Keep Bay Street at bay!

I am disturbed by a comment in the editorial "Physician resource planning in an era of uncertainty and change" (*Can Med Assoc J* 1997;157[9]:1227-8), by Dr. Bruce J. Fried. The Canadian health care system is undergoing change, and health care planners do play a vital role in the survival of our national system. However, I am concerned by his comment about our choices: regulation or a market-based economic strategy. Although regulation may not be ideal, a market-based system is far less palatable.

As a Canadian physician working in the US, I face the problems of a market-based health care system daily. Any system in which 15% of the population is uninsured, and in which an equal number of people have inadequate insurance, is a failure. Managed care and health maintenance do just that: they manage the care of *healthy* people. What they do not do is provide adequate care for the chronically ill, elderly people and those with catastrophic illness. In the free market, commercial health care organizations do their best not to treat these "costly" patients.

Canada has a chance to learn a great deal from managed care mistakes made in the US. Something is wrong with a country that spends more than 14% of its gross domestic product on health care, yet has millions of people without health insurance, a high rate of infant and maternal mortality, and lower-than-average life expectancy compared with other developed countries. Canada would be best served by choosing Fried's first option for reform: regulation. I know, because I have served in both systems.

Readers may question why I currently practise in the US. I recognize the problems in the Canadian system and would like to contribute to the solutions. However, I was offered an opportunity to train in health care management and public health planning while practising in a large emergency room, and I am using the opportunity to acquire the skills I need to help plan and deliver health care effectively. At the same time I am gaining firsthand experience in how the market economy has failed to provide universal coverage. I will return home once my training is complete.

In Canada we should keep Bay Street (and Wall Street) from making a business of health care. The health and well-being of Canadians should never be managed and traded as a commodity!

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Canada's drug problem: new solutions needed

I was pleased to see the articles "Mainstreaming methadone maintenance treatment: the role of the family physician" (*Can Med Assoc J* 1997;157[4]:395-8), by Drs. Mark Latowsky and Evelyn Kallen, and "Methadone maintenance treatment: a Canadian perspective" (*Can Med Assoc J* 1997;157[4]:399-401), by Drs. Bruna Brands and David C. Marsh. The subject was treated sensibly and dispassionately.

We need to learn more about the use of narcotics and their value, and this knowledge must be disseminated. Research has already shown that although people with chronic pain or terminal illness may become dependent on narcotics, they do not become psychologically addicted. I find it a weird contradiction that we seem to tolerate alcohol use and even alcohol abuse that can cause severe damage or death, yet drug use is treated harshly, particularly in the US.

I am not an advocate of drug taking, but it appears that the present system of drug control is failing terribly. I hope we will see more articles by experts in the field, and that more attention will be paid to scientific facts and less to emotional and biased arguments.

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[Two of the authors respond:]

Our editorial was meant to stimulate further interest and discussion, so we welcome Dr. Durnin's comments. Currently, 3 models have been proposed to deal with the illicit drug "problem": punishment, maintenance and legalization.

As discussed in our editorial, punitive models promote incarceration as a consequence and abstinence as a logical outcome goal. We agree, as others have argued, that the failure of the "war on drugs" has at its root a fundamental flaw of profit motive[1] and entails significant economic costs.[2] Many authors argue further that criminalization itself has been the most significant factor responsible for the current social problem of opioid addiction.[3]

Methadone maintenance, in contrast, has achieved a certain measure of success. Where it has failed, how-

ever, is that it has not significantly altered public prejudice and discrimination toward drug users, nor has it succeeded in shifting public policy decision-making toward maintenance as a publicly accepted and legitimate treatment alternative to punishment.

Legalization, although strongly advocated by some as more logical, humane and consistent with evolving human rights principles,[4] remains an untapped but viable treatment option that is opposed by people with powerful vested interests, who continue to lobby successfully to maintain the status quo.

Those who use public health approaches suggest that it is not the drugs themselves that cause the greatest harm, but the restrictive social and public policies that shape the human behaviour surrounding their acquisition and that affect the manner and consequences of their use. Educating the public about the health risks of drug use, the ways in which to use drugs responsibly and the social controls to prevent drug abuse and dependence are sensible alternatives.

We agree that we need nonemotional and unbiased scientific studies and arguments to help shape rational public policy. However, public policy has never been dictated solely by objective criteria of harm.[5] It has been and continues to be strongly influenced by factors that are judged or defined as problems by powerful decision-makers. This subjective construction allows for what Durnin correctly identifies as a contradiction in society's tolerance for alcohol use and its opposition to drug use. We argue that this contradiction also allows for continuing public misinformation and the consequent persistent stereotyping and stigmatization of illicit drug use.

This contradiction raises a critical point of public misconception: equating illicit drug use with abuse. We should all be concerned with preventing and treating abuse of and dependence on all drugs, whether legal or illegal. Those who incorrectly equate illicit drug use with abuse stigmatize all illicit drug users and unjustifiably invite the wrath of punishment to curb these users' "deviance."

The human rights approach adopted in our editorial considers both individual and group-level differences to be valued reflections of human diversity. Following from this, treatment goals involving drug abuse and dependence should include not only the restoration of function but the reclamation of the dignity, opportunities and freedoms that every human being deserves.

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Deaf with a small "d"

In her article "Cochlear implants: the head-on collision between medical technology and the right to be deaf" (*Can Med Assoc J* 1997;157 [7]:929-32), Lynne Swanson made the mistake of assuming that the deaf community is homogeneous and that those who sign — the "culturally Deaf" — represent the majority of that community. They do not.

Swanson is correct that some people within the signing "Deaf" culture oppose the cochlear implant. However, "oral deaf" people like me far outnumber the capital-D Deaf who use sign language. It is ironic that Swanson is guilty of the same kind of polarization and sensationalism ("the deaf" v. "the hearing") that she and Dr. Hartley Bressler deplore.

In the article, Bressler is quoted as saying that a book on the cochlear implant written by a deaf person would be diametrically opposed to one written by a hearing person. Interestingly, I have written such a book, which is to be published by Trifolium Books next spring. It describes my experience growing up deaf, obtaining a cochlear implant and hearing with it; the book also shows the subtle shadings of deafness and the complexity of the issues surrounding cochlear implantation.

No one working in this field today would ever offer the hope that a cochlear implant will turn a deaf person into a hearing person, but for the vast majority of those who obtain a cochlear implant the benefits will be gratifying.

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Despite the view of many within the deaf community that deafness should not be considered a handicap but rather a thread to bind like individuals together, hearing impairment *does* represent a handicap in the hearing world.

For the past 2 years my wife and I have experienced the anxiety, turmoil and doubt associated with deciding that our young daughter should receive a cochlear implant. In the 18 months before the surgery, we sought out every possible information resource to ensure that we made a truly informed decision. We met with the deaf culture advisor from the Robarts School for the Deaf in London to discuss the options for our daughter