retention in rural areas is improved by this interdisciplinary elective. We hope that providing appropriate background and developing skills among students who are already interested in working in rural areas will lead them to stay longer in rural practice and give them greater satisfaction in their lives there.

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Reference

1. Rourke J, for the Task Force of the Society of Rural Physicians of Canada. Strategies to increase the enrolment of students of rural origin in medical school: recommendations from the Society of Rural Physicians of Canada [editorial]. *CMAJ* 2005;172(1):63-5.

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James Rourke outlines many useful strategies to promote enrolment of students of rural origin in medical schools.[1] Alex McPherson also raises several interesting issues related to the concept of rural training.[2] Once students are in medical school, however, they need opportunities to learn in the geographic areas where we ultimately want them to practise.

Ontario now has 5 Distributed Medical Education (DME) programs, all funded by the Ministry of Health. Based in Thunder Bay, Sudbury, Collingwood, London and Perth, these programs have grown from their origins as coordinated opportunities for community-based medical school electives, and they now place both core and elective learners in high-quality sites with faculty-appointed preceptors.

The Collingwood-based program, the Rural Ontario Medical Program (www.romponline.com), was established in 1988 and operates in partnership with the 5 (soon to be 6) Ontario medical schools. ROMP offers community-based rotations ranging from several weeks to well over a year in duration. Educational rotations are offered starting in the first year of medical school and continuing into clinical clerkship and residency; short-term and long-term rotations in family medicine and specialist programs are also offered. During their rotations in the communities, trainees may visit high schools to encourage rural students to consider a medical career. At the end of their formal education, we offer new physicians placement opportunities through our Community Development Office (www.cdoprogram.com). Once new graduates have been placed, we work with them to identify opportunities for them to become teachers for the program.

The DME programs have been successful in providing one solution to the rural physician shortage. A 10-year retrospective analysis in 2001 showed that 98 (47%) of the 209 participants in ROMP are now practising in rural or underserviced communities. The 2 northern programs (based in Thunder Bay and Sudbury) have similar success rates.

As noted by the WONCA Working Party on Training for Rural Practice,[3] "After a rural background, the next strongest factor associated with entering rural practice is undergraduate and postgraduate clinical experience in a rural setting." The opportunities offered by Ontario's DME programs will play a vital role in the future sustainability of community medical practice.

Peter Wells
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Perspectives on drug withdrawals

Physicians are the ultimate decision-makers in the use of prescription drugs, but we depend on the integrity of pharmaceutical companies. We spend much of our time modifying risk factors for vascular disease, but in the past few years, 2 major classes of drugs have proven to be contributors to vascular disease. The first to fall were the menopausal replacement hormones, and now we are dealing with the fallout related to COX-2 inhibitors.[1]

When the COX-2 drugs arrived on the scene, I actually stopped prescribing older nonsteroidal anti-inflammatory drugs, because of the risk of upper gastrointestinal bleeding. I began to have doubts about the COX-2 inhibitors when some patients experienced gastric or intestinal problems anyway, and others seemed to experience rather severe hypertension.

The drug representatives showered me with so many samples that I seldom had to write a prescription. One rep gave me an entire case, which lasted for months. I tended to favour whichever COX-2 inhibitor was in my sample cupboard, but they are a hard sell now that 2 of them have been banned. Patients read newspapers too, but surely we physicians deserve to get bad news about drugs from the manufacturers well before it hits the papers.

My fear now is that those of my patients who received COX-2 inhibitors and who now have vascular disease may question my treatment, just as my menopausal patients have questioned replacement hormone therapy. Patients are surprisingly forgiving, but there is un-

doubtedly a limit to their understanding.

So goes the art and practice of medicine. Sometimes when I reach for my prescription pad, I treat it like a loaded weapon, to be used with extreme caution if at all.

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Reference

1. Vioxx: lessons for Health Canada and the FDA [editorial]. *CMAJ* 2005;172(1):5.

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Canada has one of the safest drug systems in the world and we at Health Canada are always looking for ways to improve it. For example, the Minister of Health recently committed to mandatory reporting of adverse drug reactions and has indicated his support for more transparency regarding clinical trials.

The *CMAJ* editorial on the Vioxx case and its implications for drug safety[1] notes some of the difficulties inherent in postmarketing surveillance, such as extrapolating conclusions from clinical trials to real-world clinical practice and detecting signals and relating them to a specific drug. The editorial also points to areas for improvement: better mechanisms for physician reporting, active surveillance targeting serious adverse events and improved use of other databases. Health Canada agrees and looks forward to active discussion of these issues with *CMAJ* readers, who are on the front line of postmarketing surveillance.

However, other comments in the editorial are inaccurate. Reference to a "built-in bias toward approving drugs" and a low bar for approval of drugs for sale in Canada are incorrect and misleading. The review process in Canada is thorough; involves extensive assessment of the safety, efficacy and quality of all medications; and is in line with international standards.

It is important to continue to raise the profile of adverse event reporting within the health care community and to work together to improve the system. The cooperation of *CMAJ* in the publication and distribution of the Canadian Adverse Reaction Newsletter is greatly appreciated, but much more must be done. One example of Health Canada's commitment in this area is its pilot project on active surveillance (undertaken with the Canadian Paediatric Society), which brings together a network of 2300 pediatricians to collect and analyze information on adverse reactions (see www.cps.ca/english/CPSP/Studies/drugreactions.htm). In addition, we are opening 2 new centres in our system of regional adverse reaction centres to enhance our ability to promote the reporting of adverse reactions nationally.

My colleagues and I look forward to working with *CMAJ* as well as the key players in the drug safety process to improve on the good and safe foundation that already exists.

Diane C. Gorman
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Reference

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It was with disappointment that I read the *CMAJ* editorial on the withdrawal of rofecoxib (Vioxx).[1] In particular, I am disappointed with the narrow perspective on the safety of our industry's medicines and the supposed conflict caused by a relationship between industry and Health Canada.

The member companies of Rx&D (Canada's Research-Based Pharmaceutical Companies) are committed to patients, to their health and well-being, and to the assurance that new medicines are as safe and efficacious as humanly and scientifically possible. No company wants to launch a medicine on the market to have it withdrawn at some future date. The impact for the company, in terms of both reputation and financial perspective, can be devastating. That is why any negative effect experienced by patients in the development phase of a medicine must be reported. Once a medication is made available to patients, any serious and unexpected adverse effects reported to the manufacturer must, in turn, be reported to Health Canada within 15 days.

When should a medicine be allowed to go to market? Once all possible combinations with other drugs or commonly used products have been studied? For many patients, this is not an option. Who would have thought a few years ago that grapefruit juice could have a dramatic impact on the health of patients taking certain types of medicines? Yet pharmacists now alert their patients to potential interactions between grapefruit juice and medications.[2] Patients who take medicines must understand that any pharmaceutical chemical introduced into the body is not natural; hence, they should, with the consultation and supervision of their physician, weigh concerns against benefits and make an informed decision.

Reference to potential conflict caused by an emphasis on Health Canada's "partnerships with industry" is simply not true.

When taken appropriately, medicines can provide positive health outcomes and value to patients, their families, our health care system and society as a whole.

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Canada's Research-Based Pharmaceutical Companies (Rx&D)
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2. Maskalyk J. Grapefruit juice: potential drug interactions. *CMAJ* 2002;167(3):279-80.

DOI:10.1503/cmaj.1050027

Importance of open access for clinicians and researchers in developing countries

The *CMAJ* editorial on the topic of open access[1] is of special relevance for developing countries. I am a South