL for Healthy PalmPilot is www.healthypalmpilot.com.

Reference

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Staff Barootes attended medical school at the University of Toronto. Incorrect information appeared in a death notice in the Sept. 19 issue.[1]

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