References
1. Sukkari SR, Sasich LD. Cisapride and patient information leaflets [letter]. *CMAJ* 2001;164(9): 1276-8.
2. Peterson RG. Cisapride and patient information leaflets [letter]. *CMAJ* 2001;164(9):1278-9.
3. Repchinsky C, editor-in-chief. *Compendium of pharmaceuticals and specialties: the Canadian drug reference for health care professionals*. Ottawa: Canadian Pharmacists Association; 2003.
4. Serzone-5HT2. In: Repchinsky C, editor-in-chief. *Compendium of pharmaceuticals and specialties: the Canadian drug reference for health care professionals*. Ottawa: Canadian Pharmacists Association; 2003. p. 1562-5.
5. Serzone-5HT2. Information for the patient. In: Repchinsky C, editor-in-chief. *Compendium of pharmaceuticals and specialties: the Canadian drug reference for health care professionals*. Ottawa: Canadian Pharmacists Association; 2003. p. B256-7.
6. Choi S. Nefazodone (Serzone) withdrawn because of hepatotoxicity. *CMAJ* 2003;169(11): 1187.

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[Dr. Peterson responds:]

Traditionally, physicians and pharmacists have interpreted for patients the technical prescribing information provided by drug manufacturers and approved by Health Canada. More recently, it has become apparent that manufacturers should be providing information more oriented to consumers, to bridge the gap between the technical product monograph and information needed by patients. As a result, a new section of the product monograph, entitled "Information for the Consumer," is required for all new submissions filed with Health Canada as of October 2004.

With regard to the situation raised by Sana Sukkari and Larry Sasich, in 1999 Health Canada notified health care providers, through its *Canadian Adverse Reaction Newsletter*, of 9 cases of hepatic dysfunction in Canada among patients receiving Serzone.[1] In July 2001, Health Canada issued an advisory on the risk of severe hepatic injury with Serzone.[2]

The product monograph for Serzone was updated in October 2001 to warn of potential hepatoxicity. This update included a warning to patients that Serzone had been associated with very rare cases of severe liver damage. It advised patients being treated with the drug to seek immediate medical attention if they experienced any of the symptoms on the list provided.

Health Canada reviews and authorizies updates to product monographs and patient information for drugs sold in Canada, and drug manufacturers have a responsibility to ensure that the most recent versions of these documents are released to health care professionals. It appears, for reasons unknown to Health Canada, that the changes made to the 2001 product monograph and information to the consumer were not transmitted for the 2002 and 2003 editions of the *Compendium of Pharmaceuticals and Specialties*. The product was withdrawn from the Canadian market in 2003.

Health Canada continues to pursue initiatives to make product monographs, including information for the consumer, more readily available to the Canadian public. Certainly, the number of notifications to health care professionals about important safety issues — via the Health Canada Web site (www.hc-sc.gc.ca/english/protection/warnings.html) and mailings — reflects the need for physicians and pharmacists to remain current with respect to the drugs they prescribe and dispense.

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References
1. Hepatotoxicity associated with nefazodone (Serzone). *Can Adverse React Newsl* [serial online] 1999;9(3). Available: www.hc-sc.gc.ca/hpfb-dgpsa/tpd-dpt/adrv9n3_e.html#NEFAZODONE (accessed 2004 Oct 4).
2. *Risk of severe liver injury associated with use of the antidepressant nefazodone* [advisory]. Ottawa: Health Canada; updated 2001 Jul 9. Available: www.hc-sc.gc.ca/english/protection/warnings/2001/2001_74e.htm (accessed 2004 Oct 4).

DOI:10.1503/cmaj.1041448

Catering to the customers

It is not surprising that 6 English-language journals published in North America and the United Kingdom would tend to include articles on topics of interest to English-speaking patients, physicians and researchers in those industrialized, relatively wealthy countries, as reported by Paula Rochon and associates.[1] Grant funding and the subsequent generation of manuscripts, driven by public and political advocacy and commercial interests, probably reinforce this practice.

This is not necessarily good or bad; it is simply a reflection of the professional interests of the readers. One could argue that these journals survive by focusing the bulk of their output on topics that are of interest to the subscribers and advertisers that generate their revenue streams — that's just good business practice.

The conduct and dissemination of a greater number of randomized controlled trials focused on world health priorities may ultimately depend on the development of a comparable research and publishing infrastructure in those less affluent countries, admittedly a daunting task.

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Reference
1. Rochon PA, Mashari A, Cohen A, Misra A, Laxer D, Streiner DL, et al. Relation between randomized controlled trials published in leading general medical journals and the global burden of disease. *CMAJ* 2004;170(11):1673-7.

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[Three of the authors respond:]

Sometimes, it is important to state the obvious, even if it is not surprising. In our study[1] we document that trials published in the leading general medical journals do not reflect the conditions and diseases that are the most important causes of death and disability internationally. Our study points out again the discrepancy between what has priority in North America relative to what is important for most people worldwide.

Even if a problem is obvious, it must sometimes be quantified before the medical community accepts it as a real and pressing issue. Putting numbers to an obvious issue somehow lends it credibility.

We hope our study will have other ef-

fects. For example, it may prompt people to think about how they could make a difference. We understand that it is difficult to expect researchers living in developed countries to study what they do not know. As Louis Jacques points out, research on problems of the developing world should be done by those living and working in those countries. Researchers from the developed world could, however, use their research expertise to train investigators working in low-income countries so that they can conduct and publish the studies they think are needed. We also hope our study will serve as a reminder that the human race lives in a global village. Those of us in privileged circumstances must find ways to gain a more global perspective so as to improve health for all.

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Reference

1. Rochon PA, Mashari A, Cohen A, Misra A, Laxer D, Streiner DL, et al. Relation between randomized controlled trials published in leading general medical journals and the global burden of disease. *CMAJ* 2004;170(11):1673-7.

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Care at for-profit hospitals

I was surprised to learn that Gordon Guyatt, coauthor of an influential paper on health care delivery,[1] was also a candidate for the New Democratic Party during this year's federal election. The statement in the article claiming that there were no competing interests for any of the authors is as shocking as it is false. At the very least, medical studies published by politicians should be transparent about that fact.

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Reference

1. Devereaux PJ, Heels-Ansdell D, Lacchetti C, Haines T, Burns KEA, Cook DJ, et al. Payments for care at private for-profit and private not-for-profit hospitals: a systematic review and meta-analysis. *CMAJ* 2004;170(12):1817-24.

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Peter Devereaux and associates[1] estimate the cost of care provided in private hospitals. Unfortunately, they ignore 3 important points.

The first is corporate income taxes. The authors estimate that for-profit hospital care (if half of Canadian hospitals were converted to private for-profit institutions) would cost an additional $3.6 billion. This additional money would be spent on improving care (greater capacity, shorter waiting times, newer technology) or other hospital expenses, or it would become "profit" before taxes. The average combined federal and provincial corporate income tax rate was estimated at 38.1% in Canada for 2002.[2] If none of the additional $3.6 billion were spent on additional hospital expenses, then the for-profit hospitals would have to pay $1.37 billion (38.1% × $3.6 billion) in corporate income taxes. This would reduce the impact on taxpayers.

Second, the authors ignore the role of competition. The study with the most recent data (for 1986–1994) and the most patients found that lack of competition leads to higher prices, even for nonprofit hospitals.[3] Devereaux and associates ignore the effect of competition in moderating prices.

Third, Devereaux and associates have ignored case mix. Instead, they extrapolate one pooled estimate of a congeries of hospital payment ratios to the entire Canadian hospital system.

I am sure that consideration of the above points would substantially alter the policy recommendations that were derived from the meta-analysis.

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References

1. Devereaux PJ, Heels-Ansdell D, Lacchetti C, Haines T, Burns KEA, Cook DJ, et al. Payments for care at private for-profit and private not-for-profit hospitals: a systematic review and meta-analysis. *CMAJ* 2004;170(12):1817-24.
2. Department of Finance Canada. *The Canadian tax advantage* [online]. Ottawa: The Department; 2002 Jan; updated 2004 Mar 8. Available: www.fin.gc.ca/toce/2002/cantaxadv_e.html (accessed 2004 Sep 10).
3. Keeler EB, Melnick G, Zwanziger J. The changing effects of competition on non-profit and for-profit hospital pricing behavior. *J Health Econ* 1999;18(1):69-86.

DOI:10.1503/cmaj.1041047

[Three of the authors respond:]

William Nuttley raises the issue of competing interests for our article on costs of care in for-profit hospitals,[1] with reference to coauthor Gordon Guyatt's candidacy for the New Democratic Party in the 2004 federal election. The choice of our research question was undoubtedly one of people's interests and values, but that is true of all investigators and all projects.[2] Our work was conducted before Guyatt was nominated as a political candidate. The researchers on our study team hold widely varying political views, but they shared a common conviction that it was crucial to answer the study question (regardless of the results), given