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."

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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.

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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 meatcutters 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?

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[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