



try responsible for the problem. That power remains in Ottawa with the Product Safety Bureau of Health Canada. Unless and until there is a national centre breathing down the neck of this branch, or similar pressure from many of the provinces, it will continue to pussy-foot around this problem and others like it.

Although Tonkin is correct in bringing me to task for not emphasizing the need for tougher measures at the provincial level, he is wrong in implying that I failed to do so because I think the federal government holds all the answers. The reality is that the power to take the tougher measures needed resides for the most part in Ottawa, not Victoria. If, and when, the provincial governments take this problem seriously and place it within the public health area, where it belongs, then there may be less need for a national centre of the kind I propose. However, in light of the US experience, there will always be a critical role, if only that of a standard-bearer, for the federal government.

I. Barry Pless, CM, MD

National Health Scientist
Professor of Pediatrics
and of Epidemiology and Biostatistics
McGill University
Montreal, Que.

Any of us who work in trauma treatment inevitably react emotionally to the issue of prevention of needless injuries. As Dr. Pless so clearly states in his editorial, a central structure is required if effective measures are to be taken in a way that affects all types of injuries.

Injury prevention provides an interesting paradox, because it is an area in which grassroots support is necessary. For example, the use of seatbelts and child seats in cars would have gone nowhere without social awareness, education in schools and the central prescription of standards requiring the use of seatbelts. The

legislative change has been made on a province-by-province basis because motor-vehicle legislation is a provincial area. None the less, standards for seatbelts are mandated federally. Finally, the circle is closed by a high rate of compliance with legislation, which has been encouraged by the grassroots approach.

The BC Injury Prevention Centre was started in 1987 as the Spinal Cord Injury Prevention Program because of our concern about the avoidable spinal-cord injuries we treated. The centre's strategies for prevention include research, education, legislation and enforcement. Legislation needs to be at the federal and provincial level. However, the field of injury prevention has been burgeoning in popularity and needs a measure of coalition and confederation. The multiplicity of injury-prevention bodies reflects an interest at the grassroots level that may not result in enhanced effectiveness.

We therefore suggest that a federal agency be responsible for ensuring standards, as Pless outlines in his editorial. National organizations such as the Smart Risk Foundation (formerly the Canadian Injury Prevention Foundation) may be best employed in providing common curricula and materials that can be used in all of the provinces. Provincial government agencies such as the BC Committee for Injury Prevention may be best suited to linking the legislation and enforcement at a provincial level with the implementation groups. Groups such as ours are best able to support local bodies such as schools or organizers of events that need presentation materials and supportive speakers. We can also monitor injury trends because we work within a major trauma centre, and we may therefore be the best group to prepare public service announcements to enhance social awareness of the need for injury prevention.

Peter C. Wing, MB, MSc

Medical Director
BC Injury Prevention Centre
Director, Spine Program
Vancouver Hospital
and Health Sciences Centre

Mary Ellen Lower

Director of Programs and Development
BC Injury Prevention Centre
Vancouver, BC

[One of the authors responds:]

I agree with Dr. Pless' editorial wholeheartedly, but I am confused by the letter from Dr. Wing and Ms. Lower.

The field of injury prevention is anemic, and this anemia is chronic. To be effective, practitioners of injury prevention must join the mainstream and become part of a true injury-control system. Injury control encompasses injury prevention, emergency medical services, acute care (trauma) and injury rehabilitation, all working together. Obviously, we must try to prevent the injury in the first place, but if we cannot, then we need a proper emergency-medical-services system that can respond rapidly and that has appropriately trained providers who can treat children as well as adults. Patients whose injuries threaten life or limb need to be taken to a facility that can deal with trauma, and these patients need rehabilitation from the moment they are injured. The system must include the ability to collect injury data and analyse it to better develop programs to prevent future injuries and to improve the outcomes for those injured.

As it stands, anyone can say he or she is an injury-control specialist, injury-prevention expert or injury consultant, and no one can dispute such a claim. The injury-control field needs accredited practitioners, leadership at the federal and provincial levels and appropriate resources to match the billions of dollars spent on injuries each year.

What we do not need is yet an-



other task force to tell us that we have a problem. The numbers are obvious. Who is going to lead us out of this sad situation? There is no existing foundation or organization that has the credibility or support to provide national leadership. The public, unfortunately, does not believe that injuries are a problem until they or their loved ones have been injured. We are all but a telephone call away from the devastating news that our son, daughter, mother, father, spouse or friend has been injured or killed. However, by then it is too late. Unlike the networking and cause development concerning chronic diseases, there is a lack of community-based advocacy groups for injury prevention, because injuries occur suddenly and in isolation.

So what needs to be done?

Actually, it is quite simple.

The federal minister of health should call Pless and ask him what needs to be done, what resources are required and what results we can expect. I cannot think of anyone more qualified and respected to lead us out of the quagmire in which we have stagnated for the last 20 years.

As Pless says, "Let's get on with it."

**Louis Hugo Francescutti, MD, PhD,
MPH**

Assistant Professor
Department of Public Health Sciences
and Emergency Medicine
University of Alberta
Edmonton, Alta.

Care without barriers

I am pleased that *CMAJ* published the article "Impact on health care adds to the social cost of homelessness, MDs say" (*Can Med Assoc J* 1996;155:1737-9), by Fran Lowry, on health care and the homeless. As a physician who works regularly in Canada's largest hostel for men, I can confirm the challenges of providing adequate care for a high-risk population that has significant needs.

However, it is unfortunate that the article did not suggest action on the unacceptable barriers to health care facing the homeless, which appear to be in direct violation of the Canada Health Act (CHA). As the writer states, severe psychiatric illness or the lack of an address means that homeless people may not have a health insurance card and may face the refusal of care. This outrage occurs daily. At the same time, the population at large is faced with the risks and inconvenience posed by untreated mental illness and infectious disease.

The CMA and the provincial and territorial medical associations should indicate to governments, both federal and provincial, that barriers to care are contrary to the CHA and insist that fiscal penalties be imposed until the problem is solved. All Canadian citizens, regardless of residence or health status, are entitled to care without barriers.

Bob Frankford, MB, BS

Seaton House
Toronto, Ont.
Received via e-mail

Bovine spongiform encephalopathy

In regard to the article "Bovine spongiform encephalopathy and Creutzfeldt-Jakob disease: implications for physicians" (*Can Med Assoc J* 1996;155:529-36), by Drs. Chris MacKnight and Kenneth Rockwood, I have several questions. What of the beef handlers and especially meat-cutters working in the United Kingdom since 1985? With their frequent skin cuts, incurred while dressing beef, have they had neurologic changes? It has been at least 11 years now that they would have been exposed to bovine spongiform encephalopathy (BSE).

And what of brain eaters living in the United Kingdom?

Also, what of the meat-processing plants that have processed the cattle that are carriers? If we are to destroy surgical instruments because of the lack of knowledge concerning proper sterilization techniques, what has been done with the machinery and instruments that have processed these cattle in the past?

David Mallek, MD

Vancouver, BC

[The authors respond:]

Dr. Mallek asks several relevant questions. If BSE and the new variant of Creutzfeldt-Jakob disease (CJD) are related, should there not be an increased risk among abattoir workers? Similarly, should consumers of beef brains in the United Kingdom not be at a higher risk of CJD than those outside the United Kingdom?

The peripheral route of inoculation, as opposed to inoculation into the central nervous system, is a relatively inefficient method of transmission. Sporadic CJD has not been identified in abattoir workers; however, in addition to reports of cases in farmers,¹ a case has been reported in a handler of animal feed.² Among the cases of the new variant of CJD, 1 patient had worked as a butcher and 1 had visited an abattoir.³ None of the variant cases had a history of brain consumption. This background suggests that the pathogenesis of these diseases is more complex than a simple dose-response relation.

Stronger evidence that BSE and the new variant of CJD are linked has come from molecular analysis of the prion protein.⁴ Western blot analysis of prion protein from BSE transmitted to laboratory animals and from variant CJD has shown that the 2 are similar, suggesting that they share the same source.

Canada has initiated several programs to investigate CJD and the risk of its transmission through blood