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

transfusion.[5] Any cases should be reported to the Laboratory Centre for Disease Control of Health Canada.

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A conclusion based on an unwise premise

I share Dr. Alexander Clark's grave concern about the report of the International Association for the Study of Pain Task Force on Pain in the Workplace, *Back Pain in the Workplace: Management of Disability in Non Specific Conditions*, which recommends that compensation for impairment or disability be restricted to conditions for which causation has been shown ("Back pain without apparent cause," *Can Med Assoc J* 1996;155:861-2). This conclusion is based on the unwise premise — and one that is also extremely patronizing and unfair to patients — that no physical cause for pain exists if current medical science cannot find it.

The fallacy of this premise may be illustrated by recent cervical spine research in Australia, which showed convincingly that 60% of patients with nonspecific chronic neck pain after automobile whiplash injuries, whom their doctors thought had largely psychosocial problems, in fact had an identifiable, specific source of pain.[1] This source was the facet or zygapophyseal joints at 1 or more vertebral levels. The researchers concluded that cervical facet joint pain is "extraordinarily common" and that this cause of pain "cannot be ignored" any longer. *Spine*'s expert commentator described the controlled study, which involved 10 years of research, as "rigorous and impeccable."

I suspect that similar problems affect the lumbar spine. All of this may explain why new evidence-based management guidelines for neck pain[2] and back pain[3,4] give spine manipulation, which improves range of motion in the facet joints, and early activation as the first line of management for patients with nonspecific pain.

In making decisions that have a major effect on our patients, such as whether a worker disabled by chronic nonspecific low-back pain should be compensated, we should pay due respect to the patient and be humble about the current state of medical science. Waddell and associates[5] have helped us all to understand that back pain is a biopsychosocial problem, but this does not mean that specific physical causes, such as biomechanical joint dysfunction not tested for or understood in most current medical practice, should be regarded as nonexistent.

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Consultation and counselling via e-mail

The recent article "Psychiatrist says counselling via e-mail may be yet another medical use for Internet" (*Can Med Assoc J* 1996;155:1606-7), by Cameron Johnston, suggests that counselling by e-mail may supplement office sessions between patients and psychiatrists.

I am a family physician who has recently obtained a few brief e-mail consultations from specialist colleagues. We have found e-mail to be a simple and convenient method of communication that avoids intrusive telephone disruptions.

I sometimes need to confer with a specialist to determine whether referral of a patient is necessary, to receive management advice or to ask a question about a specific topic. This usually leads to telephone tag or interrupts the specialist at a clinic. The same information can be exchanged more conveniently by e-mail, and all of the advantages mentioned in Johnston's article can apply to the family physician–specialist interaction too.

Consulting physicians can gather and present information or ask questions concisely and accurately. Consultants can review this information at their convenience and reply quickly. Information can be exchanged without identifying a patient by name, preserving confidentiality.