Job strain, health behaviours and heart disease

We read with interest the study by Kivimaki and colleagues,[1] which examines the longitudinal relationship between job strain and health behaviours on coronary heart disease. Their findings support previous Canadian research[2] that suggests psychosocial working conditions play an important role in the etiology of chronic health conditions. We were, however, surprised by the authors' conclusion that suggests that when a patient's job strain and lifestyle factors contribute to heart disease, clinicians should tell those patients to simply adopt a healthier lifestyle.[1]

That low socioeconomic position is associated with both lower job control and poorer health behaviours is well established.[3] That individualistic approaches to improving health behaviours do not improve — and can exacerbate — social inequalities in health is also well established.[4] Although we agree with Kivimaki and colleagues[1] that changing the psychosocial work environment is challenging, it is possible with concerted efforts from management and employees.[5] In addition, although primary prevention programs, such as physical activity, continue to have limited success at the population level, these programs still seem to be at the forefront of many approaches to improve the health of the population. Telling a patient who experiences a high level of job strain to lose weight is likely as effective as telling a patient who is overweight to find a better job, which based on this study, would confer some decreased risk.

We also question using obesity as a lifestyle factor. People don't start or stop being obese like they start smoking, drinking or being inactive. Obesity would be better conceptualized as a mediating factor between both health behaviours and job strain, and cardiovascular disease. This grouping would allow a more realistic estimate of the risks associated with lifestyle factors, noting that apart from smoking, the hazard ratios associated with job strain were similar to those of alcohol and physical inactivity.[1]

Work is an increasingly important part of the lives of many Canadians. Real progress on reducing the incidence of chronic diseases such cardiovascular disease and obesity are likely to be made by better understanding the relationships between health behaviours and working conditions (including job strain) rather than treating them as separate approaches to primary prevention.

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Generic controlled-release oxycodone

We wish to respond to Miller's article in *CMAJ*.[1] The US Food and Drug Administration (FDA) approved abuse-deterrent labelling for reformulated OxyContin in the United States. The new labelling indicates that the product has physical and chemical properties that are expected to make abuse via injection difficult and to reduce abuse via the intranasal route (snorting). In addition, the FDA determined that the original OxyContin was withdrawn from sale for reasons of safety or effectiveness and, accordingly, the agency will not accept or approve any abbreviated new drug applications (generics) that rely upon the approval of the original OxyContin.[2]

All available postmarketing assessments of the impact of reformulated OxyContin (OxyNEO in Canada) on abuse, as well as the FDA's draft *Guidance for Industry: Abuse-Deterrent Opioids — Evaluation and Labeling*,[3] were available to former federal health minister Leona Aglukkaq.

We are not in the market for a revival of the "cross-border controlled-release oxycodone shopping" that was observed near the Detroit–Windsor Tunnel between August 2010 and October 2011, at a time when the original OxyContin remained available in Canada and the reformulated OxyContin had been introduced in the US.[4]

The FDA has now provided the evidence-based guidance former minister Aglukkaq alluded to in her March 2013 letter to the Commissioner of the FDA. The health minister now needs to protect the health and safety of all our communities and take concrete action to reduce risk by removing generic controlled-release oxycodone from the Canadian market.

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Cervical screening

Several recent publications have challenged parts of the new Canadian Task Force on Preventive Health Care (CTFPHC) guideline on Cervical Screening[1]: a commentary by Dollin,[2] a joint statement by the Society of Obstetricians and Gynaecologists, the Society of Gynaecological Oncologists, and the Society of Canadian Colposcopists,[3] and a *CMAJ* eletter by Murphy and Elit.[4] These writers agree with the CTFPHC's recommendations to screen women aged 30 to 70 and not to screen women under age 20. The writers raise 3 main issues: age of commencement, whether to vary initiation according to women's individual preferences and risk assessment, and use of human papillomavirus (HPV) testing. We have written a detailed rebuttal of these critiques, available on the *CMAJ* and Task Force websites.[5]

Each writer has misquoted the CTFPHC, misunderstood the strength of the evidence, what evidence was used, or why we did not recommend HPV screening. The CTFPHC chose to await outcomes of ongoing trials of HPV testing. The evidence for all recommendations had at least moderate strength, but for young women, the balance of benefits against harms was equivocal and assessment of its importance is individual, and therefore lead to the weak recommendations.

The CTFPHC recommends that women aged 20 to 29 should make their own choices and start getting pap tests in their mid-20s, after discussion with their health care providers. We urge provincial guideline groups and individual doctors to focus on communicating risk information to women who can then make personal choices — this includes those women who are currently having regular tests and those who are not. To assist in this process, we have produced education tools, which are available on the CTFPHC website at http://canadiantaskforce.ca/resources/

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Organ donation programs needed in rural areas

I read the *CMAJ* article by Redelmeier and colleagues[1] with interest. I work in rural and remote regions of Canada and Australia — in centres deemed too small to have donation programs. There are locations in which I cannot even perform enucleation because the eyes cannot be transported to Toronto in less than 24 hours. According to statistics Canada, 5.9% of Canada's population lives in rural communities.[2] Aboriginal subpopulations of rural communities are desperate for kidney donations and have very high rates of trauma. We need to consider rural and remote regions of Canada as potential sites to include in donation programs.

Air transport is regualrly used to take the bodies of those who die in small communities to larger centres for autopsy, or to take take patients from small communities to places where they can receive medical care. Often patients are near death by the time they reach tertiary care centres, and the family or next of kin remaining in the community are not consulted to see if they are aware of the patient's wishes regarding organ donation. I see no reason why we cannot begin to consider transporting potential donors out of rural communities for the sole purpose of donation (when further medical treatment is futile).

We need to ensure adequate communication between families in home communities and care givers in larger centres before these sorts of decisions can be made. By refusing to allow patients in small and remote communities the ability to donate organs, we decrease the number of organs available and deny families the ability to have something positive come from the death of a loved one.

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Letters to the editor

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