the use of either a diuretic or an angiotensin-converting-enzyme inhibitor as an alternative agent. (How many other options are there?) Up to 94% of these experts, in the treatment of angina in patients with heart failure, may prefer a calcium-channel blocker over a ß-adrenergic blocking agent, which is perplexing, given long-standing concerns about the use of calcium-channel blockers in heart failure and the evidence of benefit from ß-adrenergic blocking agents in this setting.

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McLeod and colleagues state that dipyridamole should not be prescribed to prevent stroke because it is ineffective for this indication. In this regard, I would like to inform readers of the results of a recent clinical trial.[1]

In the study, 6602 patients with a mean age of 66.7 years who had had a previous stroke or transient ischemic attack (TIA) were randomly assigned to receive ASA (50 mg daily), modified-release dipyridamole (400 mg daily), a combination of the 2 agents or a placebo. This was a blinded study, and patients were followed for 2 years. The relative reduction in the risk of stroke from taking ASA was 18.1% ($p = 0.013$), from taking dipyridamole was 16.3% ($p = 0.039$) and from taking the combination, 37% ($p < 0.001$), compared with placebo.

The combination was significantly more effective than either agent alone. The authors concluded that "ASA 25 mg twice daily and dipyridamole, in a modified-release form, at a dose of 200 mg twice daily have each been shown to be equally effective for the secondary prevention of ischemic stroke and TIA; when coprescribed the protective effects are additive, the combination being significantly more effective than either agent prescribed singly; and low-dose ASA does not eliminate the propensity for induced bleeding."

The formulation of dipyridamole used in this study is not available in Canada, and stroke prevention is not an approved indication for this product in this country.

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Reference

1. Diener H, Cunha L, Forbes C, et al. European Stroke Prevention Study 2: dipyridamole and acetylsalicylic acid in the secondary prevention of stroke. *J Neurol Sci* 1996;143:1-13.

[Two of the authors respond:]

As we indicated in our article, the consensus panel members were selected arbitrarily, and an effort was made to assure a reasonable balance among geographic regions and among relevant specialties. We chose individuals with established reputations in the field of drug therapy, particularly as it affects elderly people. One family physician invited to participate refused because there was no remuneration for the task.

We did not evaluate the validity of the standard textbooks used in developing the drug lists. None of the experts on our consensus panel was an author of the lists on which the project was based. Our study design was not intended to evaluate agreement on specific items contributed by panel members, nor did it require that we exclude panel members from rating their own submissions. Since 32 specialists were responsible for developing the consensus, it is unlikely that an eccentric rating by 1 member would have an impact on the final ratings.

It is unclear to us why advance agreement on the scoring process would be necessary in a consensus procedure. We arbitrarily selected the 4-point rating scale, and none of the panel members objected to using it. As we outlined, panel members were asked to rate the clinical importance of the potential adverse drug effects by taking into account 3 criteria: (1) the prescription introduces a substantial and clinically significant increase in the risk of a serious adverse effect, (2) equally effective or more effective and less risky alternative therapy is available for most patients and (3) the practice is likely to occur often enough that a change in practice could decrease morbidity in elderly people.

As we indicated, we used a modified Delphi technique to arrive at consensus recommendations. We did not feel that the repeated iterations needed in an "actual" Delphi process would improve the clinical usefulness of the final recommendations.

We agree with Dr. Busser that some of the panel's views are difficult to reconcile. One's own biases often lead one to disagree with consensus recommendations. For example, although some of us feel that ß-adrenergic blocking agents have some limited usefulness in severe heart failure, clinical experience and conventional wisdom dictate that these drugs are risky in patients with heart failure. With respect to the treatment of hypertension in patients with a history of heart failure, there are several alternatives to diuretics and angiotensin-converting-enzyme inhibitors, including α_1-adrenergic agents and centrally acting antiadrenergic drugs. We cannot explain why 94% of the experts agreed with the use of calcium-channel blocking agents to treat angina in a patient with a history of heart failure since we did

not ask the panel members to outline the reasons for their selections.

We thank Dr. Vickerson for bringing to our attention the recent study of the use of dipyridamole for stroke prevention. We do not know how many panel members were aware of the results of the European stroke-prevention study when we were carrying out our study.

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Immunization and global ecology

It is the task of physicians to treat and prevent diseases in their patients. In this physician–patient relationship, the interests of each patient are foremost.

A reading of "Global immunization: Is a child's life worth $15?" (*Can Med Assoc J* 1996;155:1492-4), by Dr. Edward Ragan, leads one to ask, Does this also apply in the global arena? Western medicine's success in eliminating many potentially fatal diseases of childhood is largely responsible for a population growth that may correctly be termed a "population explosion." If the rising number of people on the planet achieves a Western lifestyle (which all peoples seem to strive for), this would be incompatible with the maintenance of global ecology. In this scenario, global immunization programs are of questionable value for mankind as a whole and for all life on this planet unless they are accompanied by equally effective birth control programs.

As physicians, we face a significant ethical dilemma. Successful vaccination programs without concurrent and successful birth control are apt to shift human suffering from disease to famine or ecologic disaster.

If one argues that this is not physicians' concern but someone else's, and that we as physicians are responsible for only 1 side of the coin, one would be taking a moral stance similar to that taken by the scientists who developed the means for building the nuclear bomb and yet claimed that they were free of responsibility for the consequences of its use.

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An impaired judicial system

"Weep for Adonais" (*Can Med Assoc J* 1997;156:889-90), by Nicole Baer, describes a tale too often told. An impaired driver not only kills 1 or more innocent victims but remains behind the wheel to kill or maim again. I suspect many physicians have had professional experience with the devastating impact of drinking and driving. How many emergency physicians have fought frantically to save the life of a drunken driver, reeking of alcohol and too impaired to be coherent, while his or her victim is sent to the morgue, not the emergency department?

I will always remember when a young woman and the child she was babysitting were struck by a car that had driven through a stop sign. All survived, but the young woman, bleeding from both ears due to a basal skull fracture, was evacuated for neurosurgical assessment while the impaired driver steadfastly refused to allow any blood to be taken.

The apparent inadequacy of the law in bringing justice to cases such as the one described by Baer is a challenge to the integrity of the legal profession. The legal fine points that ensure a fair trial seem immoral to anyone with personal or front-line experience with the problem.

The medical profession is well situated to deal with the social and medical problems arising from alcoholism, and assessments of the fitness of alcoholics to drive should be a routine part of caring for these patients. A recent history of heavy uncontrolled drinking, arrival at an appointment impaired or inebriated, or a history of blackouts should prompt a letter to the transportation ministry expressing concern about a patient's fitness to drive. This is in keeping with determinations of fitness to drive involving other recognized diseases, such as epilepsy or cardiac arrhythmia.

Physicians' obligation to serve a patient's interests and health does not require that they allow alcoholics to play Russian roulette with their own lives and the lives of others. Development of clinical guidelines to help us determine alcoholic patients' fitness to drive would be a welcome step forward. I would like to hear suggestions about how our profession should address this problem.

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Standards for polysomnography

In their editorial "Polysomnography: addressing the needs for standards" (*Can Med Assoc J* 1996;155:1693-4), Drs. William A. Whitelaw and W. Ward Flemons support the standards for polysomnography of the Canadian Sleep Society and the Canadian Thoracic Society (CSS/CTS). As they indicate, the field of sleep disorders medicine cannot achieve widespread recognition or credibility without appropriate standards. However, some of their statements require clarification.

Whitelaw and Flemons point out that there is no funding for sleep