foods,"^{2,3} such as those containing sugars in concentrations exceeding 250 g/L, which is the physiologic limit imposed by evolution.⁴

If a diabetes epidemic similar to the tragic one now afflicting the Pima Indians³ had ravaged Europe centuries ago, this scourge would have certainly been reported by historians, who did not fail to write about the numerous plagues that decimated the European population during the Middle Ages. However, no diabetes epidemic in Europe was reported by either medieval or subsequent historians. There is also no mention of a diabetes epidemic in Latin literature, despite the fact that half of the 468-odd recipes in a Roman cookery book call for honey as an ingredient.² The Europeans' passable adaptation to diabetogenic foods, therefore, is likely to reflect a selection that mostly occurred before their remote ancestors could leave written records.

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[One of the authors responds:]

Diabetes currently affects approximately 8% of all adults in North America.¹ However, even with 21st century biomedical technology and intense attention to this problem, the disease remains undiagnosed in more than 30% of affected individuals.¹ It is therefore quite likely that a high prevalence of diabetes in Europe in the 16th and 17th centuries might not be recognizable in a historical record that was not attuned to the measurement of chronic illness.

Thus, lack of evidence of a diabetes epidemic in such a society is not evidence of an absence of such an epidemic.

In our hypothesis,² we state that lower rates of diabetes in some ethnic groups (e.g., Europeans) may be attributable to a longer period of exposure to a diabetogenic environment coupled with a reproductive advantage for individuals exposed to such an environment. Such an environment is not restricted to specific foods; rather, it is characterized by a stable food supply plus increasing availability of labour-saving devices. We also point out that there is no reason to attribute the current epidemic to prehistoric alternating periods of feast or famine and the emergence of "thrifty genes"; indeed, this does not readily account for ethnic heterogeneity in prevalence. Moreover, millennia are clearly not required for resistance to diabetes to emerge if such resistance confers even a modest selective advantage within a diabetogenic environment. Finally, our hypothesis can be tested directly in animal models of diabetes and indirectly in population studies of fertility in dysglycemic individuals (such studies have not yet been undertaken).

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Medical wait lists

A recent *CMAJ* editorial argued that the development of wait-time benchmarks by the Canadian Wait Time Alliance might have been less useful than it seems.¹ Although it would be foolhardy

to argue with the assertion that there is a lot more to the health-reform story, there are many valid reasons for starting to deal with access to care by examining late-stage interventions rather than primary care or prevention.

First, to demonstrate success with any initiative, measurable indicators are needed. It is easy to measure the interval from the date of a decision to perform a diagnostic test or intervention to the date when that test or procedure is performed.

Second, the concentration of diagnostic and therapeutic services in tertiary care centres makes the implementation of wait-time benchmarks much simpler from an operational perspective.

Third, our well-meaning politicians do not have the expertise to appreciate where the real bottlenecks and truly dangerous delays are in the system. However, through this current initiative, physicians have an opportunity to properly inform politicians and policy-makers about a broader range of issues related to access to care.

Who can blame politicians for picking the procedures they did? In 2002, a total of 74 626 Canadians died from cardiovascular disease and 65 103 from cancer. Together, these deaths accounted for 62.4% of all deaths in Canada.² Although there is always a risk that these procedures will be completed at the expense of other important procedures, if you had to start somewhere, this would be the place. The Canadian Wait Time Alliance recognized this risk and brought it to the politicians' attention.³

Sadly, the editorial is correct in stating that there is little hard evidence for some of these benchmarks. This is the case for many services and procedures in cardiac care, although for some interventions (e.g., cardiac catheterization) there is excellent literature to support the recommended wait-time benchmarks. In 2004, the Canadian Cardiovascular Society (CCS) (1 of the 6 professional associations in the Wait Time Alliance) established an Access to Care Working Group with a mandate to develop a series of commentaries to expand on the recommendations in the report of the Wait Time Alliance. Some