Correspondance

The accidental cell phone user

We were shocked and dismayed by *CMAJ*'s recent call for regulation of cellular telephone use in cars.[1] Good legislation addresses clearly identified problems, is based on scientific evidence and can be enforced. The legislation *CMAJ* has demanded would meet none of these criteria.

Your assumption that wireless phones cause traffic deaths and injuries was apparently based on a study that made no claim to prove the devices cause collisions.[2] Moreover, the study had several shortcomings. First, the sample was small and biased: the study looked at 699 Toronto drivers, all of whom had a cell phone and had been in a collision without injuries. In contrast, a study released this year was based on a random survey of 36 000 drivers.[3] Second, the data were from 1994–1995. Since then, the number of wireless telephone subscribers in Canada has quintupled, from 1.8 million at the end of 1994 to 9 million in March 2001, whereas the number of licensed drivers has increased by 10% and the number of vehicles by only 3%. Finally, the authors assumed that young urban professionals can be expected to have very low collision rates and very safe driving patterns. The opposite is true: young drivers have more collisions and tend to be more likely to take risks than older drivers.

A recent study found that distracted drivers accounted for about 9% of serious crashes.[4] Of that number, 1.5% were using or dialing a cell phone at the time of the crash. In comparison, 11.4% were distracted by adjusting a radio, cassette or CD and almost 30% were distracted by an outside person, object or event.

Distractions can indeed be dangerous. However, laws against careless driving are already in place to prosecute drivers who do not make the driving task their top priority when using a wireless phone. For example, Ontario drivers who are caught driving carelessly while they are talking on cell phones, eating, reading or applying makeup are subject to a $325 fine and the loss of 6 demerit points. Similar penalties apply in jurisdictions across Canada.

Please don't compromise your journal's credibility by making frivolous demands for ill-conceived laws.

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References

1. Driven to distraction: cellular phones and traffic accidents [editorial]. *CMAJ* 2001;164(11):1557.
2. Redelmeier DA, Tibshirani RJ. Association between cellular-telephone calls and motor vehicle collisions. *N Engl J Med* 1997;336(7):453-8.
3. Laberge-Nadeau C. *Le risque d'accidents de la route en relation avec l'utilisation d'un téléphone mobile*. Montreal: Laboratoire sur la sécurité des transports, Université de Montréal; 2001.
4. University of North Carolina Highway Safety Research Center. *The role of driver distraction in traffic crashes*. Washington (DC): AAA Foundation for Traffic Safety; 2001.

Corticosteroids and avascular necrosis of the femoral head

Members of the Division of Orthopedics of St. Michael's Hospital in Toronto continue to maintain that a single short course of corticosteroid medication contributes to avascular necrosis of the femoral head.[1] They must be reminded that avascular necrosis was reported before corticosteroids were introduced. It remains a disorder of unknown origin. The list of patients in the article by Michael McKee and colleagues includes people at high risk for avascular necrosis, such as patients with increased intracranial pressure, alcoholism and trauma.[1] The authors' thinking is an example of guilt by association.

Short courses of corticosteroid therapy are widely used for life-threatening or disabling conditions, such as asthma, severe nasal polyposis, sinusitis and atopic dermatitis. The incidence of slightly over 1 case of avascular necrosis per year reported by the authors is tiny in comparison with the thousands of courses of corticosteroids appropriately prescribed over that time frame.

This report will embolden lawyers to sue physicians who appropriately prescribe short courses of corticosteroids to patients who end up with avascular necrosis, even though the evidence for a relationship is weak. Patients should indeed be warned of the side effects of short courses of corticosteroid therapy, such as weight gain, mood swings, sleep disturbance, muscle cramps and even avascular necrosis, although the last of these is extremely rare. Clinical judgement remains paramount.

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Reference

1. McKee MD, Waddell JP, Kudo PA, Schemitsch EH, Richards RR. Osteonecrosis of the femoral head in men following short-course corticosteroid therapy: a report of 15 cases. *CMAJ* 2001; 164(2):205-6.

[The authors respond:]

We agree with Allan Knight that avascular necrosis was reported long before corticosteroids were introduced and that it remains to some extent a disorder of unknown origin. There are cases of "idiopathic" avascular necrosis for which no precipitating or predisposing factor can be found. However, a multitude of clinical studies confirm that corticosteroids represent a risk factor for the development of this condition. In a previous study from our institution 63% of the cases of avascular necrosis were induced by steroid use.[1] At present, corticosteroids remain the single most common etiological factor for avascular necrosis seen in our centre.

Only 3 of the 15 patients in our series had other risk factors for avascular necrosis.[2] We included these patients in our article to illustrate the point that of the many patients who receive a short course of corticosteroid medication only a small percentage develop avascular necrosis. It is clear that some other predisposing condition or concomitant risk factor is responsible for the development of avascular necrosis.

We agree that short courses of corticosteroid therapy are widely used for

life-threatening conditions. However, we do not feel that such treatment is appropriate in self-limiting conditions where it is of dubious benefit (e.g., in cases of poison ivy).

Our goal is not to "embolden lawyers" or increase the number of lawsuits. Rather, we are attempting to alert physicians to what we feel is strong presumptive evidence that some association exists between short-course steroid therapy and the development of avascular necrosis. There is much more to learn regarding this condition, and our series does not provide conclusive proof that there is a cause–effect relationship between the two. However, avascular necrosis is a crippling condition in young adults and the distressing number of cases that we have seen, and continue to see, following the use of steroid medication stimulated this report.

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References

1. Louie BE, McKee MD, Richards RR, Mahoney JL, Waddell JP, Beaton DE, et al. Treatment of osteonecrosis of the femoral head by free vascularized fibular grafting: an analysis of surgical outcome and patient health status. *Can J Surg* 1999;42(4):274-81.
2. McKee MD, Waddell JP, Kudo PA, Schemitsch EH, Richards RR. Osteonecrosis of the femoral head in men following short-course corticosteroid therapy: a report of 15 cases. *CMAJ* 2001; 164(2):205-6.

The ethics of anonymous chart reviews

Although the approach used by Jacques Lemelin and colleagues to measure the effectiveness of a multifaceted intervention to improve preventive care in family practices in Ontario[1] may be methodologically valid, it raises important ethical questions.

Each of the 40 family practitioners in the study provided informed consent to participate, but it appears that repeated chart audits were done by various research personnel without the knowledge of any of the 4000 patients in the trial. In what seems to be an about-face, when telephone interviews were conducted with 1150 of these patients, all were asked for informed consent. Fifty-two (4.3%) of them refused to be interviewed. Why did the family physicians and researchers feel that they had the right to share patients' confidential files without consent as long as the patients did not know about it, but that consent was needed when the patients were to learn about the use of their medical charts for research purposes? Were the patients who were contacted for the telephone interviews told that their charts were being reviewed by strangers and were they given the option to refuse to have their charts used?

Although the study protocol was approved by the Ottawa Civic Hospital Ethics Review Board, we are left wondering whether researchers should obtain explicit consent from patients before they access patient-identifying data. Was the decision not to obtain patient consent made because the logistic difficulties associated with obtaining consent might have compromised the external validity of the study? Do the distinctive features of cluster randomized trials entail new ethical principles, or careful application of existing principles? If a physician gives consent to have his or her behaviour measured in such a trial does this transcend the right of patients to privacy?

Although we agree that outcome measurement is challenging, we feel uneasy about the achievement of research goals at the expense of patients' rights. Our letter should not be interpreted as a personal criticism of Lemelin and colleagues but as an invitation to an open discussion about the issue of obtaining consent in primary care, health services and public health research.

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Reference

1. Lemelin J, Hogg W, Baskerville N. Evidence to action: a tailored multifaceted approach to changing family physician practice patterns and improving preventive care. *CMAJ* 2001;164(6): 757-63.

[The authors respond:]

Janusz Kaczorowski and John Sellors question the ethics of an anonymous chart review. Their concern seems to be the apparent inconsistency in our approach to obtaining consent: we obtained consent from physicians to participate in the study and from patients before their telephone interview but we did not obtain consent for patient chart reviews.[1] Our approach is entirely consistent with the *Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans*, which states that researchers must obtain consent for physician participation in studies and for patient telephone interviews but not for chart reviews.[2] Section 3, paragraph C, states that "secondary use of data refers to the use in research of data contained in records collected for a purpose other than the research itself. Common examples are patient or school records or biological specimens, originally produced for therapeutic for educational purposes, but now proposed for use in research. The issue be-