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1867 prom. Alta Vista Dr.
Ottawa ON K1G 3Y6
613 731-9331, 800 267-9703
fax 613 523-0937
pubs@cma.ca
www.cma.ca/journals/cmaj

Editor's preface

Français à la page suivante

What is the risk of acquiring HIV infection from a blood transfusion? Robert Remis and colleagues report on the incidence of HIV infection in a cohort of 200 196 repeat blood donors (page 375). Some had become infected with HIV during the interval between donations; assuming a 25-day window between HIV exposure and seroconversion, the authors estimate that the risk of HIV transmission per unit of blood is 1 in 913 000 — about 1 in a million. This is a useful figure for physicians to bear in mind when counselling patients about the risks associated with surgery and blood transfusion.

Steffanie Strathdee and associates conclude that this risk is acceptable and argue that the current obsession with "zero risk" is irrational (page 391). The introduction of HIV-1 p24 antigen testing by the Red Cross in March 1996 has been extremely costly and yet affords only a slight reduction in the window period — a reduction that will have virtually no measurable effect on actual risk.

Assessing risk and explaining it to patients is particularly difficult when more than 1 risk factor is present. In an interesting and informative paper James McCormack and collaborators present easy-to-use charts to help physicians and patients calculate the impact of a range of risk factors for cardiovascular and cerebrovascular disease (page 422). For example, a 55-year-old man with no other risk factors has a 3% chance of experiencing a life-threatening or fatal cardiovascular event over the next 5 years. If this patient's cholesterol level is 6.0 mmol/L, his risk rises to 4%. Add a systolic blood pressure of 170 mm Hg and the risk goes to 8%; smoking brings it to 12%. Try out the nomograms on pages 424 and 425.

Should patients be encouraged to participate actively in treatment decisions? In a study conducted at Leiden University, The Netherlands, Anne Stiggelbout and Gwendoline Kiebert interviewed almost 200 patients and their companions and found that a substantial proportion wanted the physician to make the decisions (page 383). In an accompanying editorial Christine Laine from Jefferson Medical College, Philadelphia, urges us to be cautious in our headlong rush toward patient satisfaction (page 393). Not all patients want to be involved in treatment decisions.

Dave Davis and Anne Taylor-Vaisey present the most comprehensive analysis published to date of why clinical practice guidelines have failed at the implementation stage (page 408). Donald Farquhar reviews the situation and outlines the steps being taken to encourage and enable physicians to apply CPGs at the bedside (page 403).

On June 26 the US Supreme Court ruled in 2 unanimous decisions that patients have the right to reject medical interventions (even though they may be life saving) but do not have the right to require that physicians help them to commit suicide. These rulings draw a clear distinction between *letting* a patient die and *making* a patient die. James Lavery and Peter Singer review these decisions and comment on the situation in Canada, particularly in light of the charge of first-degree murder recently brought against Halifax physician Nancy Morrison (page 405). — JH