Letters

Correspondance

About those waiting lists . . .

Two recent articles in *CMAJ* have provided an interesting and positive contribution to the discussion of surgical waiting lists in Canada.[1,2] Unfortunately, these papers are flawed slightly by some unfortunate quotations, inaccuracies and statements that may affect readers' conclusions.

The authors state that "additional resources have also been found to *increase* list lengths or waiting times."[1] They point out that the volume of cataract procedures in Manitoba increased between 1992 and 1997 while the waiting lists also increased. Those changes were due to technical improvements in cataract surgery, which have had a similar effect worldwide. Because surgical outcomes have improved tremendously with newer techniques, the legitimate indications for surgery have increased considerably. Thus, if the surgical volumes in Manitoba had not increased during the period in question, the people of that province would have been grossly underserviced. The reason the volumes increased along with the waiting lists is that the supply of services was inadequate to meet a greatly increased and legitimate demand for services.

The authors state that "if long lists lever more operating room time, some practitioners will either actively build long lists or resist reallocation of their patients to those with shorter lists."[2] This misrepresents reality, for the authors seem to discount the effect of a surgeon's reputation on the length of his or her waiting list. Particularly in areas where there have been rapid changes in techniques, there may be a substantial difference in the quality of results among surgeons. It is virtually impossible to have both a high surgical volume and a long waiting list for surgery without providing fairly high standards of surgical care. The Saskatoon situation discussed in the article involves 2 high-volume surgeons who have established excellent reputations using the latest surgical techniques and have earned the trust of both patients and referring practitioners. I am simply trying to point out that there may be positive factors related to surgical waiting lists.

The authors suggest that redirection of referrals to physicians with shorter waiting lists be considered, particularly by publication of waiting lists. If the latter happens, then corresponding objective data on surgical outcomes should be published simultaneously, with appropriate cross-referencing of access so that patients and referring practitioners can make a genuinely informed decision.

The authors of these articles have made an excellent contribution to the discussion of waiting lists and managing access to surgical services.[1,2] Their key recommendations — to standardize the approach to waiting list reporting, auditing of waiting lists and prioritization of waiting lists — can be strongly supported. However, they appear to be less than fully informed about issues surrounding ophthalmology.

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References

1. Sanmartin C, Shortt SED, Barer ML, Sheps S, Lewis S, McDonald PW. Waiting for medical services in Canada: lots of heat, but little light. *CMAJ* 2000;162(9):1305-10.
2. Lewis S, Barer ML, Sanmartin C, Sheps S, Shortt SED, McDonald PW. Ending waiting-list mismanagement: principles and practice [commentary]. *CMAJ* 2000;162(9):1297-300.

The article and commentary by Claudia Sanmartin and colleagues[1,2] outlining the challenges we face in deciphering the true meaning of waiting lists and their impact on patient care are important additions to the debate on the future of medicare in Canada. Physicians and their patients are often caught in a baffling waiting-list maze that results in a feeling that the health care system is dysfunctional.

The ethical underpinning of the concept of waiting lists deserves greater emphasis. In Canada, the notion of distributive justice has dominated the design of the health care system.[3,4] Lately there has been a leaning toward the ethical principle of autonomy, which has been paramount in the United States. Patients struggle with their own needs and not the needs of the general public, so it is understandable how the shift toward personal priorities can lead to the erroneous belief that private medicine can solve the public resource problem.[5,6]

It will become increasingly difficult to defend medicare when premiers like Ralph Klein and Mike Harris, as well as the leaders of the Canadian Alliance party, use their political powers to undermine the public system. They will continue to find novel ways to insert private components into the system that agree with their political beliefs. For example, young physicians who now face substantial education-related debt because of government-mandated tuition increases will be less inclined to support a publicly funded system if bet-

ter financial opportunities are available in the private realm.

Thus far, Canadians have chosen the ethical principle of distributive justice over that of autonomy as the foundation of their health care system. It will take a great deal of dedication and persistence from medicare's supporters to keep this foundation from crumbling.

A meaningful and accurate understanding of waiting lists that is transparent to physicians, patients and politicians is one important step in helping maintain our commitment to a system that has served Canadians so well for so long.

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References

1. Sanmartin C, Shortt SED, Barer ML, Sheps S, Lewis S, McDonald PW. Waiting for medical services in Canada: lots of heat, but little light. *CMAJ* 2000;162(9):1305-10.
2. Lewis S, Barer ML, Sanmartin C, Sheps S, Shortt SED, McDonald PW. Ending waiting-list mismanagement: principles and practice [commentary]. *CMAJ* 2000;162(9):1297-300.
3. Gordon M, Sternberg SA, Turner L. The ethics of health-care systems: contrasting Canada and the United States. *Ann R Coll Physicians Surg Can* 1999;32:267-71.
4. Gordon M, Sternberg SA, Turner L. Ethics of health care systems. *Ann R Coll Physians Surg Can* 1999;32:459-62.
5. Sky K. Should specialists support Canada's single-payer system? *Ann R Coll Physicians Surg Can* 1997;30:12-3.
6. Dirnfeld V. The benefits of privatization. *CMAJ* 1996;155(4):407-10.

Competency of adolescents to make informed decisions

Christopher Doig and Ellen Burgess have carefully and accurately researched the rights of adolescents to accept or refuse life-sustaining treatment.[1] Pediatricians, family physicians, surgeons, nurses and paramedical staff caring for teenagers are aware of the necessity to respect the wishes of their patient, even if the patient makes decisions that are contrary to the wishes of his or her parents or the judgement of those responsible for his or her treatment.

The competency of children and adolescents to make informed decisions, if they understand the nature and consequence of that decision, has been examined by many professional bodies,[2-4] including the Canadian Paediatric Society,[5] the American Academy of Pediatrics and the Society for Adolescent Medicine.[6,7] There have also been court decisions in Canada, the United States and the United Kingdom, as cited by the authors, supporting this principle.

Where the minor's decision differs from that of parents or caregivers, ethical considerations demand compassionate counselling for decision-making but the wishes of the patient must never be overriden. I am appalled that the hospital's legal counsel ignored this minor's rights. Was he or she more concerned about the hospital's potential liability than about the child?

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References

1. Doig C, Burgess E. Withholding life-sustaining treatment: Are adolescents competent to make these decisions? *CMAJ* 2000;162(11):1585-8.
2. Rosovsky FA. The age of majority vs the age of consent. In: vol 1 of *Ethical issues in paediatrics series*. Toronto: The Hospital for Sick Children; 1991.
3. Gittler J, Quigley-Rick M, Saks MJ. *Adolescent health care decision making: the law and public policy*. Washington (DC): Carnegie Council for Adolescent Development; 1991.
4. English A. Treating adolescents: legal and ethical considerations. *Med Clin North Am* 1990;74:1097.
5. Doherty D, Kaufman M, Lindsay D, Panzer L, Sharpe D, Tonkin R. Age limits and adolescents [policy statement]. Ottawa (ON): Canadian Paediatric Society; 1994.
6. Sigman, G, Silber T, English A, Gans J. Confidential health care for adolescents [policy statement]. Blue Springs (MO): Society for Adolescent Medicine; 1991.
7. Hoffman AH. The right to consent and confidentiality in adolescent health care. In: Bandman EL, Bandman B, editors. *Bioethics and human rights. A reader for health professionals*. Boston: Little Brown; 1978.

β-Blockers as first-line therapy for hypertension

The 1999 Canadian recommendations for the management of hypertension[1] recommend against first-line β-blocker therapy for uncomplicated hypertension in the elderly and suggest that dihydropyridine calcium-channel blockers are preferable. β-Blockers had previously been recommended as alternative first-line agents.[2] The new recommendation is apparently based on results of the MRC,[3] STOP-Hypertension[4] and Syst-Eur[5] trials. We question whether the evidence truly supports this change.

In the MRC trial, a preplanned subgroup analysis suggested that β-blockers are ineffective. However, over 25% of subjects were lost to follow-up, a fig-

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