



other AIDS related decisions made at that time."⁴

Such reservations about the IOM report are not noted in Hoey's review; they apply equally to Hoey's critique of Canadian events.

Hoey's further suggestion that the Red Cross and its coappellants give up recourse to the Supreme Court of Canada to define the scope of the Krever inquiry report seems to be a *non sequitur*. The appeal, which the court has agreed to hear, addresses the rights of the appellants to fair treatment by the inquiry. It also raises legal questions about the powers and conduct of public inquiries in general, which are relevant as well to the recent inquiries into charges against nurse Susan Nelles, into the Ontario government's connections with Patricia Starr and into actions of the Canadian Armed Forces in Somalia. As coappellants, we have no intention of letting these questions go unresolved.

The appeal does not in any way impede Justice Krever from addressing proposals for the future, which we are at least as anxious to see as Hoey is.

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Drs. Davey and Perrault are principal Canadian Red Cross Society witnesses before the Krever inquiry. — Ed.

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I agree completely with the article by Dr. Hoey.

Blood is a complex and complicated brew of healthy and effete red cells; living, dead and dying white cells; platelets in various forms; known and unknown viruses (some benign, some not); living, dead, dying and fragmented bacteria; cationic peptides; endotoxins; enzymes; occasional malignant cells; proteins; salts; cellular debris; hormones; fats; antibodies; and what have you.

It is a very personal concoction, specific to each individual. Added to this are more worrisome things, such as various strains of HIV and Creutzfeldt-Jakob disease. Who knows what other constituents, which may attack recipients in mysterious ways and prove incurable, may be discovered?

I would have to be in dire straits to let such a conglomerate mixture be injected into my body. All that money should be spent on grants for blood research. It will do far more good, for example, to find a suitable blood substitute in cases of hemorrhage.

Is this not the nub of the whole problem?

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[The author responds:]

The apology from the Canadian Red Cross Society, expressed by Mr. Normand, will be welcomed by many in Canada who have felt betrayed by this noble agency. *CMAJ* applauds the Red Cross for publicly acknowledging its shortcomings and for taking responsibility for its actions in the early 1980s.

The Krever inquiry, like all inquiries, can use only hindsight to determine what went wrong with the Canadian blood supply in 1983-85. Its recommendations will, in effect, adjust the rear view of the Canadian blood supply system so that, in fu-

ture, administrative and scientific decisions come closer to the mark. Our argument is simply to get on with it.

Davey and Perrault continue to defend the 1983-85 decisions, arguing that the present criticism of those decisions derives from a "radical, recent change in public perception of risks of transfusion." The public's perception of those risks certainly has changed, but does this mean that the faulty decision-making of public officials and medical professionals may be excused by the fact that members of the lay public were not alarmed? Moreover, in their perception of risk, members of the public have little choice but to take cues from the experts. The IOM report contains evidence that, at least in the US, deliberate efforts were made to withhold information specifically because the public was interested and would have fully appreciated the risks.

John Hoey, MD

Editor-in-Chief

CMAJ

Pity the student who makes the wrong career decision

From a recent Pulse column by Lynda Buske entitled "Are medical students ready to make career choices?" (*Can Med Assoc J* 1997;156:1248), I learned that nearly two-thirds of medical students interviewed in 1996 felt well prepared to make a career choice. This is gratifying, but it would also be very interesting to know how many 1993 graduates still feel they made the right career decision and how many 1996 graduates are to be interviewed in 1999.

It is encouraging to know that today's medical students are so confident about their career choices, because many pathologists and anesthesiologists of my generation and acquaintance were not as confident at a comparable stage of development. Most of us entered



our specialty after time spent in medicine, surgery, pediatrics, family practice or other specialties.

For many students the resident-matching process begins when there are still several new rotations to be experienced. When I was interviewing potential candidates for pathology at McMaster University, students often told me they really did *not* know what choice to make, since their decisions had to be based on incomplete exposure. I know that some changes are possible at a later stage of the matching process but, as many specialists in pathology or anesthesia can attest, the need for change may become apparent much later. Any educational system should make allowances for this, yet the new system does not. It would be interesting to hear what others think.

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NBSS: opportunity to compromise the process

In 1995 I wrote to Drs. John C. Bailar III and Brian MacMahon, emphasizing to both the need to interview the individuals involved in random allocation in the National Breast Screening Study (NBSS). As the authors point out in their article "Randomization in the Canadian National Breast Screening Study: a review for evidence of subversion" (*Can Med Assoc J* 1997;156:193-9), there was opportunity to compromise the process, since the lists were open and multiple allocation numbers were frequently obtained ahead of time. As a result, lines could be skipped without any need for erasures or alterations. The most direct way to find out

whether the process was compromised would be to ask those involved in the allocation and to provide them with anonymity and protection from retribution. This was not done. Consequently, the authors' review adds little to what is already known.

The reviewers confine themselves to evaluating 3 centres. Given that allocations were supposedly random and given the relatively small number of deaths due to cancer at each centre, the problems may not have occurred in the centres where the allocations appeared to be "imbalanced"; they may well have occurred in the centres where the allocations appeared "balanced."

Adding to the already large number of problems with the NBSS was the revelation by Dr. Anthony B. Miller at the recent US National Institutes of Health (NIH) Consensus Development Conference, held in Bethesda, Md., Jan. 21-23, 1997, that the control group was apparently treated differently, in community centres, than the screened group, which was treated in larger centres. The women with cancer in the control group apparently had fewer and less extensive axillary dissections. This adds another imbalance to the NBSS.

In the abstracts printed by the NIH for the conference, Miller wrote that "the number of breast cancer deaths are now 52 in each arm." At the meeting, he stated that this had been a "mistake" and that there were 82 deaths among the screened women and 67 among the controls. An independent review of the linkage and follow-up of deaths due to breast cancer in the NBSS should be undertaken to ascertain whether there are other "mistakes."

Finally, I have been identified as the major critic of the NBSS, although numerous others have written and lectured on the same problems.¹⁻⁷ I have been struck, however, by the fact that only a few researchers di-

rectly involved with the NBSS have publicly defended the trial. Had I been a radiologist involved in the NBSS, and confident in what had transpired, I would have argued strenuously in support of the methods and results of the trial. I find the absence of such support surprising.

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[Drs. Miller, Baines and To respond:]

Dr. Kopans persists in raising concerns, most of which have previously been shown to be unwarranted.¹⁻³

The recent review of randomization in the NBSS was initiated after Kopans made a charge to the National Cancer Institute of Canada of scientific misconduct by one of us. This serious charge was based on hearsay from a radiographer previously employed at an NBSS centre; the radiographer had begun her employment after randomization had ceased, as Bailar and MacMahon discuss. In spite of assurances of confi-