Physicians of Canada is based on the assumption that family medicine is a discipline defined by setting. Chan gives the impression that family medicine cannot be practised anywhere but within the confines of a clinic with strictly scheduled patient visits. The notion that family physicians hang up their family medicine knowledge, skill set and principles at the door when they enter an emergency department is at best naive.

In 1980 the College recognized that emergency medicine is a core part of family medicine and that a formal training and certification program should be provided to those wishing to practise both family medicine and emergency medicine or full-time emergency medicine.[2] Indeed, the considerable overlap between these disciplines makes clear the need for physicians certified in both. Through its residency and certification programs in emergency medicine across the country the College has done an outstanding job in fulfilling its mandate to "provide family physicians the opportunity to bring enhanced skills in emergency medicine to their communities."[3] Graduates of CCFP(EM) programs certainly use their family medicine background to provide high-quality medical care in emergency departments and other practice settings. Thus I strongly disagree with Chan's conclusion that his study demonstrates "an incongruity between the CCFP(EM) program's objective and the practice choices of its graduates."

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[The author responds:]

Family medicine can of course encompass multiple settings outside the office, including the emergency department, case room and hospital ward. Yes, family physicians bring important knowledge and skills to these environments. However, when a family physician restricts almost all of his or her practice to an emergency setting, that individual resembles not a family physician but a specialist. He or she does not bring to these settings the perspective of long-term relationships with patients, as are cultivated in the physician's office, and is not as well positioned to act as a bridge between the office and hospital environments. The emergency department performs many important functions, but continuing care, preventive services and chronic disease management — all core functions of family medicine — are not among them.

No one disputes that physicians with CCFP(EM) certification who do full-time emergency medicine are providing an essential service, and my paper[1] suggests many plausible reasons why these physicians would choose such a career path. Nonetheless, this study has raised some important questions about the CCFP(EM) certification program. Do we want our community hospital emergency departments to be staffed by full-time emergency physicians? If yes, is 2 years of family medicine plus 1 year of emergency training appropriate, or should there be more emphasis on the latter? If no, then are the candidates selected for the CCFP(EM) program people who want to do family medicine, rather than those looking for the fastest route to full-time emergency practice? Have we inadvertently created a culture where family physicians without this certification are made to feel unwelcome or underskilled for work in the emergency department? All of these questions merit careful consideration.

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Reference-based refinements

The claim by Sebastian Schneeweiss and colleagues[1] that "between 1995 and 1997, when [reference-based pricing] was actively expanding, increases in PharmaCare's costs were contained" disagrees with data published by the Canadian Institute for Health Information[2] (CIHI). According to CIHI, BC PharmaCare's expenditures increased from $329 million in 1995 to $410 million in 1997, a 25% increase in 2 years. Over the same period, total provincial and territorial spending on public pharmaceutical benefits for the rest of Canada decreased by 2%, from $2720 million to $2668 million.[2] Furthermore, Schneeweiss and colleagues' failure to observe negative health consequences from reference-based pricing may result from the fact that only 5353 of 37 362 subjects switched from a restricted to a reference angiotensin-converting enzyme (ACE) inhibitor when the policy was established. The majority chose to pay the difference in cost themselves or received exemption through special authority. The resulting lack of statistical power meant that a 19% increase in hospital admissions for "switchers" in the 2 months after implementation of reference-based pricing for ACE inhibitors was considered insignificant because the confidence interval was –1% to 42%.[3] Therefore, the argument that reference-based pricing was not associated with negative health outcomes is unconvincing.

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Competing interests: The Fraser Institute has received charitable donations from a number of pharmaceutical manufacturers; these donations make up less than 3% of the Institute's budget. Mr. Graham has received travel assistance and an honorarium from one of these companies.

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[Two of the authors respond:]

John Graham's concerns about the effect of reference-based pricing on drug expenditures in British Columbia present an opportunity to further clarify the situation described in our commentary.[1]

Reference-based pricing was expected to produce the most savings for elderly patients (those covered by PharmaCare Plan A), because they were the primary users of reference drug classes: antihypertensives, nitrates and NSAIDs. According to official PharmaCare statistics,[2] there was minimal growth (0% to 2.6% per patient annually) in Plan A expenditures between 1995 and 1997, the time of active expansion of reference-based pricing, but this growth increased to 8% to 10% later.

Successful drug cost containment does not necessarily lead to a reduction in global drug expenditures, particularly if the elderly population is increasing rapidly, as is the case in British Columbia. However, it should significantly slow the increase in per capita expenditures in the target population. Furthermore, after the introduction of BC's PharmaNet network in late 1995, reimbursements have been provided automatically rather than being based on submissions of claims. This change resulted in a surge in reimbursements to patients under 65 years of age who had previously been unaware that they could receive coverage after reaching a certain level of expenditure. Global budget comparisons across the country are therefore unhelpful.

Successful drug policies such as reference-based pricing should not lead to lower prescribing rates but to a shift toward more cost-effective alternatives where available and toward newer breakthrough drugs where needed. Our research provides evidence that this was achieved.[3,4] Other investigators have independently come to the same conclusion. Morgan[5] showed on an aggregate level that changes in drug mix during the expansion of reference-based pricing led to substantial savings for PharmaCare while overall utilization was unchanged.

Unfortunately, Graham has misinterpreted the results of our study published in the *New England Journal of Medicine*.[3] Because only 14% of those using ACE inhibitors switched to lower-priced ACE inhibitors, the primary comparison was between those who switched drugs and those who did not. As we discussed at length, it is difficult using claims data to fully adjust for confounding by patient health status when this status is a predictor for both future hospital admissions and switching to a lower-priced ACE inhibitor (because of more frequent physician encounters if health status is poor). Follow-up beyond the 2-month period Graham mentions is therefore more meaningful. The rate ratio for changes in hospital admissions was 1.19 (95% confidence interval [CI] 0.99–1.42) for 2 months and even lower, with a tighter CI, for 10 months (1.03, 95% CI 0.92–1.14).

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An open letter from Concerned Medical Students on Iraq

We, the undersigned medical students from across Canada, strongly oppose the current military intervention in Iraq on the grounds that it constitutes an attack on the public health of Iraqi civilians and is likely to cause a humanitarian crisis.

The current military assault on an already vulnerable population affected by past wars and 12 years of harsh economic sanctions[1] is alarming. We are further concerned about its effects on international stability and the legitimacy it lends to military assaults and violence as a form of political or social action outside of international law.

As future health care professionals who aim to preserve life and health, it is our responsibility to advocate for the prevention of violence through peaceful resolution of conflicts, as well as to serve as activists for all human beings whose health and well-being is threatened by conflicts worldwide. We call upon all concerned parties to immediately recommit themselves to the collective frameworks for peace, justice, and security as enshrined in the UN Charter and other international agreements.

Please find our letter at www.cmaj.ca/cgi/content/full/168/9/1115-a/DC1. We hope it will contribute to informed discussion among members of the government, the public, and the medical profession.

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(www.uwomeds.com/iraq)

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