

Correspondance

Mandatory testing: not just an academic discussion

For me, Robert Colistro's recent comments on the testing of medical students for hepatitis B¹ are not part of an academic discussion. As an anesthesiologist, I risk pricking myself with a dirty needle at least 10 to 20 times per day. In spite of good technique, I have had many accidents — this is an occupational hazard that I have had to accept. I know I am negative for HIV because I am tested regularly, so I am not concerned with being forced to be tested. However, I feel that it is only fair that if medical students and physicians are forced to be tested then all patients admitted to hospital must also be screened.

In the past, patients were screened for sexually transmitted diseases without question or consent. What makes hepatitis B and HIV different? If you wish to violate medical students' rights, why not do it to patients too?

The term universal precautions is just the politically correct way to avoid forcing patients to be tested. We should have the right to know and protect ourselves.

I know that ethics specialists will not agree with me, but then they probably don't have anyone's blood on them at the end of the day.

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Reference

1. Colistro R. Hepatitis B and medical students [letter]. *CMAJ* 2000;163(3):259-60.

Harm reduction or reducing harm?

I am concerned that readers of the June 13, 2000, special issue of *CMAJ* on substance abuse may think that harm reduction is the central tenet of

Canadian drug policy. While aspects of harm reduction have merit under specific conditions, I am deeply concerned that some truths are missing from the articles in this issue.

Although *Canada's Drug Strategy*¹ does advocate reducing the "harm associated with alcohol and other drugs to individuals, families, and communities," its first sentence states that "Canada's drug strategy reflects a balance between reducing the supply of drugs and reducing the demand for drugs."¹ Neither of these 2 chief aims of Canada's drug strategy can be called harm reduction as defined in the *CMAJ* articles. Reducing harm should not be confused with harm reduction.

The articles also neglect to point out that demand reduction — preventing use in the first place and reducing the number of users — not only is central to the strategy but in fact constitutes the most cost-effective intervention.¹ Instead, the articles give the impression that harm reduction — reducing harms without focusing on consumption — should form the crux of drug policy. Adopting harm reduction as the flagship for drug policy is neither compassionate nor visionary. It is simply a classic case of cop-out realism.

The articles tend to downplay the seriousness of illicit drug use, citing low incidences and the relatively greater economic costs of tobacco and alcohol. Low incidence does not necessarily mean a lesser problem. Harm reduction, adopted as an umbrella strategy, would simply widen the envelope of what drug use is considered acceptable. The message this strategy would send future generations alone cancels any benefits that I could envision.

Small 'h' harm reduction, in the form of specific strategies to help specific groups avoid harm while working toward abstinence or nonproblematic use (if such exists), does need to be considered. However, we should continue to concentrate on preventing drug use, making treatment much more compre-

hensive and accessible and sticking with drug users over the long haul of rehabilitation.

Colin Mangham

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Reference

1. Interdepartmental Working Group on Substance Abuse. *Canada's drug strategy*. Ottawa: Public Works and Government Services Canada; 1998. Available: www.hc-sc.gc.ca/hppb/alcohol-otherdrugs/publications.htm (accessed 24 Nov 2000).

[The editor of the *CMAJ* special issue on substance abuse responds:]

Although *Canada's Drug Strategy* does indeed start as quoted by Colin Mangham, it explicitly states its long-term goal to be "to reduce the harm associated with alcohol and other drugs to individuals, families and communities."¹

In the *CMAJ* special issue, Eric Single and colleagues' objective quantification of mortality and morbidity does place illicit drug use in third place after alcohol and tobacco, which are both legal psychoactive substances.² But their report of 805 deaths and 6940 hospitalizations in 1995 can hardly be said to "downplay the seriousness of illicit drug use." The role that injection drug use now plays in the transmission of HIV and hepatitis C virus in Canada is further cause for concern. Benedikt Fischer and colleagues and Catherine Hankins argue that our traditional approach to illicit substance use is in part responsible for this tragic metric.^{3,4}

Mangham posits a narrow definition of harm reduction — essentially use-tolerant interventions — yet also raises some of the concerns addressed by Yuet Cheung, who notes that "during its evolution [harm reduction] has been ... criticized for sending the wrong message to drug abusers and the public and disparaged as promoting a defeatist position."⁵

Eric Single has written about the