ferential response to hydromorphone and morphine are not established, but possibilities include: differences in metabolism — hydromorphone is metabolized primarily to hydromorphone-3-glucuronide and, unlike morphine, does not form a 6-glucuronide metabolite that has opioid activity;[8] incomplete cross-tolerance; or as yet uncharacterized differences in opioid receptor subtype activity.

We believe that the clinical evidence for individual differences in opioid response, recently summarized in a comprehensive review of hydromorphone from the Cleveland Clinic,[9] fully supports the accuracy of the statement in the advertisement criticized by Dr. Rashiq.

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Wait times affect kids too

We are pleased that Dr. Brian Postl has been named the new Federal Advisor on Wait Times.[1] Despite a mandate prescribed by the First Ministers' Health Accord of 2004 to concentrate on five key areas (heart, cancer, diagnostic imaging, joint replacement and sight restoration), we hope that Dr. Postl's experience as a pediatrician will give him insight into a 6th key area: children's surgical wait times. Children rarely need heart revascularization, cataract surgery or hip replacements, but they may need surgery for serious birth defects, cancer, traumatic injuries and a variety of other conditions, ranging from minor to life-threatening. In BC, we have compared our wait times for children's surgery with those suggested by our professional organizations and have found that only 35% of BC children undergoing elective surgery did so within recommended wait times. Among children requiring cancer surgery, only 38% had operations during weekday working hours.[2] From this we conclude that the combination of deferred elective surgery and increased out of hours emergent or urgent (cancer) surgery are the adjustments necessary to enable timely surgical treatment for children of BC. Neither approach is safe or sustainable.

The Pediatric Surgical Chiefs of Canada believe that there is much to be done for children's surgical care delivery in Canada: let's set national "benchmarks" for children's waiting times and monitor our performance.

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Medical care delivery

As an admirer of the invariably high standards of *CMAJ*'s lead editorials, I would like to record a small comment about the one on monitoring the quality of medical care delivery.[1] A hospital admission is frightening enough for patients, without their learning from an authoritative source that hospitals "are particularly dangerous places" and that "the overall incidence rate of adverse events that result in death, disability or prolonged hospital stay in Canadian hospitals is 7.5 per 100 hospital admissions." From this, the trembling patient would reasonably assume that 7.5% of admissions can be expected to result in one of these fearful outcomes. However, the source article for this statistic tells us that nearly one-third of these events occurred in the 12 months preceding the index hospital admission. Thus, the rate of adverse events occurring during a hospital stay was closer to 5.2%.[2]

Doctors and patients are well aware that few therapies have a 100% success rate and that perfectly appropriate treatment can be associated with unwanted outcomes. The figure we all need to know is the rate of preventable adverse events. In the study by Baker and colleagues this was 2.8%.[2] We also need to know whether the consequences of these events are really "death, disability or prolonged hospital stay." Some proportion of adverse events in the study probably resulted only in slight extensions of the patient's stay in hospital; most (56%) resulted in no impairment, minimal impairment or impairment with recovery within 1 month.[2] The 7.5% figure cited in the editorial is barely relevant and unnecessarily frightening.

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