Harassment from misguided mayoral candidate

I was astounded to read that Toronto City Councillor Robert Ford went on record as saying that doctors should not be advocating for the poor.[1] Ford went so far as to file a complaint with the College of Physicians and Surgeons of Ontario against Dr. Roland Wong, a family physician who had found a novel way to allow welfare recipients to obtain financial assistance for food to avoid diet-related problems. Ford considers this going well beyond the duties and responsibilities of doctors.

The poor have greatly increased risks of cardiac disease and diabetes, among other problems. I find it extraordinary that a city councillor would think that a doctor advocating for his poverty-stricken patients is doing something out of line.

I am also concerned that the complaints process is being used inappropriately in this instance. If one can put pen to paper, one can put the college's complaints process in motion, no matter how vexatious or frivolous the matter. This situation constitutes harassment of a well-intentioned physician. One can only hope that reason prevails when the matter goes to a hearing at the college.

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For the full letter, go to: www.cmaj.ca/cgi/eletters/182/9/E401

DOI: 10.1503/cmaj.110-2091

The right to give blood

A news item in *BCMJ*[1] is relevant to the article by Wainberg and colleagues.[2] It reads: "New data from the US Centers for Disease Control and Prevention (CDC) show that gay, bisexual, and other men who have sex with men (MSM) are over 44 times more likely than other men to contract HIV, and over 40 times more likely than women to contract HIV. Further, MSM are over 46 times more likely to contract syphilis than other men, and over 71 times more likely than women to contract syphilis. According to the CDC, MSM comprised 57% of people newly infected with HIV in the US in 2006, even though MSM are only 2% of the adult population."

Are the lessons from Krever now on the back burner?

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For the full letter, go to: www.cmaj.ca/cgi/eletters/cmaj.091476v1#474640

DOI 10.1503/cmaj.110-2088

Wainberg and colleagues[1] argue for a change in blood donation policy that would allow some low-risk men who have had sex with other men (MSM) to donate. They cite an estimate based on modelled data that suggested that shortening the MSM deferral period from lifetime to one year would result in one additional HIV-infected unit of blood escaping detection in Canada every 16 years, or one additional unit per 11 000 000 transfusions.[2] This 2003 estimate, however small, still represents a substantial overestimate of risk. When the rates of laboratory error used for modelling were updated to more current levels, the risk estimates decreased 10-fold.[3] This risk calculation represents an estimate for the first year that newly eligible donors would enter the donor pool; they cannot be accurately extended over longer periods without adjusting for the effects of repeat donations. Tests of new donors represent prevalence screens, detecting both recent and long-standing infections. Because repeat donors have previously been tested, the test represents an incidence screen for new infection since the previous donation. Therefore, repeat donors typically have rates of infection half those of first-time donors.[4]

As testing has improved dramatically and the epidemic has shifted, other countries have shortened their deferral periods for blood donation. Indeed, the reports of international blood donation policies in Wainberg and colleagues' article are already outdated. Last year, New Zealand shortened its MSM deferral period from 10 years to 5 years, and South Africa from 5 years to 6 months.

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DOI: 10.1503/cmaj.110-2087

End of life

Sumner has presented his perspective on the end of his own life: "I want to be the one who decides."[1] The desire for individual autonomy is very much in line with attitudes in Canada that assign priority to individual rights and privileges. However, such priority does not exist in a vacuum.

The moral and social environment inheres not only in separate individuals but also in a society. There is a need to reflect on the impact of any decisions on the quality of our society, on our humanity. Although I agree that it might be comforting to be legally permitted to decide when and how I may

end my life, this conveys an attitude, and therefore future decisions, about the value of a human life apart from its "worth" or its "meaning." To compare the death of a cat to the death of a human is not a useful analogy. As a culture, we shall favour alleviating pain even if it shortens life. To encourage and make possible the intentional killing of myself or my fellow is not good for our society and will backfire.

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For the full letter, go to: www.cmaj.ca/cgi/eletters/182/9/1004

DOI: 10.1503/cmaj.110-2090

Why can't I get my veins unblocked in Canada?

I have multiple sclerosis, but I also have blocked veins. Why can't I get my veins unblocked in Canada, just because I have pre-existing multiple sclerosis? I agree, treatment for any disease should be based on science, not hope (see editorial on page 1151).[1] So I ask, what is the best way to gather evidence in this case? The Multiple Sclerosis Society of Canada wants to spend two years determining whether patients have blocked veins, while providing no treatment. If there are blocked veins, why not provide the treatment, then study the patient? Wouldn't we gather more evidence that way?

In fact, I guarantee more will be learned. I flew to Bulgaria June 10 and had the "liberation procedure" June 14. The procedure has provided continuous gradual improvement. There might be only published evidence from 65 patients, but over 1000 people have received this treatment, with a substantial number of them showing noticeable improvement. When I told the people at my multiple sclerosis clinic that I was going to Bulgaria for the treatment, I asked them if they'd like to see me before I went and again when I returned. They replied that they were too busy. The lack of resources allocated by the Multiple Sclerosis Society of Canada and their actions demonstrate their lack of interest in pursing this novel treatment. Government funding needs to go to research programs that involve patients' views.

I am more than willing to be a study subject and a patient advocate. By studying the outcomes of the liberation procedure, maybe the medical community can gather the evidence to prove what I already know.

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DOI: 10.1503/cmaj.110-2085

Hear some evil, see some evil, report no evil

Croskerry has suggested that the magnitude of the health system problem with mistakes was unmasked and that "the new century ushered in an era of openness."[1] How open is a system where none of the organizations that participated in the 2004 study on health system error by Norton and colleagues[2] can or will report whether they make more mistakes, fewer mistakes or the same number as they did six years ago? If hospital board members, administrators and governments really cared, they would ask about and report on whether the rate of unnecessary and preventable death, discomfort and disability is going up, going down or staying the same.

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