lack of understanding of why … . Patients need to be interviewed to find out what motivates them to leave." To fill this gap in the literature, data should be collected systematically, from diverse patient samples and in methodologically sound studies. Some — perhaps many — of the patients in those samples will confirm what Brown has reported. In the meantime, I see no reason to wait to act on the data already provided by high-quality research, which suggest that we should address addictions properly in patients who have them.

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1. Anis AH, Sun H, Guh DP, Palepu A, Schechter MT, O'Shaughnessy MV. Leaving hospital against medical advice among HIV-positive patients. *CMAJ* 2002;167(6):633-7.
2. Saitz R. Discharges against medical advice: time to address the causes. *CMAJ* 2002;167(6):647-8.

A practical case

I'd like to thank *CMAJ* for printing Robert Slinger and Theodore Scholten's article about the boy with a botfly infestation.[1] I experienced a similar history for 11 weeks after my vacation. The correct diagnosis had been missed, and I was booked for removal of a sebaceous cyst. Then my husband, who is also a physician, read the case report and, suspecting that a botfly infestation might be the problem, extracted a 2.4-cm larva from my scalp.

If one of the reasons for printing unusual case studies is to help physicians, then this article certainly filled the bill. I just never suspected that I would be the patient!

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Reference

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National Network of Libraries for Health

In their article on technology-enabled knowledge translation, Kendall Ho and colleagues[1] emphasize physicians' need to "locate and access evidence to support decision-making." Organizing information, particularly electronic information, is exactly what libraries do, and we commend the initiative that Ho and colleagues describe.

The Canadian Health Libraries Association has proposed a National Network of Libraries for Health, which would build on existing resources and ensure universal access to licensed publications available through the Web. The proposal was recognized in the Romanow report[2] and is supported by Health Canada, the Canada Institute for Scientific and Technical Information, the Association of Canadian Medical Colleges, the US National Library of Medicine and the Canadian Cochrane Network and Centre. However, it has not yet been funded.

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1. Ho K, Chockalingam A, Best A, Walsh G. Technology-enabled knowledge translation: building a framework for collaboration [editorial]. *CMAJ* 2003;168(6):710-1.
2. Commission on the Future of Health Care in Canada (Romanow RJ, chair). *Building on values: the future of health care in Canada*. Saskatoon: The Commission; 2002. Available: www.hc-sc.gc.ca/english/pdf/care/romanow_e.pdf (accessed 2003 Jun 4).

[One of the authors responds:]

The notion that libraries are integral to evidence-based decision-making for health care professionals is well worth emphasizing. Librarians have tremendous expertise in searching the literature, devising and refining search strategies, and pinpointing the evidence, activities that usually involve the use of modern information and communication technologies, such as those we described.[1] Physicians and, for that matter, all health care professionals, can benefit from librarians' expertise and from their coaching as they acquire these important skills themselves.

The Division of Continuing Medical Education within the University of British Columbia Faculty of Medicine has been offering workshops to help physicians in using the Internet for evidence-based medicine, and librarians have been members of the workshop faculty since the inception of these courses. Similar approaches are being used across Canada and internationally.[2] An even more interesting model is the integration of librarians or information specialists into the clinical setting for team-based practice and learning.[3]

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Creating immunity

The argument in a *CMAJ* editorial[1] that "Unless a large proportion (usually over 95%) of the population is vaccinated, herd immunity will not result and outbreaks will recur" had me scratching my head. The same editorial notes that "the near-complete immunization of whole populations in childhood has led, decades later, to whole populations of adults with waning immunity to some childhood diseases," giving as an example pertussis, which

"is now as common among adults as among children." This is not the first time that the efficacy of vaccines has been called into question.

"Herd immunity" was defined in the first half of the last century as protection of any given population from a transmissible disease, through lifelong or long-term immunity caused by contraction of and recovery from the disease;[2] immunity related to high standards of nutrition, cleanliness and sanitation was a cofactor.[3] As the case of pertussis and other examples show, herd immunity through vaccination is a flawed concept. For various reasons, the efficacy of vaccines is highly variable (and never complete), and any immunity derived from vaccines is only short-lived.[4]

It wouldn't be so bad if all we had to worry about was lack of efficacy — after all, we managed to survive for thousands of years with no vaccinations. However, the fact that these agents of dubious effect are also harmful is another matter. However, recent data from the US Vaccine Adverse Event Reporting System show that deaths following pertussis vaccine far surpass deaths from pertussis (20 deaths yearly from the disease, 57 following vaccinations, which is a gross understatement because only 10% of reactions — at most — are reported).[2]

I agree that we need national leadership on vaccination policy and a much improved national system of recording morbidity and mortality related to specific diseases. Much more pressing is the need for an adverse reaction reporting system that encompasses all possible adverse events and is easily accessed by the general public. What we don't need is multitudes of expensive new vaccines on top of the many we already have, within an already faltering health care system.

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1. A patchwork policy: vaccination in Canada [editorial]. *CMAJ* 2003;168(5):533.
2. Tenpenny SJ. *Vaccines — what CDC documents and science reveals* [video]. Strongsville (OH): New Medical Awareness Seminars; 2002.
3. James W. *Immunization: the reality behind the myth*. 2nd ed. Westport (CT): Praeger Publishers; 1995.
4. Fine P. Herd immunity: history, theory, practice. *Epidemiol Rev* 1993;15(2):265-302.

[The editor responds:]

Regarding our editorial,[1] Susan Fletcher's conclusion that "herd immunity through vaccination is a flawed concept" is based on 2 undeniably true facts: first, infectious disease rates have fallen over time as living conditions have improved; second, that immunity after exposure to infectious disease (by vaccination or infection) also declines over time. But it is illogical to conclude that because living conditions are important, immunity is not. Both factors have contributed enormously to the observed decreases in death and illness resulting from infectious diseases.

Science and common sense concur that if there is less infectious disease in the community (because almost everyone is vaccinated), then there is much less chance that those not immunized or only partly immunized will come into contact with the infectious agent and become ill. Furthermore, if very large proportions of the "herd" are effectively immunized, diseases that survive only in humans can be eliminated. Polio and measles in Canada and many other countries are good examples (not to mention smallpox). Vaccination and herd immunity undoubtedly play important causal roles in the declining rates of infectious diseases, but they are not the only factors.

I agree with Fletcher that we need better reporting systems for adverse reactions to vaccines. The public health sector in this country and elsewhere also need to find better ways to share existing knowledge about the serious health effects of infectious diseases and about the risks and benefits of vaccination.[1]

John Hoey
CMAJ

Reference

1. A patchwork policy: vaccination in Canada [editorial]. *CMAJ* 2003;168(5):533.

Corrections

An error occurred in a recent Practice section article on the toxic effects of supplements.[1] In the second footnote of Table 1, the word "anticoagulant" should be replaced with "coagulant." Vitamin K is a coagulant.

Reference

1. Wooltorton E. Too much of a good thing? Toxic effects of vitamin and mineral supplements. *CMAJ* 2003;169(1):47-8.

In a recently published paper on DEET-based insect repellants,[1] the second sentence of the section on the toxic effects on children should read as follows: "However, we found only 10 reports describing seizures in children in North America following dermal application of DEET… ."

Reference

1. Koren G, Matsui D, Bailey B. DEET-based insect repellants: safety implications for children and pregnant and lactating women. *CMAJ* 2003; 169(3):209-12.

New letters submission process

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