

ure to discuss their medical condition with their physician. Since the newsletter article,² "Dear Healthcare Professional" letters, prepared in collaboration with Health Canada and the manufacturers, were issued for rofecoxib and celecoxib on Apr. 15 and May 13, 2002, respectively. Health Canada also released public advisories for these drugs in April and May 2002 (available at www.hc-sc.gc.ca/hpb-dgps/therapeut/htmleng/advhp_e.html). Ongoing evaluations and expert consultations are being conducted by Health Canada, and any new safety information will be reflected in the product monographs of these drugs.

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Newsletter

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References

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2. Vu D, Murty M, McMorran M. Selective COX-2 inhibitors: suspected cardiovascular/cerebrovascular adverse reactions. *Can Adverse React News* 2002;12(2):2-3

Blood alcohol limit: the CMA is right on

I agree with the CMA's recommendation to lower the legal blood-alcohol concentration (BAC) for driving from 0.08% to 0.05% and with Henry Haddad's response.¹ It should be noted what currently occurs in forensic practice regarding the 0.08% limit.

Police do not routinely charge a drinking driver for an offense of over 0.08% unless one of the results of the evidential breath-alcohol instrument is 0.1%.² In field use, the evidential breath-alcohol instruments used by the police have been found to read approximately 12% lower than the actual BAC.³ In addition, the Criminal Code allows for a 2-hour presumption, whereby it is presumed that no alcohol

has been eliminated from the body during that period of time, even though the average rate of alcohol elimination found in drinking drivers is approximately 0.02% per hour.⁴

Taking these factors together, it is possible that a drinking driver who had a BAC of 0.152% at the time of an accident may not be charged with over 0.08% when an evidential breath alcohol test is conducted 2 hours later. For this and other reasons indicated by Haddad,¹ the CMA's recommendation of a lower BAC limit is well justified.

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1. Haddad H. Blood-alcohol levels: show me the evidence [letter]. *CMAJ* 2002; 166(9):1132-4.
2. Hodgson, BT. Alcohol. In: Chayko GM, Gulliver ED, Macdougall DV, editors. *Forensic Evidence in Canada*. Aurora (ON): Canada Law Book; 1991. p. 55-76.
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Quality of care in for-profit hospitals

What are the implications of allowing for-profit delivery of health care? Although I admire the courage of P.J. Devereaux and coauthors¹ in attempting a meta-analysis of this literature, as they noted there is enormous variability within each category. Not all hospitals are alike. In addition to the distinction the authors accurately make between private for-profit and private not-for-profit hospitals, the literature also suggests there are major differences between for-profit firms that are investor owned and those that operate as small businesses. Differences may also exist between organizations because of varying degrees of control by health professionals. Further compounding the difficulty in making comparisons, the for-profit

hospitals included in the studies that Devereaux and coauthors reviewed tended to occupy niche markets, serving different target populations (and often performing different mixes of services) than did the not-for-profit organizations. Comparisons therefore often depend on what and how various factors are controlled for, making precise point estimates even more tenuous.

Regardless of the implications for costs (which are subject to similar apples-to-oranges difficulties), quality differences between for-profit and not-for-profit organizations appear to be less pronounced when clinicians are able to influence the care they give without direct pressure to balance their clinical judgement against shareholder returns.

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Reference

1. Devereaux PJ, Choi PT, Lacchetti C, Weaver B, Schunemann HJ, Haines T, et al. A systematic review and meta-analysis of studies comparing mortality rates of private for-profit and private not-for-profit hospitals. *CMAJ* 2002;166(11):1399-406.

[Ten of the authors respond:]

Raisa Deber states that "quality differences between for-profit and not-for-profit organizations appear to be less pronounced when clinicians are able to influence the care they give without direct pressures to balance their clinical judgement against shareholder returns." This may be the case. However, our systematic review demonstrated that private for-profit hospitals employed less highly skilled health professionals, and there is a demonstrable association between health professionals' skill level and patient mortality. Therefore, even if the private for-profit hospitals do not pressure their health professionals to balance their clinical judgement against the return to shareholders, the lower skill level provides one explanation for

the largely consistent higher mortality rates in private for-profit hospitals.

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Delivery volume debated

CMAJ is to be congratulated for publishing Michael Klein and colleagues' article.¹ For many family physicians, like myself, who are committed to practising obstetrics (low-risk, dare I say), it was a breath of much-needed fresh air. The Society of Obstetricians and Gynaecologists of Canada (SOGC) policy statement 24 never did make much sense in the absence of evidence when subjected to critical review by individual family physicians practising low-risk, low-volume obstetrics. Any policies or clinical practice guidelines that affect a broad section of practising physicians such as family doctors ought to be subjected to due diligence and mandatory endorsement or rejection by the body that represents us, the College of Family Physicians of Canada (CFPC). I am not

really surprised by the conclusions of the study and was indeed very pleased to read the bottom line, the postscript.

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Reference

1. Klein MC, Spence A, Kaczorowski K, Kelly A, Grzybowski S. Does delivery volume of family physicians predict maternal and newborn outcomes? *CMAJ* 2002;166(10):1257-63.

Klein and colleagues¹ overstate the case when they conclude that "the conventional wisdom related to volume and outcome is based primarily on surgical practices and should not be applied to other types of practice" (such as delivering babies). The authors studied this problem in a teaching hospital with residents, readily available obstetricians as consultants, teaching rounds, quality assurance programs and established maternal-care policies and procedures. This setting surely has an effect on the quality of obstetric care practised by family physicians. The problem of volume (experience) influencing practice outcomes should not be an issue in today's teaching hospitals, but it may be in rural areas. The findings of this study, therefore, should not be used as the basis for altering obstetric experience criteria set by the SOGC.

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Reference

1. Klein MC, Spence A, Kaczorowski K, Kelly A, Grzybowski S. Does delivery volume of family physicians predict maternal and newborn outcomes? *CMAJ* 2002;166(10):1257-63.

Although Michael Klein and colleagues¹ have not established a relation between delivery volume and outcome in obstetrics, we cannot say that no relation exists. Their sample size does not allow enough precision to exclude a clinically meaningful association.

The adjusted odds ratios of 0.908 and 0.849 (high volume v. low volume) for low Apgar score and neonatal intensive care unit/special care unit (NICU/SCU) admissions were not statistically significant, but some might consider such odds ratios *clinically* significant if they are true. More important, the confidence intervals for these odds ratios were wide and include effects that would certainly be clinically meaningful. In multivariate analysis, there were trends (again not statistically significant) of more episiotomies, cesarean sections and instrument deliveries in the low-volume group.

This study (which included 549 births attended by low-volume physicians) adds to reassuring literature that suggests no association between delivery volume and outcomes. However, the trends favouring higher delivery volume and the relatively rarity of poor neonatal outcomes necessitate a larger sample size to demonstrate that no clinically significant association exists between adverse outcomes and delivery volume.

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Reference

1. Klein MC, Spence A, Kaczorowski K, Kelly A, Grzybowski S. Does delivery volume of family physicians predict maternal and newborn outcomes? *CMAJ* 2002;166(10):1257-63.

[One of the authors responds:]

Dan Dattani makes an important point regarding who scrutinizes the establishment of clinical practice guidelines. We are therefore pleased that the SOGC has joined the CFPC and the Society of Rural Physicians of Canada (SRPC) in developing a new policy statement on the number of births required to maintain competence. Since more than half of family physicians in both rural and urban settings attend fewer than 25 births per year, the previous