infection and psychological harm and the time that participants must devote to the screening process are not generally accounted for in these evaluations.

- Although all of the published economic evaluations that CCOHTA reviewed showed that screening was cost-effective, the NCCCS[3] analysis showed that cost-effectiveness and reduction in deaths from colorectal cancer depend strongly on the assumed participation rate for the first screen (67% in the base case) and the frequency of screening. However, the participation rate that can be achieved in Canada is largely unknown.

To our knowledge, no country has implemented a population-based screening program at the national level, although several countries have undertaken pilot studies or large-scale programs. If Canada embarks on an expensive ($112 million per year, according to the NCCCS study[3]) community-based screening program for patients at average risk, then health care professionals and the general public should understand that this would be an experiment. Whether the benefits will outweigh the harms is unknown.

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In his commentary, Richard Schabas compared various tools for colon cancer screening.[1] Regarding fecal occult blood (FOB) testing, he stated that the test is "undeniably imperfect" and that "it misses almost as many cancers as it finds." He went on to say that colonoscopy is "probably a better screening tool than FOB" and "appears to be at least as cost-effective." Schabas concluded that we must start doing FOB testing and not colonoscopy in Canada because we believe in "the principles of equity and distributive justice." Instead of setting a goal of increasing the capacity to offer widespread screening colonoscopy, which could significantly reduce the incidence of and mortality associated with colon cancer, Schabas suggested that we opt for a clearly inferior test and accept our "inadequate health system capacity."

By comparison, there is no consensus on the value of mammographic screening for breast cancer, yet we are prepared to spend millions of dollars on such programs. Why should colon cancer not be regarded as at least of equal importance?

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[The author responds:]

In discussing my commentary about colorectal cancer screening,[1] Ted Mitchell is quite right to point out the importance of informed consent for cancer screening. The Cancer Care Ontario[2] and NCCCS[3] reports both emphasize this point. However, it is inappropriate to suggest that these reports do not reflect a "thoughtful weighing of the risks." Both groups included strong consumer representation and put much thought into the issue.

Mitchell is also concerned that colorectal screening will place a new burden on family doctors. However, this burden would be minimized if provincial governments introduced organized screening programs, with provisions for follow-up recall and timely colonoscopy assessment.

There are 3 problems with Bruce Brady's analysis. First, it should be remembered that an intervention with a modest clinical (i.e., individual) benefit can still have a significant population impact. The 20% reduction in mortality projected by the Cancer Care Ontario report[2] would result in about 1500 fewer deaths from colorectal cancer annually in Canada by 2015. Second, cost-effectiveness does not necessarily depend "strongly" on participation rate. In fact, a colorectal screening program would have relatively low fixed costs and high discretionary costs. Our own (unpublished) work at Cancer Care Ontario suggested that the cost-effectiveness curve is very flat above 20% participation, which is hardly a daunting target. Third, Brady refers to a national screening program as an "experiment," but it would be more appropriate to view the randomized clinical trials as the experiments. An evidence-based program emulating these randomized clinical trials would be good health policy, not just an experiment.

Brady is properly concerned about the risks of colonoscopy assessment by inexperienced operators. This is a compelling reason for offering colorectal screening through an organized program rather than on an ad hoc basis (as would be the case with simply issuing clinical guidelines).

With regard to Gordon McLauchlan's letter, there is no need to choose between starting colorectal screening with FOB testing (because we are able to do so) and building our endoscopy capacity so that some day we can replace FOB testing with endoscopy.

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Drug supply and drug abuse

The article by Evan Wood and colleagues[1] suggesting that the seizure of 100 kg of heroin made no difference to heroin abuse in Vancouver is interesting, but its conclusions are open to doubt and its implications are cause for concern.

In Australia over the past 2 years, there has been a significant decrease in heroin overdoses (and subsequent deaths) in association with a decrease in reported abuse of heroin.[2] Over the same period, law enforcement authorities here have had a series of major successes in intercepting shipments of heroin and arresting those responsible.[2]

Wood and colleagues[1] admit that the Vancouver Injection Drug User Study was not designed to look at the effects of a large seizure of heroin on supply to addicts but rather was aimed at analyzing factors related to HIV in drug abusers. Hence, their article reports an incidental post hoc analysis. It is possible that neither the sample of drug abusers they interviewed nor the time frame in which the interviews took place was appropriate for determining changes in drug abuse after a large seizure of heroin. For example, it might be that large shipments of illicit drugs are usually stored for months before being distributed (to help avoid linking importation with subsequent distribution), so that the impact of a seizure on abuse would take months to appear.

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[Three of the authors respond:]

We thank Michael Copeman for his interest in our study.[1] While Weatherburn and associates[2] speculated that interdiction efforts might have led to a heroin drought in Australia in early 2001, they also found no reduction in crime and a concomitant rise in cocaine injection. It is also noteworthy that others[3] have speculated that the drought may have been due to factors other than interdiction.

In our study we moved beyond speculation and looked retrospectively at interviews with addicts regarding the availability of heroin after a record seizure.[1] Instead of this post hoc analysis being a limitation, as suggested by Copeman, our approach reduced the potential for bias because the subjects and interviewers were blinded to this eventual use of the data.

With regard to the time frame of our analyses, Fig. 1 of our original study[1] presents data as far ahead as 3 months after the seizure. Furthermore, even if storage were a factor, basic economic theory predicts that any significant impact on supply should immediately affect price, regardless of storage.[4]

We believe that the ideal case study of interdiction and enforcement efforts comes from the United States, where the resources directed to this approach dwarf what is spent in other nations such as Australia and Canada. For instance, in the United States the number of nonviolent drug offenders in prison exceeds by 100 000 the total incarcerated population in the European Union (EU), despite the fact that the EU has 100 million more citizens.[5] Nevertheless, US drug supply and purity have reached an all-time high.[1,6]

We agree that the implications of our study are of concern, especially since the vast majority of resources spent on the drug problem continue to be directed to enforcement.[1] We hope that the politicians charged with protecting public health take a closer look at the wealth of studies showing the failure of this approach[1-3,5-7] and at the evidence supporting more effective alternatives.[8,9]

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Emergency docs or family physicians?

I am concerned that Benjamin Chan's research letter[1] dealing with the practice patterns of physicians with emergency medicine certification (CCFP [EM]) from the College of Family