tion Action Society; 2000. Available: www.cfdp.ca/safei.pdf (accessed 2002 Jan 18).

[Thomas Kerr and Anita Palepu respond:]

Although we agree that there is need for an expansion of treatment services in Canada, evidence from Germany, the Netherlands and Switzerland suggests that a continuum of services that includes low-threshold services (e.g., safe injection facilities) constitutes the most effective means of reducing drug-related harm.[1,2] No intervention, be it abstinence-based treatment, methadone treatment or safe injection facilities, can stand alone as a panacea.[2] We believe that safe injection facilities could serve a purposeful and complementary role in our continuum of services, and therefore a rigorous trial and evaluation of safe injection facilities is warranted.

With respect to the complementary effects of safe injection facilities, research from Switzerland has shown that low-threshold services such as safe injection facilities serve to increase the number of injection drug users entering treatment.[1] During the mid-1980s Swiss medium- and high-threshold services (e.g., methadone and drug treatment) only contacted 20% of active injection drug users.[1] Following the implementation of safe injection facilities and other low-threshold services, the number of injection drug users entering treatment increased to 65%, and by necessity, treatment services were expanded.[1] According to Swiss reports, the remaining 35% of injection drug users were in regular contact with low-threshold services, which in turn served to minimize harm among people who continued to inject while reducing the impact of drug use on communities.[1]

Safe injection facilities have contributed to higher rates of referral to drug treatment. This can in part be attributed to increased opportunities for sustained contact between health care professionals and street-based injection drug users.[3] Although needle exchange and street-outreach workers make frequent contact with injection drug users, the great majority of these interactions tend to be cursory and on-the-run.[4,5] Safe injection facilities place trained staff in direct proximity with injection drug users while they are waiting to consume their drugs, as well as after they have done so and have returned to the waiting room. Moreover, safe injection facilities offer many needed services on-site: needle exchange, counselling, primary medical care, drug treatment, shower and laundry, and other services, depending on resources. There is substantial research that indicates that injection drug users will avail themselves of drug treatment and other services at much higher rates if they are offered on-site rather than externally.[6,7] Although Gordon Brock and Vydas Gurekas may question the transferability of these effects, we can conceive of no reason why Canadian drug users would be less likely to avail themselves of these services when similar referral mechanisms are implemented.

Discussions concerning the costs and interventions associated with injection drug use should not be limited to health service budgets and the associated priorities. As the Auditor General pointed out in a recent report, the total cost of illicit drug use in Canada is estimated to be $5 billion.[8] Of the $500 million devoted to enforcement, prevention, treatment and harm reduction, $475 million is used for enforcement. Perhaps what is needed is a redistribution of funds rather than increased investment in only one component of the health system. Clearly, a more comprehensive approach is needed to reduce the health, social and economic consequences of injection drug use in Canada.

Thomas Kerr
Department of Psychology
University of Victoria
Victoria, BC
Anita Palepu
Centre for Evaluation and Outcome Sciences
St. Paul's Hospital
Vancouver, BC

References

1. McPherson D. *Comprehensive care for drug users in Switzerland and Frankfurt, Germany. A report from the 10th annual international conference on the reduction of drug related harm and a tour of harm reduction services in Frankfurt, Germany*. Vancouver: Social Planning Department; 1999.
2. Fischer B, Rehm J, Blitz-Miller T. Injection drug use and preventive measures: a comparison of Canadian and Western European jurisdictions over time. *CMAJ* 2000;162(12):1709-13.
3. Drugs and Crime Prevention Committee. *Safe injecting facilities: their justification and viability in the Victorian setting*. Melbourne (Australia): Parliament of Victoria; 1999. Available: www.parliament.vic.gov.au/dcpc (accessed 2002 Jan 18).
4. Murphy P, Sales P, Choe J, McKearin G, Murphy S. The dynamics of needle exchange and other service provision. American Society of Criminology meeting; 2000 Nov; San Francisco (CA).
5. Broadhead RS, Fox KJ. The occupational risks of harm reduction work. In: Albrecht GL, Zimmerman R, editors. The social and behavioural aspects of AIDS. vol 1 of *Advances in medical sociology*. Greenwich (CT): JAI Press; 1993.
6. Altice FL, Friedland GH. The era of adherence to antiretroviral therapy. *Ann Int Med* 1998; 129:503-6.
7. Umbricht-Schneiter A, Ginn DH, Pabst KM, Bigelow GE. Providing medical care to methadone clinic patients: referral vs. on-site care. *Am J Public Health* 1994;84:207-10.
8. Office of the Auditor General of Canada. Illicit drugs: the federal government's role. In: *2001 Report of the Auditor General of Canada*. Ottawa: Government of Canada; 2001. Available: www.oag-bvg.gc.ca/domino/reports.nsf/html/0111ce.html (accessed 2002 Jan 18).

[Wayne Weston responds:]

Mark Latowsky applies the concept of informed and shared decision-making to physicians' work with a challenging group of patients, injection drug users, and suggests that we have a moral obligation to treat them with respect, as people with a disease rather than as bad people deserving punishment. Finding common ground[1] with these patients is often difficult because we want them to change too much, too fast and we become frustrated and judgmental when they do not follow our advice. Finding common ground does not mean coercing, cajoling or even coaxing our patients to agree with our treatment guidelines. Rather, it means seeking to understand the patient's world and their illness experience well enough that we can empathize with their plight and appreciate the difficult and sometimes unhealthy choices they feel compelled to make. We need to stick with them so that they know we care and they learn to trust us. Then, together we can tackle their problems.[2]

Two concepts help physicians to be more helpful and less pessimistic. Motivational interviewing methods are based on the theory of stages of change[3,4]: peo-

ple first ignore the issue, then they think about it and make plans to change, and finally they undertake the hard work of changing and preventing relapse. Success is measured in moving from one stage to the next, not jumping from denial of the problem to lifelong cure in a single leap. The second, and related, concept is harm reduction.[5] It is not realistic to expect every patient to be cured of their drug addiction. It is important to encourage any move in the direction of less risk, such as drinking 6 beers a day instead of 12 or using clean needles instead of shared needles. Whether this is the first step in the long road to controlling their substance abuse or the only step, it is a step in the right direction. We need to be there to support our patients in this struggle, not to judge their failings.

W. Wayne Weston
Department of Family Medicine
University of Western Ontario
London, Ont.

References

1. Stewart M, Brown JB, Weston WW, McWhinney IR, McWilliam CL, Freeman TR. *Patient-centered medicine: transforming the clinical method.* Thousand Oaks (CA): Sage Publications; 1995.
2. Suchman AL, Botelho RJ, Hinton-Walker P, editors. *Partnerships in healthcare: transforming relational process*. Rochester (NY): University of Rochester Press; 1998.
3. Miller WR, Rollnick S. *Motivational interviewing: preparing people to change addictive behaviour*. New York: The Guilford Press;, 1991.
4. Rollnick S, Mason P, Butler C. *Health behavior change: a guide for practitioners*. Edinburgh: Churchill Livingstone; 1999.
5. Skinner W, Drake J. Helping cocaine and heroin users. In: Harrison S, Carver V, editors. *Alcohol and drug problems: a practical guide for counsellors*. 2nd ed. Toronto: Addiction Research Foundation; 1997. p. 541-6.

Interplanetary health care report cards

Jack Tu and colleagues raise important issues concerning the interpretation of health care report cards.[1] In addition to writing science fiction about interplanetary travel and life on other planets, Edgar Rice Burroughs speculated about effective medical performance evaluation systems.[2]

In *The Pirates of Venus*, Burroughs created a world in which various forms of intelligent life formed city-states that were in a continual state of conflict. Medical sera prolonged life indefinitely. The primary role of physicians was to treat injuries resulting from accidents and battles.

Burroughs described an ongoing physician performance evaluation system in which all physicians were required to report the course of treatment and resulting outcomes for every patient. These reports were filed with a central agency and were made available to the public.

The Burroughs system addresses many of the concerns raised by Tu and colleagues by making the physician report on his or her own cases. The quality of the data and the risk-adjustment process, the completeness of the chart, and the accuracy of the full story on both process and outcomes are all the responsibility of the physician. These reports by physicians constitute an early example of providing administrative records for an external entity. Although the reports lack standardized measures of disease severity, health status or quality of life, Burroughs' system offers a first step toward accountability and quality improvements.

Vincent Richman
Research Associate
AlgoPlus Consulting Limited
Halifax, NS

References

1. Tu JV, Schull MJ, Ferris LE, Hux JE, Redelmeier DA. Problems for clinical judgement: 4. Surviving in the report card era. *CMAJ* 2001; 164(12):1709-12.
2. Burroughs ER. *The pirates of venus*. New York: Dover Publications; 1932.

[Two of the authors respond:]

We thank Vincent Richman for bringing to our attention the work of Edgar Rice Burroughs, who wrote about effective medical performance evaluation systems back in 1932.[1] Although we agree that physicians have an important role to play in quality improvement,[2] we believe it would be difficult in the current climate to expect busy clinicians to be solely responsible for reporting on the course of treatment and outcomes for every patient to a central agency. Such a system could raise concerns about the accuracy of the data, because clinicians would have an incentive to overestimate the severity of their cases and underreport the frequency of adverse outcomes. Nevertheless, the idea of physician performance evaluation systems is not a new one, and all suggestions for developing a better system are most welcome.

Jack V. Tu
Institute for Clinical Evaluative Sciences
Sunnybrook and Women's College
Health Sciences Centre
University of Toronto
Toronto, Ont.
Donald A. Redelmeier
Institute for Clinical Evaluative Sciences
Sunnybrook and Women's College
Health Sciences Centre
University of Toronto
Toronto, Ont.

Reference

1. Burroughs ER. *The pirates of venus*. New York: Dover Publications; 1932.
2. Tu JV, Schull MJ, Ferris LE, Hux JE, Redelmeier DA. Problems for clinical judgement: 4. Surviving in the report card era. *CMAJ* 2001; 164(12):1709-12.

The staff and the "fiery serpent"

I write concerning the recent letter by H.J. Scott concerning Asklepios' staff (the karykeion) and Hermes' winged 2-serpent wand (the caduceus).[1] Perhaps I can spoil the broth or symbol further. Several years ago I read in a book on surgical history, the title of which I have now unfortunately forgotten, that the serpent on the staff may in fact represent the guinea worm (*Dracunculus medinensis*), commonly called the fiery serpent. The serpent and staff are symbolic of the removal of the worm by winding it around a staff and slowly withdrawing it from the unfortunate victim's tissues.

M.C. Crocker
Anesthesiologist (retired)
Winnipeg, Man.

Reference

1. Too many serpents spoil the symbol [letter]. *CMAJ* 2001;165(10):1299-300.