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.

**Peter J. McLeod, MD**
**Robyn M. Tamblyn, PhD**
McGill University
Montreal, Que.

## 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.

**Klaus D. Teichmann, MD**
King Khaled Eye Specialist Hospital
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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.

**Stephen Workman, MD**
Master's student
University of Toronto Joint Centre for Bioethics
Toronto, Ont.

## 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

studies or nasal continuous positive airway pressure (CPAP) in Alberta. In Ontario, although funding for diagnosis and therapy is readily available, it is neither comprehensive nor open ended. The stated cost of approximately $1000 per patient is just about double what is paid for full, overnight polysomnography with physician supervision and reporting (including both technical and professional fees and allowing for government clawbacks). Moreover, the Assistive Devices Program of the Ontario Ministry of Health provides 75% of the cost of CPAP (up to a maximum) 1 time only. Continuing costs are not covered. Compared with the coverage in Alberta, this may seem "comprehensive and open ended." And indeed, such a fee schedule has invited abuse, which is all the more reason to establish standards.

The CSS/CTS standards have already been used as a template for provincial standards in Alberta and Ontario. In 1994, the College of Physicians and Surgeons of Ontario (CPSO) established a task force to develop clinical practice parameters and facility standards for sleep medicine. This document has recently been completed. Under the direction of Dr. Gerry Gold of CPSO, and task force cochairs Drs. Harvey Moldofsky and Murray Moffat, this work extends the facility and test standards of the CSS/CTS standards by including details on indications for sleep studies, type of sleep studies, follow-up, post-sleep-study interventions and medicolegal issues. (The document is available through Ms. Corinne Berinstein, CPSO, tel. 416 967-2600.)

Sleep apnea is an extremely common sleep disorder that causes a significant rate of injury and death. Patients with sleep apnea may consume

## An invitation

# Experience

*CMAJ*'s Experience section offers a forum for physicians to reflect on the often-unanticipated opportunities for growth that arise in our professional and personal lives.

"Experience" can mean the lessons of the past or the knowledge gained as events accumulate. But it can also describe our engagement with the present: times of difficulty, moments of insight. For physicians, it begins with direct encounters with people whose "illness experience" enters our professional and personal experience.

Physicians have used this new forum to reflect on family illness, uncomfortable questions about the right to die, personal confrontations with mortality and the ghosts of humanitarian medical missions.

*CMAJ* invites inquiries from authors interested in sharing their experiences and personal perspectives to enrich the thinking of others. Contact John Hoey, MD, Editor-in-Chief, *CMAJ*; tel 800 663-7336 ext. 2118, fax 613 523-0937 or e-mail hoeyj@cma.ca. If writing, please include your telephone number.

## Une invitation

# Expérience

La chronique Expérience du *JAMC* offre aux médecins une tribune de réflexion sur les possibilités d'épanouissement souvent imprévues qui se présentent dans nos vies professionnelles et personnelles.

Le mot «Expérience» peut signifier les leçons tirées du passé ou les connaissances acquises au fil des événements. Il peut aussi décrire notre engagement envers le présent : périodes de difficulté, moments d'introspection. Pour les médecins, l'expérience commence par des rencontres directes avec des gens dont le «vécu de la maladie» envahit notre expérience professionnelle et personnelle.

Les médecins ont utilisé cette nouvelle tribune pour présenter des réflexions sur la maladie familiale, des questions troublantes comme le droit de mourir, des confrontations personnelles avec la mortalité et les fantômes de missions médicales humanitaires.

Le *JAMC* invite les auteurs intéressés à faire part de leur vécu et de leurs perspectives personnelles afin d'enrichir la réflexion d'autrui. Veuillez communiquer avec John Hoey, MD, rédacteur en chef, *JAMC*; tél. 800 663-7336, poste 2118; télécopieur 613 523-0937; ou courrier électronique hoeyj@cma.ca. Si vous vous adressez à lui par écrit, veuillez inclure votre numéro de téléphone.

more health care resources before diagnosis and treatment than after.[1] Whitelaw and Flemons are correct in stating that we need research on better and cheaper methods of diagnosis and treatment. We must not, however, lose sight of the fact that sleep apnea is but 1 of more than 75 sleep disorders, each with associated problems. These cannot be addressed without adequate training and appropriate application of the diagnostic tools available.

**Charles F.P. George, MD**
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Standards Committee
Canadian Sleep Society
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Received via e-mail

**Reference**

1. Kryger MH, Roos L, Delaive K, Walld R, Horrocks J. Utilization of health care services in patients with severe obstructive sleep apnea. *Sleep* 1996;19(9):S111-6.

## Our future physicians deserve better

I continue to be appalled that medical students must decide what postgraduate program they are going to pursue around the end of their second undergraduate year. In many cases this is almost impossible because their experience and exposure to medicine are far too limited. It is even sadder that once a course of action has been chosen, the young physician's future is written in stone.

I am eager to enter this fray because of the article "Little room for error in Canada's postgraduate training system" (*Can Med Assoc J* 1997;156:682-4), by Sandy Robertson. I was invited to train in surgery because the late Angus D. McLachlin caught me working on a public surgical ward as a junior intern. Of course, that latter post no longer exists. My happy 35 years doing pediatric surgery could not have happened under present rules and conditions.

The junior internship year was the most valuable year of my medical life. According to Robertson, this training year was abolished by the demands of the College of Family Physicians of Canada. It is serious and very sad that only rarely can physicians change their course of action, although it appears that some have made career changes. As well, some provinces are trying to improve things. A Mar. 3, 1997, bulletin from the Ontario Ministry of Health[1] refers to re-entry opportunities for 10 Ontario general/family physicians, who will be able to pursue advanced skills in emergency medicine, anesthesia or geriatrics. There are also 15 re-entry specialty positions available in general surgery, obstetrics, general internal medicine and psychiatry. The snag — and of course there is one — is that these people must return to practice in an underserviced area. This is to start July 1, 1997.

If deans of medicine would consider this problem, perhaps changes could be made. A few days ago, an internist told me he has never before seen the high level of anxiety found in today's medical students. The demand that they make too early a career choice is a big factor in this.

I hope that this article will be read, thought about and acted upon for the good of our medical students and future trainees.

**Donald G. Marshall, MD**
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**Reference**

1. Ontario Ministry of Health. Re-entry opportunities for Ontario general/family physicians [letter]. Ontario: The Ministry; 1997.

### Submitting letters

Letters must be submitted by mail, courier or e-mail, not by fax. They must be signed by all authors and limited to 300 words in length. Letters that refer to articles must be received within 2 months of the publication of the article. *CMAJ* corresponds only with the authors of accepted letters. Letters are subject to editing and abridgement.

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