Editor's preface

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A study by William Ghali and colleagues has revealed that the risk of in-hospital death after coronary artery bypass grafting (CABG) in Canada was just below 4% in 1995/96 (page 25). The authors also report a remarkable decline — by 17% — in the risk-adjusted death rate after CABG between 1992/93 and 1995/96. The decline occurred despite the potentially negative effects of intensive hospital downsizing in most of the country during that period. Although the findings for overall death rates are encouraging, there were differences between provinces: for example, Nova Scotia had the lowest risk-adjusted death rate (2.4%) and Alberta the highest (4.3%).

The issues here are complex. According to William Williams, the CABG study indicates that the quality of this type of surgery has been maintained during a time of stress to the health care system (page 39). Nonetheless, he is concerned that differences in case severity between provinces remain. He points out that case selection practices might lead to declines in death rates. Patients and governments both seem keen on performance "report cards" for hospitals and surgeons, and Williams reminds us that hospitals and surgeons in the US avoid high-risk patients as a way of improving their report cards.

In cases of sexual assault, police, prosecutors and defendants often rely on evidence from a physician's examination, and the absence of genital injury may be taken as proof that the intercourse was consensual. Marleen Biggs and colleagues examined the records of a random sample of 132 women who had suffered vaginal or anal penetration during an assault (page 33); half of the women had had no prior experience of sexual intercourse. As expected, women without prior sexual experience had higher rates of genital trauma than women with prior sexual experience (65% v. 26%). Even so, 35% of the women without prior sexual experience and 74% of those with such experience had no visible evidence of trauma. Thus, consent cannot be inferred from absence of genital injury.

Physicians infected with hepatitis B virus, hepatitis C virus, HIV or almost any other pathogen can, on rare occasions, transmit these infections to their patients. The CMA publishes its updated policy on preventing transmission of hepatitis B (page 71). The policy encourages all physicians to use universal precautions, to be vaccinated against hepatitis B and to know their serologic status. In contrast to the CMA's emphasis on voluntary action (page 64), Health Canada insists that testing and vaccination be mandatory for physicians who perform "exposure-prone procedures."[1] Those with hepatitis B e antigen would be prohibited from performing such procedures and would thus be forced to seek other work. The question of mandatory testing is a difficult one. We provide an editorial comment on page 45.

Canadians face a continuing shortage of human organs and tissues for transplantation. Xenotransplantation — the use of animal cells, tissues or organs for human transplants — is explored by Eilleen Tackaberry and Peter Ganz (page 41). The development of pathogen-free herds and of strategies to address the problems of rejection gives us the prospect of a new era in transplant science. Tackaberry and Ganz review the remaining obstacles and risks.

Reference

1. Proceedings of the consensus conference on infected health care workers: risks for transmission of bloodborne pathogens. *Can Commun Dis Rep* 1998;24[Suppl 4]. Available: www.hc-sc.gc.ca/hpb/lcdc/publicat/ccdr