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Yet another Dr. King

After reading Charlotte Gray's article "Dr. Max King: the sad life and early death of Mackenzie King's physician brother" (*CMAJ* 1998;158[8]:1066-70), I thought readers would be interested to know that Mackenzie King had another close relative who was not only a doctor but also his namesake.

A recent book about the Canadian destroyer HMCS *St. Croix* and the German submarine *U 305* and their roles in the Battle of the Atlantic[1] mentions that on one mission "there [was] a celebrity of sorts aboard: Surgeon-Lieutenant William Lyon Mackenzie King, thirty, [who] is the nephew and namesake of Canada's Prime Minister." This Dr. King was one of the twin sons born to Max King and May Wookey.

The *St. Croix* sailed from Plymouth on Sept. 15, 1943, and was torpedoed 5 days later. Dr. King was among the missing.

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Lifestyle and genetic susceptibility

Dr. Michael M. Burgess and colleagues, in their article "Bioethics for clinicians: 14. Ethics and genetics in medicine" (*CMAJ* 1998;158[10]:1309-13) correctly conclude that counselling patients at high risk for genetic diseases is complicated and may be associated with unexpected reactions. For example, from the caregiver's viewpoint it might seem obvious that a person with relatively high genetic susceptibility to a disease would be willing to modify some of his or her risk factors. However, patients may not reach this conclusion on their own.

As an example, we studied a family in which several members had early-onset coronary artery disease and virtually no high-density lipoproteins (HDL), the result of homozygosity for a truncated variant of apolipoprotein (apo) AI.[1] Although homozygosity for the apo AI mutation was clearly associated with increased risk of coronary artery disease, some elderly homozygous family members were unaffected. We found that risk factors such as smoking and hypertension modulated the onset and severity of the condition in homozygous people.[2] When we informed these family members about their genetic susceptibility, some of them incorrectly inferred that the development of the condition was genetically predestined and that its future expression was outside their control. Therefore, they felt justified in continuing such high-risk behaviours as smoking. However, their attitude changed when we explained to them that (1) the relative hazard from genetic factors for a complex disease such as coronary artery disease was much smaller than that for a monogenic disease, such as cystic fibrosis,[3,4] and (2) modifiable nongenetic factors contributed at least as much as genetic factors to the risk of coronary artery disease.[3,4]

Coronary artery disease results from the interaction of genetic and environmental factors, of which the latter are largely within an individual's control.[4] The influence of a particular genetic factor in an individual at risk for this condition is usually the aggregate of many small effects.[3] However, even in a family with a major gene affecting high-density lipoprotein metabolism, the expression of coronary artery disease can be delayed by modification of risk factors.[2] For almost all complex diseases, the inherited factors create a background of susceptibility but are not the ultimate cause of the disease. With the potential for increased application of genomic diagnostic methods, health care providers must anticipate the full spectrum of patients' responses and allow sufficient time to properly explain test results.

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New guidelines nurture fear, not confidence

I agree with Dr. John Hoey's assertion in the editorial "When the physician is the vector" (*CMAJ* 1998;159[1]:45-6) that Health Canada's new guidelines for preventing the transmission of bloodborne diseases amount to "an extraordinary step, an infringement of the basic human right to dignity and privacy." These guidelines will nurture rather than allay patients' fears and anxieties, and they sanction and abet public paranoia.

In an article by Barbara Sibbald in the same issue, "CMA says no to mandatory hepatitis B vaccination, screening for MDs" (*CMAJ* 1998; 159[1]:64-5), Dr. Ian Gemmill is quoted as saying "Where there is a small but real risk that can be avoided by [mandatory] immunization and testing, it's hard to argue against doing it." I disagree. This argument is refuted by statistics and, philosophically, by Drs. James Wright and Peter Singer, who posited that "[t]he same policies should apply in the case of all equivalent or greater risks to patients. . . ."[1] They also pointed out that "anecdotal cases of disease transmission should not drive public health policy."

Political correctness should not be a substitute for rational, scientific, evidence-based policies and practices. Hepatitis B is topical today. Tomorrow will beget guidelines, regulations and "moral imperatives" for other subclinical seropositive states. For example, what should be done about physicians who have had malaria, a bloodborne disease at least as virulent as hepatitis B?

The real and significant hazards and risks can be properly addressed by experts in infection control, occupational health, public health, and hygiene and safety. Health Canada's unnecessary and regrettable new guidelines are contrary to scientific knowledge. Furthermore, they will be nearly impossible to implement. Unless the medical community takes a logical, united stand, all health care providers will soon face restrictions, and the public will be left with no one to attend to them.

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1. Wright JG, Singer PA. HIV-seropositive surgeons: informed consent and public health policy. *CMAJ* 1992;147[1]:29-31.

Correction

In the letter "Secondhand smoke and cancer: Where's the proof?" (*CMAJ* 1998;159[5]:441-2), by Drs. Dildar Ahmad and W. Keith Morgan, the confidence interval for the relative risk of a nonsmoker who lives in a house with a smoker was given incorrectly. The relative risk, reported from a study by the World Health Organization, was 1.16 and the confidence interval should have been 0.93 to 1.44. We apologize for the error. — Ed.

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