change programs: an economic evaluation of a local experience," *Can Med Assoc J* 1997;157[3]:255-62), is that they mention only in passing the syringe that is used. Surely the barrel must also become contaminated when the plunger is drawn back to see if the needle is in a vein. The role of syringes in transmitting infection was investigated almost 50 years ago.[1,2] It was later shown that even the slight vacuum caused by removal of the needle resulted in infected material backing up into the syringe,[3] and a "one-way valve" needle was suggested to correct the problem.[4]

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3. Evans RJ, Spooner ET. A possible mode of transfer of infection by syringes used for mass inoculation. *BMJ* 1950;2:185-8.
4. Gispen R. A one-way valve for multiple injections from one syringe [letter]. *Lancet* 1952;2:171-2.

[The authors respond:]

Dr. Battershill is correct about the potential role of a contaminated syringe in transmitting HIV. However, the exchange that takes place in a needle exchange program involves a prepackaged unit containing both a sterile needle and syringe, which is given to injection drug users in exchange for used equipment.

Needle exchange is only one component in a range of services that are provided by most "needle exchange programs" to meet the broader health needs of injection drug users. The Van Needle Exchange Program in Hamilton, Ont., for which we conducted our economic evaluation, provides other harm-reduction services such as assessment and referral to addiction treatment services, anonymous HIV testing, hepatitis B vaccines and safer sex counselling.

The recommendations of the May 1997 National Task Force on HIV and Injection Drug Use advocate further development of policy, legislation and programs to reduce stigmatization and marginalization of injection drug users. Community collaboration and mobilization are integral to this process, but it takes time to build trusting relationships with clients and develop strong community partnerships.

There is much work to be done and the issues are complex. Only by working together will communities be able to build a supportive system that not only reduces barriers to service for injection drug users but also decreases the risk of HIV transmission in the community as a whole.

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Safe havens for addicted mothers

Dr. Elizabeth Flagler and associates outline several dilemmas in pregnancy and an approach to working out what is right in their article "Bioethics for clinicians: 12. Ethical dilemmas that arise in the care of pregnant women: rethinking 'maternal–fetal conflicts' " (*Can Med Assoc J* 1997;156[12]:1729-32). They conclude that "coercion of the woman is not permissible no matter what appears to be in the best interest of the fetus." I don't disagree with this statement, because personal autonomy requires vigorous protection. However, we received no clear insight into the right approach to take when a medical intervention can benefit both fetus and mother, as in the case of a mother who is addicted to or abuses drugs.

In which situations may autonomy and consent be superseded by other considerations? A mother may not be able to make a decision because of mental incompetence or addiction, and she may be slowly destroying her health and that of her fetus. The potential costs for the long-term care of a damaged child will be enormous. In these situations medical intervention can benefit everyone, even if the woman's autonomy is temporarily removed. This is not coercion. To leave women in these desperate situations without therapeutic intervention is, in effect, abandonment. These women are already imprisoned by their addiction; they need a safe, therapeutic haven.

I was disappointed to see a lack of balance in the ethical analysis: it is not enlightening to suggest that the term "maternal" be discarded because the pregnant woman is yet to become a mother.

Clearly this debate needs to continue, and fair and just principles for each of the situations have to be established. Let us not think the analysis is complete or universally acceptable, because this issue is growing in importance. As a society we need to dedicate more resources to treatment and prevention programs for women who find themselves addicted and pregnant.

Albert E. Chudley, MD
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Received via email

I was surprised to learn from Dr. Flagler that I now have a bioethical obligation to ignore unborn babies who are being abused by their mothers. It does not really surprise me that the courts pretend these babies have no rights, because I have become

used to a legal system that is out of touch with common sense. However, I would have presumed that a physician who is also an ethicist would stay in touch with reality.

All of my teachers at medical school and beyond have instilled in me the notion that pregnancy involves 2 patients. This has also been my intuitive learning as a husband and father. I am afraid that I will never be able to ignore the needs of babies as yet unborn, even if this renders me unethical.

Howard L. Bright, MD
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I confess to a longstanding suspicion that "ethicists" are simply individuals with strongly held opinions concerning right or wrong, an impression confirmed by this article. The article included the following among its lines of reasoning:

- The law says you must do something and therefore it is ethical.
- There cannot be opposition between the interests of the fetus–mother dyad but there can be opposition between the interests of the newborn–mother dyad.
- State intervention to protect someone is hypocritical unless all societal evils are addressed at the same time.

I strongly support abortion rights for women but am still undecided on the issues surrounding fetal–maternal rights. This article simply stated one side of that debate. There is no doubt that this article is an opinion piece. It should have been published as an editorial, not within your Education section.

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[One of the authors responds:]

These letters illustrate the complexity of the ethical dilemmas that arise in the care of pregnant women. The topic taps into many layers of personal and professional beliefs. The assigned length and structure of articles in this series limited the discussion. However, careful reading of the paper will reveal a firm commitment to consider — not ignore — fetal interests within the framework of respect for the autonomy of the competent pregnant woman. The cases presented clearly relate to situations in which the pregnant women is deemed competent. Decision-making for incompetent patients (whether pregnant or not) is more fully discussed in "Bioethics for clinicians: 5. Substitute decision-making" (*Can Med Assoc J* 1996;155 [10]:1435-7), by Dr. Neil M. Lazar and associates.

There is a difference between rights (guaranteed under law) and interests (not guaranteed under law but deserving of consideration by those responsible). To pursue this issue further, readers are directed to the references in our article. The question is to determine who is most appropriate to speak for the interests of the fetus — at any point during the pregnancy.

State intervention in health care decisions is a serious infringement on personal liberty and requires intense scrutiny of the associated harms and benefits. This includes critical analysis of similar situations in society. Where is the line to be drawn before forcing treatment of individuals for the benefit of others? Should the nicotine-addicted heavy cigarette smoker be incarcerated for treatment of his addiction because of the impact secondhand smoke has on his pregnant wife and their asthmatic children?

We agree that this important topic needs continued discussion and better understanding, which necessarily entails consideration of the broader social and political context. Clear and compassionate thinking about these issues is essential in the development of policies such as those concerning treatment and prevention of substance abuse. The language of that debate is vital for consistency and clarity.

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Cutting immunization aid: Penny wise, pound foolish?

Some of the things we take for granted in Canada can make the difference between life and death in other countries. Immunization is one example. After evaluating the impact of immunization programs in my country, Senegal, I concluded that the termination of Canada's International Immunization Program, as recently announced by the Canadian International Development Agency (CIDA), would be regrettable.

Children in developing countries are often victims of a vicious cycle of malnutrition and infectious disease. Although some of them face more elaborate forms of injustice, such as displacements caused by armed conflict, we would be shamefully guilty if we did not at least continue to fight battles already being waged, principally in the areas of maternal and child health, malnutrition and vaccination.

Every year infectious disease kills 2 million children under age 5. The ailments that kill them are not exotic, but rather diseases such as measles, mumps, diphtheria, neonatal tetanus and tuberculosis. In spite of this terrible toll, global vaccination programs, which Canada has supported until now, currently save more than 3 million lives per year. The Canadian contribution has been about $6 million per year, which is less than 0.3% of the CIDA budget. An evaluation