FOR THE RECORD

Breakfast behind bars

Inmates in Britain's prisons eat better than patients in National Health Service hospitals. That conclusion was reached by researchers from Bournemouth University's Foodservice and Applied Nutrition Research Group after comparing the nutritional intake of prisoners and hospital patients.

The raw ingredients and preparation methods were similar, "with little salt, butter or margarine added to enhance flavour, as you might do in a commercial setting," says John Edwards, head of the group at the School of Services Management.

But many hospital patients — including an estimated 40% who were malnourished upon admission — did not consume enough food and fluids. Most hospitals lack procedures for monitoring patients' actual food intake and patients who need help with eating or drinking do not always receive it.

"We came across many cases where people who were physically unable to feed themselves had their uneaten food taken away," he says, adding that other patients have diminished appetites caused by their illnesses and the hospital ward setting is not conducive to eating, "especially if you have someone in the bed next to you using a bedpan or vomiting."

In other instances, patients sometimes missed meals when they had conflicting treatment or therapy sessions. Some hospitals have introduced the practice of "protected meal times," (in which all nonurgent activity ceases), along with the use of day rooms with table seating for patients able to leave their beds. Patients sitting at tables usually consume more than those who are bedridden but budget cutbacks have threatened this practice. A Department of Health spokesperson says that most patients are satisfied with the food they receive in hospitals and that "we are working to improve services further." — Mary Helen Spooner, London, England

Medical restraining orders?

Emergency room closures and reductions in hours of operation have become altogether common in several rural areas of Nova Scotia, largely as a consequence of the unavailability of physicians. Less common, though, were aspects of a polite missive issuing from the Cumberland Health Authority as it notified area residents that their local emergency department would be shut down for 36 hours and then no longer be open around the clock.

In what could be viewed as the medical equivalent of a restraining order, the authority simultaneously urged residents not to accost physicians on the street, in stores or in their offices. Nor, the authority added, is it appropriate to go to a physician's office or private residence, or attempt to locate an individual physician elsewhere in the community in search of emergency medical treatment.

The admonition issued in response to concerns from local physicians, one of whom was physically threatened in a grocery store, says Ann Keddy, spokesperson for the Cumberland Health Authority.

Physicians don't appear to be concerned about a public relations fallout resulting from such admonitions, Keddy says. The two family physicians in the town of Pugwash, along Nova Scotia's north shore, who saw the notice "were not concerned about perception."

Delineating and maintaining boundaries between physicians and other residents of small communities has always been an issue, says Dr. Ross Leighton, president of Doctors Nova Scotia. "The familiarity is there even if it is only a perceived one."

While physicians are trained to deal with corridor consultations, there's always a concern about giving advice in nonclinical settings, where the patient's medical information and history may be sketchy, Leighton says.

As for those who need medical advice when emergency rooms are closed and they aren't allowed to accost a community's doctor in the store, relief may be a phone call away. The provincial government has launched HealthLink 811, a 24-hour telecare service that directs callers to registered nurses who assesses symptoms and advises on next steps. — donalee Moulton, Halifax, NS

Psychiatric hospital closes beds

The Alberta government is drawing fire for a plan to move mental health beds out of a major psychiatric hospital into the community rather than redevelop the facility, which has been in operation on the edge of the city of Edmonton for nearly nine decades.

Critics fear that the decision to cancel redevelopment of Alberta Hospital Edmonton sacrifices quality care at the altar of deficit reduction.

"The history of deinstitutionalization has been that those resources have not been adequate to manage psychiatric patients," says Dr. Alberto Choy, president of the facility's medical staff association.

The provincial government faces a $7-billion deficit, while the Alberta Health Services Board, which cancelled redevelopment of the facility, is in the red to the tune of $1.1 billion.

"It is curious to us that this announcement was made at the time when the government also announced they had a $1-billion shortfall," says Choy.

But Dr. Patrick White, regional clinical director of mental health services, denies that financial pressures drove the decision. "We have patients there, one-third that should not be in hospital

and some of them are regressing because we don't have the proper community facilities."

Police agencies, social workers, nursing unions and the criminal trial lawyers' association have lined up in opposition. Choy says that's because they know the consequence of having fewer beds. "This is going to have effects in the emergency room as well as the legal and social services systems."

But White says that while he understands those concerns, mistakes of the past won't be repeated. "That is going to happen over my dead body here. Under no circumstances am I going to tolerate that."

The government has indicated it wants to close at least 246 of the facility's 400 beds. — Ryan Tumilty, St. Albert, Alta.

Building reactors

Canada's medical isotope production woes make it imperative that the United States move immediately to develop capacity to produce a domestic supply of molybdenum-99, a US congressional committee was told as hearings began into legislation calling for an end to American dependency on foreign isotope suppliers.

The bipartisan legislation, the *American Medical Isotopes Production Act*, would see US$163 million spent over the next five years to develop a reactor. That would ensure that American patients are not, as resolution cosponsor and Massachusetts Democrat Edward J. Markey said, "held hostage to old and faulty nuclear reactors from other countries."

Testimony before the House Energy and Commerce Committee's subcommittee on energy and the environment has included arguments that the US dependency on Canadian supply is both unhealthy and unwise, given the uncertainties surrounding the reliability of the National Research Reactor in Chalk River, Ontario.

Meanwhile, Canadian Natural Resources Minister Lisa Raitt cast security of supply of medical isotopes in Canada largely as a function of global efforts to develop a contingency supply plan.

The effort to develop a global plan is being led by a steering group of the Nuclear Energy Agency and will focus on "coordinating reactor schedules, increasing production where possible, and bringing greater transparency to the private sector supply chain," Raitt told the Economic Club of Canada on Sept. 11.

Raitt did not completely shut the door on the possibility that Canada might create a new isotope producing reactor within the next five years, stating that the government is awaiting a report from its Expert Panel on Medical Isotopes. "The panel received 22 submissions and is giving each one due consideration."

Raitt also indicated that the minority Conservative government is contemplating splitting up Atomic Energy of Canada Ltd. into two entities: a research division that would include the troubled National Research Reactor and an electrical power division that would include responsibility for CANDU reactors. — Wayne Kondro, *CMAJ*

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