Homeless shelters and substance misuse

We read with interest Wendy Muckle and Jeffrey Turnbull's guest editorial on homelessness.[1] Although shelters are not perfect, they do protect people from some aspects of homelessness. For example, there is evidence of cognitive impairment in some homeless people,[2] and this association is partially dependent on housing quality.[3]

We compared substance misuse in 31 homeless people staying in supportive shelters with that in 15 people who were literally roofless in Sheffield in the United Kingdom. Thirteen (87%) of the roofless people had injected drugs in the past month compared with only 4 (13%) of the people in shelters. All 15 (100%) of the roofless people had been using heroin or crack cocaine regularly in the past year compared with only 10 (32%) of the people living in shelters.

Homelessness is inevitably harmful and can become self-perpetuating. In our study, despite the lower level of drug use in people living in shelters, 18 (58%) of the people in this group had started taking at least 1 new drug since becoming homeless. If the homeless do not receive significant levels of help, the problems they experience can multiply. A public policy of increasing resources to address the problems of the homeless would likely be highly cost-effective over the longer term. Muckle and Turnbull are right to be concerned about the possibility of cutbacks by the current Canadian government to the homelessness funding program.

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Family practitioners and the Canadian Diabetes Association

I recently attended the national Canadian Diabetes Association (CDA) conference in Toronto. The conference was attended by a host of professionals and lay people from various walks of life, but family physicians were not well represented. Where were my fellow family physicians with a special interest in diabetes management?

At conferences and continuing medical education events, speakers often make disparaging remarks about mistakes or oversights by family physicians. Everybody seems to be busy compiling treatment guidelines to get those overworked and rusty old family physicians back in line.

I believe that family physicians with a special interest in caring for patients with diabetes mellitus should create a separate group under the auspices of the CDA. The group would hold its own meetings where members could share their knowledge and experience, participate in continuing medical education, share their research findings in a constructive environment and set standards of care for family practice that we can all strive to meet. Such a group could also lobby on behalf of family practitioners for better remuneration for time spent in attending to patients with diabetes. Attendance at the CDA conference and at the meetings of the family physicians' group would be requirements of membership in the "club," with advantages, such as increased renumeration, flowing back to the members of the group. As family physicians we must take control once again of the ongoing care of our patients with diabetes. I welcome responses to this proposal (drsnyman2003@yahoo.com).

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Cardiac risks with COX-2 inhibitors

Linda Levesque and colleagues' findings concerning the timing of cardiovascular risks in elderly users of cyclooxygenase-2 (COX-2) inhibitors are interesting,[1] but they might reflect the superiority of rofecoxib over other agents as an analgesic and anti-inflammatory agent rather than any specific cardiotoxic effect of this drug. The peak in the risk of cardiac events in the second week of treatment with rofecoxib might simply be related to increased activity levels in patients who had previously been in pain and who therefore had probably been less active and had experienced a decline in physical fitness. With a half-life of 24 hours, it takes 6 half-lives (about a week) for rofecoxib to reach steady state and maximal sustained efficacy. The finding that cardiac risk dropped back toward baseline after the second week could be explained by the patients' improved cardiac fitness result-

ing from a further week of increased physical activity. Perhaps we should be careful about how well we treat long-standing arthritis in those who long to be more active again.

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Access to abortion

The guest editorial in the July 4, 2006, issue[1] contains 2 factual errors.

First, Sanda Rodgers and Jocelyn Downie have misrepresented the 1988 Supreme Court decision in *R.* v. *Morgentaler* by stating that as a result of this decision "a woman's right to continue or terminate a pregnancy is protected by the Canadian Charter of Rights and Freedoms." In fact, although the Court identified section 25 of the Criminal Code as objectionable because of its procedural requirements, it also stated that the primary objective of this section, the protection of the fetus, "does relate to concerns that are pressing and substantial in a free and democratic society and which, pursuant to s.1 of the Charter, justify reasonable limits to be put on a woman's right."[2]

Second, the authors have misrepresented the CMA Code of Ethics by linking the failure to provide referrals for abortion with the prohibition of "discrimination on the basis of sex, marital status and medical condition." The relevant section of the Code only states the following: "Inform your patient when your personal values would influence the recommendation or practice of any medical procedure that the patient needs or wants."[3]

These factual errors could seriously mislead *CMAJ* readers.

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Sanda Rodgers and Jocelyn Downie[1] imply that there is a constitutional right to abortion. The Supreme Court of Canada, in the 1988 Morgentaler decision, did rule that the Criminal Code provision violated women's rights; however, all of the judges agreed that Parliament has a legitimate interest in protecting the unborn fetus. In 1990, Parliament considered a bill that would have restricted abortion, particularly in the latter stages of pregnancy. Given that abortion and its regulation and restriction continue to be hotly debated in Canada, it is not simply "like any other medical procedure."

It is also inaccurate to portray a physician who exercises a right of conscientious objection to participating in abortion as violating CMA policy. The 1988 CMA Policy on Induced Abortion[2] specifically allows for such a right of conscientious objection.

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If Sanda Rodgers and Jocelyn Downie[1] hold that the Supreme Court decision[2] establishes a positive legal right for women to have abortions, we believe that they have exaggerated the decision. But is that what they really said? The title of the editorial and its opening paragraph speak to questions of access, and we believe that the Supreme Court did speak to this matter in 1988. The existing abortion law was struck down because therapeutic abortion committees of the day were unpredictable and often unavailable. The whole structure had begun to unravel by 1988, and it's no surprise that it could not withstand a Charter challenge.

But if Rodgers and Downie are truly exercised about women's access to good medical attention around issues of "reproductive health," we think that their net should be thrown wider. Is it only access to abortion referrals and abortion services that is wanting in Canada? How difficult is it for women to see a family physician, an obstetrician or a public health nurse for good contraceptive advice or for pre- and post-natal teaching and assessment? It troubles our conscience that our system of universal health care has isolated wait times for cataract surgery and hip replacement and plans strong guarantees that Canadians won't have to wait for these procedures, but has said nothing about access to the less exotic care that is needed by women as they make decisions about whether to have a baby.

The differences about the ethics of abortion are deep, and these differences should not be minimized. That there are health professionals who may feel bullied into compliance is disturbing. We ourselves hold conservative views, and we may never see eye-to-eye with Rodgers and Downie on the ethics of abortion. But surely we can all agree that the number of unwanted pregnancies in Canada is not a matter to celebrate. Better assured access to preconception, prenatal, obstetric, and maternal and newborn health care is something we all could make a matter of professional conscience.

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