



should instead focus on ranking the top candidates.

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Received via e-mail

**[The author responds:]**

The writers raise some interesting issues. I would like to emphasize Dr. Taylor's important point that, despite the flaws and imperfections in our existing CaRMS program, it is still a very good system. I chose to focus particularly on one issue: how the system may reward dishonesty. My intent was to stimulate discussion of an issue that has not been addressed in the literature.

Taylor draws our attention to a very precise example of how the system allows, if not encourages, applicants to behave dishonestly. Currently, candidates have the option of either sending their reference letters to programs via CaRMS or directly. Specific letters can be directed to specific programs, thereby masking the applicant's true intentions. Although Taylor may be correct in contending that an applicant's true intentions may be revealed in the list of electives required on the CaRMS general application, a candidate may have done electives in 2 closely linked specialties such as obstetrics/gynecology and family medicine, which complement each other. This would still allow the candidate to appear interested in either option. Perhaps we should consider returning to the previous and perhaps more honest system in which an applicant used the same 3 reference letters for each program.

Dr. Healey addresses important points about the source of lying behaviours. I feel these issues merit further discussion separate from the issues that I have raised. I do not seek to analyse, understand or justify the

behaviour of students who lie: I am only observing a behaviour that the system unwittingly endorses by reward. Dr. Austin argues that deception is justifiable in the CaRMS process because it is a necessary skill for the "real world," which is a "jungle." I do not believe that any benefit of lying can justify its action. Dishonesty should not be accepted in medical practice simply because it is found in other professions. Our profession, which professes truthfulness as a value, must not institutionalize incentives for lying.

I appreciate Dr. Tigchelaar's support for my view of the inherent dishonesty in the resident-selection process. In her case, truthfulness brought her deserved success. Despite the weighty factors that regrettably take priority over integrity, her reminder that honesty begins within each candidate should be heeded by all. However, what about those who were honest and did not get their first choice as she did? If only Tigchelaar's anecdotal case could be generalized and could make every applicant feel confident that choosing honesty will bring the highest chance of success. This is a goal worth striving for.

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### Needle-stick concerns

Thank you for the article "HIV postexposure prophylaxis: new recommendations" (*Can Med Assoc J* 1997;156:233), by Dr. David M. Patrick.

I work in a small community hospital where needle-stick injuries are not uncommon. In most cases the HIV status of the patient involved is unknown, but the prevalence of HIV infection in our community appears

to be quite low. Unfortunately, patients are not always willing to undergo HIV testing after a health care worker has received a needle-stick injury. What is the appropriate course of action when the HIV status of the patient involved is unknown?

**Jeffrey R. Sloan, MD**  
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**[The author responds:]**

Dr. Sloan raises a practical issue. Most guidelines call for initiation of antiretroviral therapy following percutaneous or mucous-membrane exposure to potentially infectious body fluids from persons known to be HIV-positive or who are at high risk for HIV infection. Potentially infectious fluids include blood and semen, and vaginal, cerebrospinal, synovial, pleural, peritoneal, pericardial or amniotic fluids. People at high risk for HIV infection include men who have sex with men, injection-drug users, people who received multiple blood transfusions between 1978 and November 1995 and sexual partners of the people in these risk groups.

When less is known about the patient, every effort should be made to counsel him or her about HIV and to obtain consent for HIV testing. When patients fully understand what is at stake for the health care worker, most will proceed with the test. A few days of antiretroviral therapy may then be prescribed for the injured worker, with a decision on further treatment made on receipt of the result.

Even if testing is not done, details about possible high-risk behaviour may be pursued during counselling. If such a history is unambiguously absent, postexposure prophylaxis may be legitimately deferred in most cases. Sloan correctly implies that when HIV status or risk status cannot be determined, judgement is more



difficult, and health care workers have to rely on a knowledge of HIV prevalence in the patient population. Factors that should prompt consideration of therapy in these difficult cases include a patient population with a high prevalence of HIV infection — patients seen at an inner-city emergency department, for example — or a massive percutaneous exposure to a large volume of blood.

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### Childproof caps open Pandora's box

Dr. Lynette Sutherland's letter "Childproof caps, revisited" (*Can Med Assoc J* 1996;155:1550) is written from the perspective of "a little old lady with arthritis and high blood pressure" and not from that of a physician. The Canadian Association of Poison Control Centres is concerned that her letter could be cited in reference to child-resistant closures (CRCs) for drug containers.

It is important to emphasize that CRCs save lives. Evaluations of the impact of CRCs have shown a 40% to 55% decrease in the ingestion of various products containing acetylsalicylic acid by children<sup>1</sup> and a 42% decrease in the ingestion of many drugs and consumer products.<sup>2</sup> Data published a few months ago show a 45% decrease in the mortality rate among children due to poisoning as a result of CRCs.<sup>3</sup> At Winnipeg Children's Hospital, we had 32 admissions for poisoning with caustic alkali drain cleaners during the 7 years before mandatory CRCs and only 2 during the 7 years after implementation of that regulation. And, although this was not the intention,

CRCs also seem to have decreased the severity of intentional drug overdose in adults.<sup>4</sup>

CRCs have been described as "a success and a model for accident prevention."<sup>5</sup> A particular strength of CRCs is that "the package is the message and serves as a constant reminder of safety education in the market place as well as in the home."<sup>6</sup> There also seems to be strong public approval for this type of packaging.<sup>6</sup>

The association recognizes and acknowledges that CRCs present an obstacle to some senior adults.<sup>7,8</sup> Sutherland and her physician can request that her pharmacist dispense her prescriptions in conventional containers. However, this approach must be carefully considered if young children visit her home. Studies show that 13% to 17% of all poisonings involving children less than 6 years old occurred away from their homes, with the most common site being grandparents' homes.<sup>8,9</sup> However, a better solution is the development of CRCs that are easier to use for seniors, a step that our association supports.

The CMA agrees with the need for child-resistant packaging for hazardous drugs,<sup>10</sup> which has been a remarkably successful injury-prevention intervention.

#### Milton Tenenbein, MD

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#### [The author responds:]

I appreciate the interest that the Canadian Association of Poison Control Centres has taken in my problems with childproof caps. Although I wrote my letter with tongue in cheek, there is a serious issue here that I believe deserves debate and research.

Although the association believes that its activities have resulted in a victory in the battle for the safekeeping of children without there being a loser, I do not know whether that assumption is correct. Have we transferred a problem from one vulnerable social group to another? In our zeal to protect children, have we inflicted the cost of that protection on elderly people? Has anyone studied scientifically or economically the cost to seniors of the comprehensive use of childproof caps in the drug industry?

Do we know how many elderly people have suffered discomfort, disease exacerbation or even death simply because they were unable to open a bottle? Is society in a net "win" position as a result of the use of CRCs?

Prescription drugs are routinely dispensed with CRCs, and most adults are unaware that they have a choice. "Muddled" seniors are the last people who would be aware of such a choice. There is a good chance they may not think to raise the issue with their physicians or pharmacists and, if someone else is monitoring their affairs, they may suffer silently for years.