The experience resonates

Thanks for publishing the beautiful essay "A princess dies, a surgeon reflects" (*Can Med Assoc J* 1997; 157[10]:1402-3), by Dr. Ian B. Ross, so soon after the tragedy — and heartfelt thanks to Dr. Ross for writing it.

My days of running to the emergency department and experiencing all the other unhappy things Ross relates have long since passed. Even so, throughout the early days of September I repeatedly found myself thinking exactly the same thoughts and reliving the very same horrors he describes so well. And again, not for the first time in our lives and probably not for the last, my wife and I came to the same conclusion: "No man is an island."

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No radiographs for muscle spasm

Although there may be medicolegal reasons for ordering neck and back radiographs in the emergency department after trauma, as suggested by Dr. Raymond Shandera in his letter "Ordering radiographs with the law in mind" (*Can Med Assoc J* 1997;157[10]:1352), the detection of muscle spasm is not one of them. Muscle spasm in this situation is a myth, both clinically and radiologically. In up to 42% of normal subjects radiography reveals a straight cervical spine. Thus, the observed spinal alignment on the radiograph may represent the subject's posture at the time the image was obtained, a normal anatomic variant or the positioning of the subject by the technician.[1,2]

As for the physical examination, muscle spasm is neither a valid nor a reliable physical sign. Nothing in the medical literature proves that muscle spasm in the neck or back can be diagnosed clinically with any precision by superficially touching the skin. Tenderness to palpation is an unreliable sign,[3] one that has never been correlated with a gold standard for muscle spasm. "Attempts to objectify muscle spasm have not been rewarding. Needle electromyography has shown that areas of muscle tenderness are electrically silent."[4]

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A timely question about physicians' work hours

The article "Wake-up call issued about drowsy truck drivers" (*Can Med Assoc J* 1997;157[9]:1195), by C.J. Brown, struck a nerve. I searched in vain for the obvious point that the results are important to physicians not only because they often assess patients' fitness for work but also because they themselves are often expected to work far more hours than any truck driver. Doctors are the only people who seem to think a 24-hour or even a 36-hour shift is normal and just goes with the job. It's time we stopped endangering our patients and our family lives and simply explained to government that more, not fewer, doctors are needed to reduce on-call and shift hours to safer levels. Of course this will cost money, but don't patients deserve it, just as road users deserve licensed truck drivers who are sufficiently alert to drive safely? We have ourselves to blame for the current situation, but I believe it's time to change. If we don't demand it for our patients' sake and our own, who will?

This question of onerous on-call duty is one reason why, after 12 years of good and faithful service as a rural physician, I will be taking a sabbatical abroad. I will have to think long and hard before returning to my former role. Regrettably, my colleagues left behind now have to work on-call more frequently and so the vicious circle continues. It's time the CMA and its provincial associations called "Halt!"

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Needle exchange programs and drug use

Reading and rereading the article "Needle exchange programs: an economic evaluation of a local experience" (*Can Med Assoc J* 1997;157[3]:255-62), by Michelle Gold and associates, reduces my confidence in the quality of articles published in our beloved *CMAJ*.

I am incredulous that respected researchers would not only publish an article about the incidence of HIV and AIDS but also speculate about the number of cases they are preventing and the amount of money that they are saving without once mentioning the word "homosexual." Neither do they mention the number of homosexual intravenous drug users!

The article involves incredible speculation and a voluminous repetition of other people's experiences. The article's most telling statement — "It is clear that if more drug users than we first estimated used this service, then the program would prevent an even greater number of HIV cases" — clearly reveals the authors' bias. In fact, the more cases of HIV infection that are diagnosed, the