Letters
Correspondance

TB SURVEILLANCE IN CANADA

Dear Editor,

We recently reported on the immigration medical surveillance program for TB in Ontario. While we agree with the assertion of the accompanying editorial that TB control must be considered in the global context, we do not agree with the apparent suggestion that TB prevention programs among high-risk immigrants in Canada be discontinued.

Two prospective and one retrospective study in Canada suggest that persons referred for medical surveillance for TB are at increased risk for TB. These studies found that 1.5-2.8% of persons referred for medical surveillance were diagnosed with active TB at their first medical evaluation in Canada. In the Netherlands an immigration screening program detected cases earlier, resulting in fewer hospital admissions, shorter duration of symptoms and therefore probably reduced tuberculosis transmission.

In the face of the increasing prevalence of TB HIV co-infection and multidrug-resistant TB, tolerance for local transmission needs to be close to zero. Serious attempts to reduce transmission as well as to make a timely diagnosis to optimize the health of the affected individual are required. Clearly operational shortcomings, such as referral of low-risk populations, poor notification and lack of appropriate medical follow-up will seriously compromise the effectiveness of any program. The task facing TB controllers in Canada is the repair and maintenance of the referral program.

TB among persons migrating to countries that enjoy a higher level of development will continue to dominate the TB control concerns of the receiving countries. It is the obligation of TB control officers in these countries to protect the interests of their population. It is clear from our study that there are major problems with the medical surveillance program in Ontario. Clearly we are missing opportunities to reduce the future burden of TB in Canada.

We strongly believe that evidence-based redesign of the system will better preserve the health of Canadians than dismantling it.

W. Wobeser
M. Naus
J. Brunton
N. Heywood
A. Uppaluri

REFERENCES


Response from authors

Dear Editor,

We are grateful to Dr. Wobeser and her colleagues for giving us the opportunity to clarify the opinion we expressed in the editorial concerning tuberculosis in immigrants. We certainly did not intend to imply that the screening of immigrants for tuberculosis was without value. The process does serve to identify and treat those with tuberculosis and those who are at high risk for developing tuberculosis on the basis of their x-ray findings. We did, however, wish to emphasize that the immi-

grant screening process fails to identify nearly 90% of immigrants who subsequently develop tuberculosis. We therefore proposed that additional interventions were necessary if we are to have an impact on tuberculosis in Canada. We thought that the most effective approach was to assist in global initiatives to deal with this disease.

Robert L. Cowie
Stephen K. Field
Donald A. Enarson

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BAC LEVELS

Dear Editor,

Your May-June issue on alcohol and youth was of great interest. As president of the Canada Safety Council, I would like to comment on some aspects of the impaired driving problem.

Canada recorded 1,134 alcohol-related traffic fatalities in 1999, the last year for which official data are available. Mann et al. have cited a figure without stating the year. "Alcohol-related" crashes include, for example, pedestrian and cyclist fatalities with alcohol in their blood, who were killed by non-drinking drivers. (Transport Canada data for 1999 show that 414 pedestrians and 69 cyclists were killed. Two out of every five pedestrian fatalities and one out of five cyclist fatalities had alcohol in their blood.)

In 1999, road crashes involving an impaired driver killed 906 people; preliminary figures for 2000 indicate a further 5% reduction. Drinking drivers comprised half of these fatalities, and their passengers...
made up another quarter. This indicates that to reduce one’s chances of dying in an impaired driving crash, the best policy is never to drink and drive, and never to ride with a driver who has been drinking.

According to a 2001 survey by the Traffic Injury Research Foundation, five million impaired driving trips were taken in one year. Just 5% of drivers accounted for a stunning 87% of these trips. Health professionals can play a key role in identifying and treating this small hard core of drinking drivers, most of whom are alcohol-dependent.

The weight of evidence from other countries does not indicate that Canada should reduce the BAC limit in the Criminal Code from 0.08 to 0.05, as suggested in Single’s editorial. A study by Prof. David Paciocco of the Faculty of Law at the University of Ottawa, published in March 2002, found that Canada would be bucking international norms if it were to legislate a criminal response for low blood alcohol counts.

Only 4 of the 77 independent legal jurisdictions studied by Prof. Paciocco use a criminal law approach at 0.05. In most of the countries studied, drivers with BACs below 0.08 are simply fined, and where licence suspensions are possible, they tend to be for very short periods of time.

In most provinces and territories, drivers are subject to licence suspensions if they are caught driving with a BAC of 0.05 or if they refuse to provide a sample. Only Alberta, Quebec and the Yukon Territories have no legislation prohibiting driving with BACs lower than 0.08. There is zero tolerance for new drivers under graduated licencing systems. Putting 0.05 in the Criminal Code would give low-risk offenders life-long criminal records, year-long suspensions, and would potentially even imprison them.

The Paciocco study found that Canada’s sanctions for impaired driving are among the strictest in the world, even when compared with jurisdictions that have 0.05 BAC limits.

More resources must be dedicated to combat impaired driving. Our police are challenged to enforce the current limit. However, funding must be provided throughout the system. If police lay more charges, the courts and Crown Attorneys must be available to process those charges; and treatment must be available for offenders with an alcohol problem.

Given that many chronic offenders are alcohol-dependent, intervention by health professionals is critical. Proper treatment has been shown effective in reducing crashes and preventing recidivism. Consistent assessment and treatment of offenders, including first offenders, should be a focus for health professionals in the fight against impaired driving.

Emile-J. Therien
President, Canada Safety Council

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Response from author

Dear Editor,

Mr. Therien objects to my alleged endorsement of lowering the BAC limit to 0.05. In fact, I was careful to point out that the evidence is not conclusive and what I actually stated was that “the weight of evidence from other countries indicates that reducing the BAC limit from 0.08 to 0.05 for impaired driving offences under the federal Criminal Code would likely reduce impaired driving injuries and fatalities.” I think there is little doubt that this statement is true. Given the evidence regarding lowering BAC limits from 0.10 to 0.08 in the U.S. and given the positive impacts of lower BAC limits for new drivers, lowering the BAC limit is indeed likely to reduce impaired driving injuries and fatalities. Of course, this is not the same as saying that Canada should necessarily adopt a 0.05 BAC limit. There are a host of other considerations that have to be taken into account, including not only the impacts on convicted offenders but also the economic ramifications to the hospitality and alcohol industries. Data are lacking on those impacts.

Nonetheless, I lean strongly towards lowering the BAC limit. In practice the police must give a certain leeway due to variations in breathalyser readings, so machines are currently calibrated to 0.10% BAC rather than 0.08%. Thus, a 180 lb. man could consume 5 drinks in two hours — clearly, enough to cause serious impairment for most persons — and still not be charged with impaired driving. This suggests that the current limits may be too high and we should not dismiss the potential benefits to public health and safety that could result from lowering the BAC limit. We need better and more complete data to be certain, but clearly there is a good deal of potential benefit from a close consideration of lowering the current BAC limit under the Criminal Code.

I also do not agree with Mr. Therien’s implication that Canada has a particularly good record regarding impaired driving. There has been progress in the past few years, but if our countermeasures are so good, impaired driving would not still be the leading cause of death among young Canadians.

Eric Single
Professor of Public Health Sciences
University of Toronto

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