had, by 1991, resulted in extraordinarily high costs. Contract changes instituted in 1993 have addressed many of these issues and have reduced the per capita cost for primary medical care to an amount only marginally greater than that for fee-for-service patients. I am unable, however, to verify Gibson's assertion[4] that, within the current contract, capitation rates are based on the provincial average per capita costs.

Wallik mentions the scepticism associated with the HSO program; this may result from problems, especially with costs, that the program experienced before reforms were introduced in 1993. It would be unfortunate, as I attempted to point out in the original article, if this were interpreted either as evidence against capitation funding in general or as implying that there is no role for the CHC system in primary care reform.

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CPGs: To reach the unreachable goal?

The articles "The effects of clinical practice guidelines on patient outcomes in primary care: a systematic review," by Dr. Graham Worrall and associates (*Can Med Assoc J* 1997;156[12]:1705-12), and "Canadian physicians' attitudes about and preferences regarding clinical practice guidelines," by Dr. Robert S.A. Hayward and colleagues (*Can Med Assoc J* 1997;156[12]:1715-23), and the accompanying editorial "Clinical practice guidelines on trial," by Dr. Hayward (*Can Med Assoc J* 1997;156[12]:1725-7), are valuable additions to the literature on the topic of clinical practice guidelines.

However, I am concerned with the concept that change in patient outcomes is the only measure of success or failure of guidelines. In my view, a guideline that can reduce the resources needed to care for a patient, without changing the patient outcome, releases resources to be used elsewhere and can hardly be seen as a failure. We should set high standards, but let us not make them unattainable or unrealistic.

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Received via email

Addressing needle-stick concerns

One solution to the problem of patients not consenting to testing for diseases communicable to a health care provider, described in the letter "Needle-stick concerns," by Dr. Jeffrey R. Sloan (*Can Med Assoc J* 1997;156[9]:1267) is to get consent for such testing in advance. Every consent form used in an institution should contain a section stating that if a health care provider is exposed to the patient's blood or body fluids, consent is given for appropriate testing of the patient for communicable disease.

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The US attack on Cuba's health

The remedy for Cuba's problems is simple — free elections, not the pro-totalitarian propaganda presented in "The US attack on Cuba's health" (*Can Med Assoc J* 1997;157[3]:281-4), by Dr. Anthony F. Kirkpatrick.

The only "attack" on the health of Cubans comes from its totalitarian regime, which is incapable of producing wealth. Only the US maintains a trade embargo on this dictatorship, which can purchase whatever it wants elsewhere — if only it had something to trade in exchange.

Fidel Castro and his communist hierarchy are well provided for in their own exclusive health facilities, even as the population suffers.

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Although an anti-US mode is almost mandatory in Canadian journalism, it is unacceptable that our journal should be used by an American dissident to expound his political distortions against his own country. He has done the same thing in the United Kingdom and elsewhere. To make matters worse, you have obviously not peer reviewed his contentions properly.

Please tell me which dread epidemic caused 50 000 people to suffer from "optic neuropathy, deafness, loss of sensation and pain in the extremities and a spinal cord disorder that impaired walking and bladder control" as a result of the Cuban Democracy Act, within 5 months of the act being passed by Congress. What is the diagnosis and how is it so rapidly attributable to US calumny? Who is blockading supplies from Cuba's friends in China and Europe? Why should the US provide succour to a country that voluntarily lent its territory as a platform for nuclear Armageddon?