individuals.[4] Many areas such as Asia and South America are high-risk regions for gastric cancer.[3] Asian-Pacific guidelines on gastric cancer prevention recommend screening for and eradicating *H. pylori* in high-risk populations.[5] Importantly, Canadian guidelines also recommend screening for and eradicating *H. pylori* in immigrant populations where the incidence of gastric cancer is high.[6]

The Canadian *Helicobacter* Study Group recently convened a meeting addressing at-risk populations for infection in Canada. In addition to native Canadians, data regarding recent immigrants were extensively reviewed and indicated that immigrant populations were at increased risk.[3] *Helicobacter pylori* should be among the infectious diseases selected as high priority for Canadian immigrant guideline development because the majority of immigrants come from high-prevalence regions, which also have an increased risk for gastric cancer. Furthermore, screening tools as well as inexpensive and effective interventions exist to eliminate infection, which could prevent the development of disease complications.

Nicola L. Jones MD PhD
Pediatric Gastroenterologist, Hospital for Sick Children, Toronto, Ont.
Naoki Chiba MD, Carlo Fallone MD, Richard Hunt MD,
Alan Thomson MD PhD
For the Canadian *Helicobacter* Study Group

References

1. Swinkels H, Pottie K, Tugwell P. Development of guidelines for recently arrived immigrants and refugees to Canada: Delphi consensus on selecting preventable and treatable conditions. *CMAJ* 2011; 183:E928-32.
2. Fuccio L, Zagari RM, Eusebi LH, et al. Meta-analysis: Can *Helicobacter pylori* eradication treatment reduce the risk for gastric cancer? *Ann Intern Med* 2009;151:121-8.
3. Jones NL. *Helicobacter pylori* in First Nation and recent immigrant populations in Canada. *Can J Gastroenterol*. In press.
4. Gibney KB, Mihrshahi S, Torresi J, et al. The profile of health problems in African immigrants attending an infectious disease unit in Melbourne, Australia. *Am J Trop Med Hyg* 2009;80:805-11.
5. Fock KM, Katelaris P, Sugano K, et al. Second Asian-Pacific Consensus Guidelines for *Helicobacter pylori* infection. *J Gastroenterol Hepatol* 2009; 24:1587-600.
6. Hunt R, Fallone C, Veldhuyzan van Zanten S, et al. Canadian *Helicobacter* Study Group Consensus Conference: Update on the management of *Helicobacter pylori* — an evidence-based evaluation of six topics relevant to clinical outcomes in patients evaluated for *H. pylori* infection. *Can J Gastroenterol* 2004;18:547-54.

***CMAJ* 2012. DOI:10.1503/cmaj.112-2006**

Canada's low-risk drinking guidelines

In the Nov. 8, 2011, issue of *CMAJ*, Latino-Martel and colleagues[1] suggested that new evidence connecting alcohol consumption and increased risk of cancer means that drinking guideline limits are too high, at least as far as the prevention of cancer is concerned.

As scientific advisors for the forthcoming Canadian guidelines,[2] we acknowledge the clear evidence that having even one drink per day may significantly increase the risk of cancer if this pattern is maintained over several years. We also acknowledge the importance of communicating this information to consumers. This was considered in our efforts to find a basis for a national consensus to replace the diverse sets of guidelines previously offered by different Canadian provinces.[3,4]

Has alcohol just now approached the status reached by tobacco over 60 years ago, when the connection between smoking and lung cancer was first established? Consuming alcohol is more complex because low levels of alcohol consumption may increase the risk of many conditions and reduce the risk of others — notably heart disease and diabetes. We relied on evidence from meta-analyses of alcohol consumption and all-cause mortality[5] to identify a level of consumption at which potential risks and benefits are, for the average person, balanced in comparison with abstainers (i.e., at the ascending portion of the J-shaped curve where risk approached 1.0). The science underlying these studies is not perfect but it does provide a simple and intuitive basis for advice on upper limits for average daily consumption of alcohol (the level at which lifetime risk of premature mortality from all causes does not exceed that of an abstainer). The best available evidence was judged to suggest weekly upper limits of 10 standard drinks for women and 15 for men, so to limit the risk of serious illnesses (note: one Canadian standard drink contains 17.05 mL ethanol). Recommendations for upper daily limits, strategies to reduce short-term risks associated with drinking, and other recommendations are also provided in an independent scientific report to be published later in 2011.[2] We strongly agree with Latino-Martel and colleagues[1] that these are low-risk, not *zero* risk, guidelines, and that people deserve complete information about risks and possible benefits of alcohol upon which to make informed decisions.

Tim Stockwell MD, Doug Beirness MD, Peter Butt MD, Louis Gliksman MD, Catherine Paradis MD
Members of the Low-Risk Drinking Guideline Expert Advisory Panel, commissioned by the National Alcohol Strategy Advisory Committee

References

1. Latino-Martel P, Arwidson P, Ancellin R, et al. Alcohol consumption and cancer risk: revisiting guidelines for sensible drinking. *CMAJ* 2011;183: 1861-5.
2. Stockwell T, Butt P, Beirness D, et al. The basis for Canada's new low-risk drinking guidelines: a relative risk approach to estimating hazardous levels and patterns of alcohol use. Surry Hills (Australia): Australian Professional Society on Alcohol and Other Drugs. In press.
3. Focus sheet: low risk drinking guidelines. Regina (SK): Saskatchewan Ministry of Health; 2009.
4. Alcohol and heatlh: low-risk drinking 2 3 4 5 0. Montréal (QC): Educ'alcool; 2007. Available: www.educalcool.qc.ca/en/alcohol-and-society/alcohol-and-health/index.html (accessed 2010 Apr. 20).
5. Di Castelnuovo A, Costanzo S, Bagnardi V, et al. Alcohol dosing and total mortality in men and women: an updated meta-analysis of 34 prospective studies. *Arch Intern Med* 2006;166:2437-45.

***CMAJ* 2012. DOI:10.1503/cmaj.112-2007**

When patient and doctor disagree

Physician practice in the area of end-of-life care has been shown in previous investigations to vary considerably. In the study by Sprung and colleagues,[1] religion of the practitioner and geographic location had a material influence on end-of-life decisions. In the Canadian single-payer system, patients in intensive care have little or no ability to select the intensive care unit (ICU) doctor. Patients wrongly assume that all ICU doctors are equivalent with respect to important decision-making. Turgeon and colleagues[2] reveal that which week a patient arrives in the ICU might mean the difference

between life and death. Doctors spin powerfully and patients and families believe that the choice before them is the only one. The withdrawal of treatment is treatment, and as such, requires consent. What obligations do doctors have to reveal their biases? When faced with patient–physician conflict, what is the doctor's obligation to set aside biases when patients are powerless to seek care from an alternate physician whose views on end-of-life care may more closely match their own?

Joel Bruce Zivot MD
Medical Director, Cardiothoracic Intensive Care Unit, Emory Healthcare, Atlanta, Ga.

References

1. Sprung CL, Cohen SL, Sjokvist P, et al. End-of-life practices in European intensive care units: the Ethicus Study. *JAMA* 2003;290:790-7.
2. Turgeon AF, Lauzuer F, Simard, J-F, et al. Mortality associated with withdrawal of life-sustaining therapy for patients with severe traumatic brain injury: a Canadian multicentre cohort study. *CMAJ* 2011;183:1581-88.

***CMAJ* 2012. DOI:10.1503/cmaj.112-2008**

Conclusions about specialties don't match evidence

The *CMAJ* news article "Specialty training out-of-sync with job market"[1] claims that "Canada's aging population and the increasing incidence of chronic disease is driving a need for generalists." Evidence suggests that future demands, at least in Ontario, will be for certain specialties and that generalists will be faced with the worst job prospects.[2] In 2030, the three specialties in Ontario with the greatest surplus will be general internal medicine (832), family medicine — emergency room (514) and emergency medicine (273). The three specialties with the greatest demand will be diagnostic radiology (–434), psychiatry (–334) and cardiology (–204). Highly competitive specialties such as dermatology (–66), ophthalmology (–116) and plastic surgery (–19) will be in demand also.[2] As a current representative of medical students, I completely agree with the spirit of this article. More assistance with career planning and understanding the realities concerning human resources in different fields is needed. A focused effort from the national level to the medical school level is required. However, conclusions about future needs should be put on hold until the evidence is collected.

Adam B. Papini
Vice President, External Schulich Hippocratic Council, London, Ont.

References

1. Vogel L. Specialty training out-of-sync with job market. *CMAJ* 2011;183:E1016.
2. Singh D. Lalani H, Kralj B, et al. *Final report: Ontario population needs-based physician simulation model*. Toronto (ON): HealthForceOntario; 2010. p. 40.

***CMAJ* 2012. DOI:10.1503/cmaj.112-2009**

Letters to the editor

In submitting a letter, you automatically consent to have it appear online and/or in print. All letters accepted for print will be edited by *CMAJ* for space and style. Most references and multiple authors' names, full affiliations and competing interests will appear online only. (The full version of any letter accepted for print will be posted at cmaj.ca.)

Correction

Cover text of Dec. 13, 2011 *CMAJ*, Vol. 183(18)

The Analysis article originally scheduled for the Dec. 13, 2011, print issue was rescheduled at the last moment. Inadvertently, the corresponding text was not removed from the cover. The cover text should read "REVIEW: Breast reconstruction after mastectomy. PRACTICE: Fractures in postmenopausal women." *CMAJ* regrets any inconvenience this error may have caused.

***CMAJ* 2012. DOI:10.1503/cmaj.112-2005**