Internet access

The article "Life in the information highway's fast lane" (*CMAJ* 1998;158[4]:537), by Warren Lampitt, was incomplete and thus inaccurate. It would appear that *CMAJ* is unaware of the services available here in the boondocks! In Saint John, cable modem access is available, although it is a bit slow for some of us. NBTel has a service called Vibe that will soon be available in most parts of the province. It is an asynchronous transfer mode (ATM) system currently running at 10 megabits per second (mbps), with the capacity to increase to 150 mbps; it currently costs about $50 per month. The integrated services digital network is not available because it is deemed to be too slow here. Asynchronous digital subscriber lines are currently available, if only as an interim measure. Why bother if you can get ATM?

Gerald E. Stiles, MD
Saint John, NB
Received by email

[The author responds:]

When I wrote the column I was aware of the New Brunswick program. However, NBTel had indicated that the residential service was only a trial project for Moncton and Saint John. I understand that they were planning the roll-out for full service in Moncton in May and would be looking to expand after that. The company has just confirmed that no fixed date has been set for these activities.

Over the past 3 years of tracking trends, I have learned to be very cautious of statements made by telephone and cable companies. The actual schedule for implementation is usually considerably different from the original plan, and the bandwidth delivered is either narrower or more expensive than initial estimates.

I will be tracking the progress of this service and may provide an update in *CMAJ*'s On_the_Net column if the service is made available commercially over a wider area.

Warren Lampitt
Timmins, Ont.
Received by email

The stigma facing drug abusers impedes treatment

I want to commend *CMAJ* for continuing to highlight problems related to substance abuse and dependence.

As is hinted in Michael OReilly's recent article, "MD at centre of Somalia controversy finds peace in Northern Ontario" (*CMAJ* 1998;158[2]:244-5), the Somalia affair involved an undercurrent of alcohol-related problems. Despite concerted efforts by some military physicians, a lack of education and a naïve, liberal attitude toward alcohol use stood in the way of adequate interventions.

Dr. Kirsten B. Emmott's article "A really bad locum" (*CMAJ* 1998;158[2]:235-6) highlights the indiscriminate prescribing of opioids and benzodiazepines that can complicate the problems of alcohol abuse and dependence. Physicians must take personal responsibility for becoming better educated about this issue.

In addition, better understanding is needed to avoid pitfalls such as those mentioned in Charlotte Gray's article, "Legalize use of marijuana for medical purposes, MDs and patients plead" (*CMAJ* 1998;158[3]:373-5), in which the harmful effects of marijuana (including addiction) are acknowledged yet minimized. In addition, clarification is needed concerning the reply by Drs. Mark Latowsky and Evelyn Kallen to Dr. Robert A. Durnin's letter "Canada's drug problem: new solutions needed" (*CMAJ* 1998;158[2]:167-8). Latowsky and Kallen argue that illicit drug use is not abuse. By definition, continued drug use despite harm is drug abuse. Furthermore, preoccupation and compulsion, combined with impaired or sustained loss of control, characterizes dependence or addiction.[1]

Instead of moving away from making appropriate diagnoses, it is important to remove the stigma faced by people experiencing substance abuse or dependence. It is "the wrath of punishment" that needs to be curbed. Our patients deserve proper assessment and treatment, not punishment for "deviance," nor liberal

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access to potentially harmful licit and illicit drugs.

Raju Hajela, MD, MPH
Major (retired)
President
Canadian Society of Addiction Medicine
Kingston, Ont.

Reference

1. Miller NS, editor. *Principles of addiction medicine*. Chevy Chase (MD): American Society of Addiction Medicine; 1994.

"Support groups" by another name

The excellent overview of the principles of palliative care in "Death: A rewarding experience?" (*CMAJ* 1997;157[12]:1687-8), by Drs. Tom A. Hutchinson and John F. Seely, is much appreciated. I agree that the attitude of physicians needs to undergo a major paradigm shift if we are to deal with some of the weighty issues surrounding death.

I also have good news for Hutchinson and Seely. Support groups for people with chronic illnesses other than alcoholism already exist: they are called churches.

William D. Gutowski, MD
Chilliwack, BC

[One of the authors responds:]

We agree that churches are an excellent source of support for those with chronic illnesses. The problem is that the specificity of the beliefs required in various churches may make it difficult for some people to join. That is why we alluded to Alcoholics Anonymous as a model, since it and similar support groups (such as Alanon and ACOA [Adult Children of Alcoholics]) incorporate spiritual belief in a "higher power" without any dogma about what the nature of that higher power might be — each person chooses his or her own. We believe that this approach may be more effective and acceptable in the secular age in which we live.

Tom A. Hutchinson, MB
Professor
Department of Medicine
McGill University
Montreal, Que.

The risk is in the transfusion, not the donation

In the article "Plasma-collection plant has to overcome tainted-blood fallout in search for donors" (*CMAJ* 1998;158[3]:380-1), Michael OReilly wrote that "the odds of becoming infected with HIV following blood *donation* are now 1 in 1 million" [emphasis added].

The risk to which he refers is the residual risk of a unit of blood being positive for HIV if it is donated during the period between infection and detectability of the virus by current screening assays. This is a potential risk to the *recipient*, not the *donor*, and is currently estimated at 1 in 913 000 in Canada.[1] Blood donors face no risk of infection through donation.

The perception persists that donating blood may cause HIV infection, and this perception must be dispelled as we attempt to regain donor confidence and ensure an adequate and safe blood supply. Because *CMAJ* has published considerable literature on the blood system in Canada, I believe it is imperative to clarify this point and to avoid errors that could perpetuate myths about the risks of blood donation.

Graham Sher, MD
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Toronto Centre
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Princess Margaret Hospital
Toronto, Ont.

Reference

1. Expert Working Group. Guidelines for red blood cell and plasma transfusion for adults and children. *CMAJ* 1997;156(11 Suppl):S1-24.

[The news and features editor responds:]

Dr. Sher is correct. We should have replaced the word "donation" with "transfusion," which was the meaning the author intended.

Patrick Sullivan
News and Features Editor
CMAJ

Letting the public know

I read with interest the article "Common bile duct injury during laparoscopic cholecystectomy in Ontario: Does ICD-9 coding indicate true incidence?" (*CMAJ* 1998;158[4]:481-5), by Dr. Bryce Taylor, and the editorial "Administrative databases: Fact or fiction?" (*CMAJ* 1998;158[4]:489-90), by Dr. W. John S. Marshall. As a scientist who has been engaged in health services research for over a decade and who is engaged to a journalist who has written about laparoscopic surgery in the popular press, I have a unique, though perhaps not unbiased, perspective on the issues these authors raise about research into quality of care and the responsibilities of researchers, peer reviewers, editors, the media and the medical profession.

As both Taylor and Marshall point out, researchers developed an approach to measure what they called "bile duct injuries" that was first used in 2 peer-reviewed studies[1,2] and was reported in a story published in the *Toronto Star*.[3] The newspaper story was consistent with the peer-reviewed publications in suggesting a potentially serious quality-of-care issue, but only the newspaper story identified specific hospitals. That story, but not