subject,' demonstrating that impairment begins at 0.02%. The review noted the following three factors.

First, on a driving simulator, American researchers found that the percentage of subjects who were impaired in their ability to maintain lane position was 70% at 0.02% BAC.

Second, a 1997 study reported that, in the 6 years following the introduction of the 0.02% BAC limit in Sweden, there was a 9.7% reduction in fatal crashes, an 11% reduction in single-vehicle crashes and a 7.5% reduction in all crashes.

Third, Maryland’s 0.02% BAC restriction resulted in a 21% decrease in the number of young crash-involved drivers judged to have been drinking. In addition, a public education campaign resulted in a further 30% decrease.

No one should be driving under the influence of alcohol. While targeted approaches to high-risk groups are necessary for dealing with the public health problem of alcohol-related injury, these are not sufficient. A comprehensive, multi-pronged approach, dealing with public awareness and education initiatives, addiction prevention, treatment and counselling, and enforcement of deterrent legislation are key components of a global health approach to this problem.

When CMA develops policy, our standard process is to consult broadly within the profession, building on current policies, and inviting input into our proposed submission. We also consult outside of the profession.

Grass roots membership views are brought to us by the Board of Directors and General Council’s advisory groups (for example, the Council on Health Care and Promotion, the Committee on Ethics, and so on), which have broad, expert representation from specialty and general practice physicians across the country.

The final response is then approved by the CMA Board of Directors or General Council. We understand that the result may not necessarily reflect the views of all of our 53000 members, but we strive to develop evidence-based policies that reflect a consensus among our elected officials.

Henry Haddad
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Reference

Assessing the risks of cervical manipulation for neck pain

I agree with Moira Kapral and Susan Bondy that more research is needed concerning cervical manipulation and the risk of stroke. However, I strongly disagree with their view that the study by Rothwell and colleagues provides a “theoretically less biased estimate of the risk of stroke secondary to chiropractic manipulation” than the study by Haldeman and colleagues. The paper by Rothwell and colleagues is a correlational study and in no way describes a causal relationship.

They reported that patients aged less than 45 years who were admitted to hospital with a vertebrobasilar accident were 5 times more likely to have visited a chiropractor within a week of the accident than controls and were 5 times more likely to have had 3 or more visits with a cervical diagnosis in the month before the accident than controls.

There are several potential confounding factors in this study. For example, chiropractors do not always perform spinal manipulation for patients with a cervical diagnosis; they may use one of the many other modalities available in chiropractic medicine (and in physical therapy, for that matter).

As a second example, a patient with a pre-existing vertebrobasilar compromise visits a chiropractor complaining of neck symptoms that are unrelated to that compromise, and manipulation treats these symptoms but does not affect the vertebrobasilar artery in any way.

As a third example, a patient sustains a vertebrobasilar artery injury from a motor vehicle accident and visits a chiropractor, who suspects vertebrobasilar compromise. An immediate referral is made to a neurologist, who misses the diagnosis of compromise. The patient dies in the parking lot outside the neurologist’s office, having visited the chiropractor and the neurologist that week.

The relationship between stroke and visits to a neurologist or other medical provider should be studied; this relationship may well be stronger than that between stroke and visits to a chiropractor.

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References

In the United States, gastrointestinal complications induced by non-steroidal anti-inflammatory drugs (NSAIDs) result in more than 100 000 hospital admissions and an estimated 16 500 deaths annually. Any discussion of the adverse effects of cervical manipulations for neck pain should take into account the dangers of other therapies.

Although I do not advocate cervical manipulation, I think that the risk of cervical artery dissection following this procedure should be weighed against the risk of complications associated with the use of NSAIDs, because these drugs are commonly prescribed for neck pain. The risks and benefits of less dangerous treatments such as acetaminophen and soft collars should also be compared with those of chiropractic and NSAIDs.

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Protestant bioethics

Merrill Pauls and Roger Hutchinson faced a challenging task in trying to describe Protestant bioethics in a 5-page article,1 and they certainly did not have the space to provide an adequate account of autonomy and freedom as values for those who are not traditionally religious.

Regarding autonomy, they state: “Many secular formulations emphasize personal freedom and argue that autonomy is best served by minimizing restrictions on individual choice. Protestants would argue ... that individuals must account for their personal relationships and their responsibilities to the larger community.”

This implies that the nonreligious (atheists, agnostics) are self-centred he- donists who likely act without regard for their responsibilities to others, including “the larger community.” Surely this is an incomplete and unfair representation of the views of a great number of secular ethicists.2,3

Secular humanists have formulated ethical views pertaining to personal freedom and the obligations an individual has to others. The humanist view is that a belief in God is not necessary for the recognition of our responsibilities toward others or for beneficence.4,5

Paul C.S. Hoaken
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References

[The authors respond:]

We appreciate Paul Hoaken’s comments. Classic philosophical conceptions of autonomy present the rational, dispassionate individual as the ideal decision-maker. Many current ethical perspectives recognize and validate the role that emotional, relational and spiritual factors play in autonomous decision-making. We argue that Protestant ideas have played an important role in promoting this broader understanding of autonomy. We did not mean to imply that other traditions and viewpoints, including those advocated by humanists, have not also played an important role, or that acceptance of Protestant beliefs is a necessary prerequisite for the moral life.

With regards to Lynette Sutherland’s concerns, we have used the word casuistry in a descriptive manner to refer to a form of moral reasoning that is case-based and is historically associated with the Catholic Church. Our use of the term reflects its current use in the bioethics literature,1,2 and was not meant to carry a negative connotation.

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References

Corrections

In the Letters section of the Feb. 5 issue of CMAJ, the name of the first author of the first letter was misspelled as the result of an editorial error.1 The first author’s name is Dalia L. Rotstein.

Reference

In the Mar. 19 issue of CMAJ, an error occurred in Fig. 3 (p. 731) of the article entitled “Comparison of diagnostic decision rules and structured data collection in assessment of acute ankle injury.”2 In the figure, the Ottawa and the Leiden ankle rules are reversed. The Ottawa rules are represented by the dotted line; the Leiden rules are represented by the solid line.

Reference