## Blood transfusions: listen to the patient

In November I attended a conference on "Building a Blood System for the 21st Century" in Toronto. The participants included representatives from national medical associations, provincial and federal governments, consumer groups and other stakeholders in Canada's blood system. Of the 54 recommendations made by the 9 working groups, 20 urged that medical alternatives to blood transfusion be made more available to Canadians.

In the final report of the Commission of Inquiry on the Blood System in Canada, Justice Horace Krever recommended that because blood products will never be without risk, education and funding should be made available for alternatives to allogeneic blood.

Several conclusions can be drawn. First, "bloodless surgery" offers a practical solution to concerns about blood safety and supply. The term has been used in the medical literature for more than 35 years, and Krever used it to refer to the systematic use of combinations of medical and surgical strategies for minimizing or avoiding allogeneic transfusion.

Second, patients are becoming increasingly knowledgeable about the risks, benefits and alternatives to transfusions. Consequently, as one conference speaker warned, physicians could incur liability if they do not inform and offer patients medical alternatives to allogeneic blood.

Third, although major centres may be better equipped to provide bloodless surgery, there is a misconception that smaller regional hospitals cannot offer alternatives to donor blood. Smaller facilities can employ various advances such as electrocautery, hematopoietic growth factors (including erythropoietin) and volume expanders. Moreover, a simplified intraoperative autotransfusion system[1] that does not require a specialized technician[2] can be assembled from a volumetric infusion pump and continuous reinfusion autotransfusion collection equipment with suitable filters and administration sets. A pump costs under $2000 and the disposable items cost less than $100 per patient.

Finally, in 1996 a national Gallup poll found that "89% of Canadians, if informed they required a blood transfusion due to a surgical operation, would prefer an alternative."[3] Risk managers and medical advisory committees would be well advised to pay attention to the patients. Their concerns can be met safely and cost-effectively.

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**References**
1. Heimbecker RO. Blood recycling eliminates need for blood [letter]. *CMAJ* 1996;155:275-6.
2. Green DM. Perioperative autologous transfusion service: a logical extension of our role in the operating room. *Anesthesiology* 1997;87(2):458-9.
3. Picard A. Poll on blood finds anxiety. *Globe and Mail* (Toronto) 1996 Apr 23; Sect A:4.

## Was an 8-hour wait really unreasonable?

The article "Despite some PR fallout, proponents say MD walkouts increase awareness and may improve health care" (*CMAJ* 1997;157[9]:1268-71), by Nicole Baer, begins with a vignette about a patient who was 3 months pregnant and "bleeding profusely." It is claimed that the patient waited 8 hours without being assessed.

I suspect that in fact the patient's case was assessed first by a nurse and then by an emergency physician. Did she really wait 8 hours to see a physician, or did she wait that long before seeing a gynecologist?

If the former, she certainly does have a beef with the medical profession, but if the latter, methinks the lady doth protest too much.

In most Ontario emergency departments, patients who have first-trimester bleeding in the face of an otherwise normal physical examination are usually treated with reassurance and sent home to await developments. If a patient demands that she see a gynecologist and undergo ultrasonography, perhaps an 8-hour wait is not unreasonable.

One hates to be picky, but the physicians in the article who are most critical of physician job action seem to be those who are no longer practising medicine! Is there a message here?

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## Address unknown — or at least uncertain

The article "Recent trends in infant mortality rates and proportions of low-birth-weight live births in Canada" (*CMAJ* 1997;157[5]:535-41), by Drs. K.S. Joseph and Michael S. Kramer, and the related editorial "A warning from the cradle?" (*CMAJ* 1997;157[5]:549-51), by Dr. Graham Chance, are relevant to planners and researchers in the population health field, highlighting as they do some serious errors in birth weights in the Ontario vital statistics data and given the consequences of such errors for surveillance of low-birth-weight births in Canada.

Another serious problem has been

discovered by health unit epidemiologists working with information supplied by the Public Health Branch of the Ontario Ministry of Health. In these records the place of residence of the mother was coded inaccurately or inconsistently, making it impossible to obtain correct counts of live births by geographic area.

To illustrate the error, we compared 2 sources of information for 1994 births, both obtained through the Ontario Ministry of Health: vital statistics birth data for which place of residence was given as within the metropolitan Toronto area and hospital discharge data from the Canadian Institute for Health Information (CIHI) for live births to women residing in Metropolitan Toronto (Table 1).

Although the total number of Metro Toronto births is similar for the 2 sources, the differences among the 6 municipalities are substantial. Similar differences have been found in some rural areas of Central East Ontario. Which figures are correct? And which should be used to support local planning?

In a letter entitled "Error corrected, conclusions the same" (*CMAJ* 1997;157[6]:646-7), Indira Singh of the Ontario Ministry of Consumer and Commercial Relations and Janet Hagey of Statistics Canada acknowledge the birth weight errors in Ontario vital statistics data. They replicate Joseph and Kramer's analysis with corrected data and conclude that there has been a statistically significant increase in low-birth-weight births in Ontario in recent years.

Although this may be true at the provincial level, the apparent errors in geographic coding make it impossible for local health authorities to identify the specific areas where low birth weight is a problem and to take the appropriate remedial action.

Because this information is extremely valuable to health researchers and planners, efforts should be made to set national standards for the collection, management and reporting of these data, so that trends in reproductive health outcomes can be followed at the national, provincial and local levels. Without good local data, the integrity of health planning and program evaluation is jeopardized.

It appears that the time has also come to consider whether the collection and management of such data should be transferred from the provincial Ministry of Consumer and Commercial Relations to the Ministry of Health.

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Received by email

**Table 1: Place of residence of mothers for births in the metropolitan Toronto area in 1994, according to data from Ontario vital statistics and Canadian Institute for Health Information (CIHI)***

| | Data source; no. of births | | |
|---|---|---|---|
| Recorded place of residence | Vital statistics | CIHI | Difference† |
| City of Toronto | 13 400 | 8 925 | 4 475 |
| City of East York | 503 | 1 683 | 1 180 |
| City of Scarborough | 8 257 | 8 518 | 261 |
| City of York | 1 167 | 2 514 | 1 347 |
| City of Etobicoke | 4 306 | 4 814 | 508 |
| City of North York | 6 676 | 8 498 | 1 822 |
| Total | 34 309 | 34 952 | 643 |

*CIHI data has been selected for the calendar year 1994.
†Absolute value.

## Debating the management of osteoporosis risk

My experience as a participant in the BC Study of Osteoporosis Risk has been enlightening.

Until slow progressive multiple sclerosis developed 16 years ago, I was physically active and sports oriented. Even when my physical activities became severely limited, I maintained daily yoga exercises. Eventually, even that became impossible, and for the past 6 years I have had quadriplegia. During the time that I have had slow progressive multiple sclerosis, my general practitioner, my neurologist, the research team at the University of British Columbia and even my husband, who is a physician, never broached the possibility of osteoporosis. However, from the ultrasound test I underwent as part of the study, I learned that my bone density is seriously deficient. I reported this information to my doctor immediately and began a program that we hope will impede further deterioration.

In my view, osteoporosis risk assessment is a worthwhile exercise, and I hope its use will be expanded. In a letter returned to the organizers of the BC study along with my participant questionnaire, I suggested that they consider a targeted program for both women and men with impaired mobility, especially those in wheelchairs, since osteoporosis might be a factor in their disability.

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**[Dr. David Kendler, BC Study of Osteoporosis Risk, responds:]**

This letter is typical of many received after the BC Study of Osteoporosis Risk suspended recruitment in January 1997. The study, cosponsored by the Osteoporosis Society of British Columbia, the British Columbia's Women's Hospital, the