a clinician. The patient may subsequently be prosecuted in court after subpoena of the hospital medical records. This is a contentious and separate issue, but because of it physicians should understand the differences between a clinical and a legal estimation of the blood ethanol concentration, which are summarized in Table I.

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CVMA opposes chloramphenicol ban

In the article "Chloramphenicol and the politics of health" in the Feb. 15, 1986, issue of *CMAJ* (134: 423, 426-428, 433, 435) it is stated that "veterinarians are not against the ban" on the use of chloramphenicol in food-producing animals. The fact is, the Canadian Veterinary Medical Association (CVMA) has always strongly opposed the ban.

Chloramphenicol is a very effective and inexpensive drug. It was mainly used to treat infectious diseases in young calves and pigs. The veterinary profession thinks it would be practical and feasible to increase the withdrawal period before an animal is slaughtered; previously the withdrawal time was only 5 days.

The CVMA has always thought that the use of chloramphenicol in food-producing animals presents a minimal risk to the health of humans. The only reported cases of chloramphenicol-induced aplastic anemia occurred after people were treated with chloramphenicol. It is hypocritical to ban the use of chloramphenicol in food-producing animals because of the risk to humans while continuing to permit its direct use in humans.

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Counselling on smoking

The latest update from the Canadian Task Force on the Periodic Health Examination recommended "counselling about the risk of smoking and the smoking cessation strategies available" (*Can Med Assoc J* 1986; 134: 724-727). I would like to comment on the impact that this maneuver is likely to have on the problem of smoking.

The task force states that "sustained cessation rates of at least 5% have been shown to be attainable when general practitioners offer routine, minimal advice to quit smoking". This statement is supported by one 1974 study,[1] but two recent clinical trials, in 1979 and 1980, showed no difference in the rates of long-term cessation of smoking between a group given advice and a control group.[2,3]

Since there has been a steady decline in the proportion of smokers in the general population,[4] we may be left with a different population of smokers — people who know about the effects of smoking but will not or cannot stop smoking. In support of this hypothesis, most people who go to a family physician's office know that cigarette smoking is harmful to their health.[3] In a recent survey in Ottawa-Carleton 64% of smokers stated they had tried to stop smoking in 1985.[5] If physicians counsel patients about cigarette smoking they must provide more than minimal advice about the health effects of smoking. Wilson and associates[6] suggested that follow-up visits could improve the success of counselling on a single occasion. However, most physicians receive little training in health education, so they may not have the skills to counsel effectively.

The task force overestimates the proportion of smokers (70%) who can be reached through physician counselling in the office. According to the Canada Health Survey 70% of people aged 20 to 45 years visit a physician at least once a year, but the survey does not state whether the visit was to a family doctor, a specialist or a physician in an emergency department.[7] Most people in this age group (about 80%) do not visit a physician more than once or twice a year. In addition, their visits are probably for specific health problems rather than for periodic health examinations. Is there time to adequately counsel a person during such a visit, or will the patient return for another appointment to specifically discuss smoking in more detail?

The danger in accepting recommendations that will not produce the desired effect is that one can be lulled into thinking that nothing more needs to be done about the problem. Knowledge and beliefs are only two issues that influence the decision to smoke.[8] Rosser[9] has suggested that physicians could increase their impact on the problem of smoking by lobbying for changes in the social and political environment through the new organization "Physicians for a Smoke-Free Canada". The issue of cigarette smoking must be addressed comprehensively if physicians are to have any impact on this preventable cause of disease.

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