access to potentially harmful licit and illicit drugs.

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"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
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[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.

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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.

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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

the peer-reviewed publications, generated a heated public response from the medical profession.

Taylor undertook his study after the newspaper story had been published. As he acknowledges, his work was not designed to estimate accurately the number of bile duct injuries in Ontario but rather to evaluate the approach used in the earlier studies.[1,2] He concluded that there had been problems with that approach. His systematic questioning of previous research is a normal component of scientific progress and debate. He did not criticize the researchers who did the original work, the reviewers and editors who endorsed it, or the journalist who responded to the quality-of-care issue they first identified.

Ultimately, Taylor, Marshall and the journalist all agreed that public accountability is important and that there is a real need to give the public accurate information on quality of care. We need to understand that researchers face a learning curve in developing ways to produce that information. Furthermore, we should not be surprised if journalists and the public have a keen interest in research on quality of care. Public accountability means just that — letting the public know. It means naming names rather than hiding behind anonymous data, and it means publicizing existing peer-reviewed research rather than waiting, perhaps forever, until we find the perfect way to measure quality of care.

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1. Cohen MM, Young W, Thériault ME, Hernandez R. Has laparoscopic cholecystectomy changed patterns of practice and patient outcome in Ontario? *CMAJ* 1996;154(4):491-500.
2. Cohen MM, Young W. Complications after laparoscopic cholecystectomy. In: Goel V, Williams JI, Anderson GM, Blackstien-Hirsh P, Fooks C, Naylor CD, editors. *Patterns of health care in Ontario. The ICES practice atlas*. 2nd ed. Ottawa: Canadian Medical Association; 1996. p. 187-90.
3. Priest L. The low-scar surgery with a high risk. *Toronto Star* 1997 Sept 21; Sect A:1,14,15.

[Dr. Taylor responds:]

The popular press undoubtedly played an important role in focusing on an apparently important issue of quality of care. As events unfolded, however, the newspaper story was misdirected: the fault lay not in the quality of care by Ontario's general surgeons, but in the coding system for documenting complications. The newspaper article was correct, therefore, in recognizing a discrepancy that should have been investigated, and the scientific community (general surgeons, *CMAJ* and the Institute for Clinical Evaluative Sciences [ICES] included) could learn from that method of intense investigative reporting. However, we must remember that although accountability to the patient is of prime importance, the concern, fear and outright paranoia that can be generated can, in the end, be counterproductive. Ironically, we are now concerned that patients will present with life-threatening complications of their gallstone disease that could have been avoided if they had not ignored, on the basis of the newspaper article, their surgeons' advice to undergo elective cholecystectomy. That reaction is not surprising, given that phrases such as "slashed bile ducts" were used repeatedly to characterize what turned out to be, in over 90% of cases, coding notations of events inconsequential to patient outcome.

I support the pursuit of truth and the naming of names; however, if names are to be named it is all the more important that the truth be established first. The authors of the original article stated that their finding should be investigated further.[1] If such an investigation had been carried out more quickly by the scientific community, the truth would have come to light and perhaps the recent over-reaction avoided. We can only hope that the scientific community, in the speed with which it seeks the truth, and the lay press, in its sense of responsibility and methodology, will both do better next time.

On the subject of responsibility, I must commend Mr. John Honderich, publisher of the *Toronto Star*. After completing my independent review, I was encouraged to submit an article for publication in *CMAJ* because of the potential value of my conclusions to the scientific community in general and to medical records departments in particular for future assessments of computerized data from the Canadian Institute for Health Information. While the article was in peer review, the *Star* quite legitimately wanted to publish my findings to clear the air. Such a premature account would have made publication in *CMAJ* impossible. A personal plea to Mr. Honderich received a sympathetic and gracious response; he simply wanted the truth to come out, and he assured me that the *Star* would withhold the story until after *CMAJ*'s embargo date. That experience convinced me that the scientific press and the popular press have the same objectives after all.

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Reference

1. Cohen MM, Young W, Thériault ME, Hernandez R. Has laparoscopic cholecystectomy changed patterns of practice and patient outcome in Ontario? *CMAJ* 1996;154(4):491-500.

[Dr. Marshall responds:]

Dr. Anderson correctly concludes that I endorse accountability for the provision of care if it is based on accurate data. My plea was to avoid careless use or labelling of unvalidated data, since such practices bring the use of administrative databases for accountability into question. I agree that researchers, like surgeons, have a learning curve, but like surgeons they also have an obligation to minimize the damage they do during that learning process. I believe that in this instance the researchers minimized the damage by not identifying hospital sites when the data they had were unvalidated. Unfortunately, the same could not be said of the press.

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Rural medicine: real action needed

I found that the paper "Alberta's Rural Physician Action Plan [RPAP]: an integrated approach to education recruitment and retention" (*CMAJ* 1998;158[3]:351-5), by Dr. Douglas R. Wilson and colleagues, was one-sided, lacked outcome measures and might have left readers with the impression that this program has been successful. At least 3 problems were either glossed over or left unmentioned.

The article makes a passing reference to the independent review of RPAP's effectiveness[1] but fails to mention the reviewers' strong criticism of the program mix. Although rural Canada needs infrastructure to support training for anesthesia, cesarean section and general surgical procedures, these areas have not been emphasized by the training programs. Even though there is no significant need for full-time emergency physicians in rural Canada, much of the training has been in this area. The reviewers pointed out that most of the physicians who received this training under the plan subsequently left to work in urban emergency departments.

The paper also failed to mention that the plan itself may consider the measures described inadequate. Why else would Alberta be going to Africa to recruit 25 to 40 doctors this year?[2] These doctors are to be ghettoized in rural Alberta through restricted licensure — until they can prove they are competent!

The most damning criticism of RPAP is that from January 1994 to January 1998 the number of rural GP/FPs in Alberta dropped from 442 to 292 (Lynda Buske, Canadian Medical Association: personal communication, 1998).

Training doctors for rural practice is an important part of any solution. However, when no attempt is made to make rural medicine attractive, even the best physicians with rural training may eventually set up shop in the city. A truly integrated action plan would also offer significant retention incentives to overcome the opportunity costs of doing necessary but low-volume work in obstetrics, emergency medicine or other areas.

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1. MacDonald CA and Associates. *Evaluation of the Rural Physician Action Plan*. Edmonton: Alberta Health; 1996.
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After reading this article, I find it difficult to see how such a well-conceived, integrated approach could fail to succeed. Still, 7 years after RPAP was launched, objective evidence of its success is lacking.

Current events indicate that the plan is a failure or, at best, inadequate. This year it is to receive an extra $1 million, which will be spent on the urgent recruitment of 40 physicians from other provinces and overseas.[1] In the 2 years since the evaluation mentioned in the article, the number of rural physicians in the province has declined substantially.[2] The decline suggests that Alberta is not doing any better than provinces without "plans" that are undergoing similar health care restructuring.

This article leaves the impression that RPAP is bringing the problem of rural physician recruitment under control, and it is unfortunate that it appeared in the midst of the AMA's negotiations with Alberta Health. The province's rural physicians had hoped that the problems of rural recruitment and retention would be dealt with adequately during those negotiations.

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[The authors reply:]

Our paper was intended to describe the development and characteristics of RPAP and to present some early indicators of success. One problem in preparing a paper for publication is the gap between completion of the manuscript and publication; many events can occur during that period. Our opinion that