This issue's letters

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Funding for Canadian health care research

In a recent editorial, Matthew Stanbrook and Paul Hébert discuss Canada's inadequate support for health research.[1] Their comparison of the expected per capita investments in academic health research in 2007 in Canada and the United States (showing that the United States invests significantly more than Canada) downplays the divergent priorities of the Canadian and US health care and medical research jurisdictions.

In 2004, Canada spent 9.8% of its gross domestic product on health care whereas the United States spent 15.4%.[2] However, there is little reason for us to be jealous of the American health care system. Could the situation with respect to research be similar?

In 2006, $55.2 billion was spent on pharmaceutical research in the United States, or $182.16 per capita. The equivalent market in Canada was worth $1.15 billion in 2006, or $34.85 per capita.[3] Medical research is burgeoning in the United States because it is largely funded by private pharmaceutical companies.

Stanbrook and Hébert recognize that we must offer "made-in-Canada solutions, reflecting Canadians' priorities and values" through our research undertakings. Canada need not abandon its goal of being a global player in health care research, but research within a public health care system must show public benefit. Bolstering careers or filling coffers is not enough. We must give up our attempts to duplicate the American medico-industrial research machine and end the "me too" approach that results in Canadian funds being allocated to research that does not uphold Canadian values merely because it would be funded in the United States. Canadian research investments must reinforce distinctly Canadian values. We do not want American health care research any more than we want American health care.

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Competing interests: None declared.

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3. Patented Medicine Prices Review Board. *PMPRB annual report 2006.* Ottawa: The Board; 2007. Available: www.pmprb-cepmb.gc.ca/english/view.asp?x=903&mid=720 (accessed 2007 Dec 20).

DOI:10.1503/cmaj.1070164

Organ procurement and futile medical care

As Robert Sibbald and colleagues pointed out in their recent *CMAJ* study,[1] there has been no increase in the rates of documented discussions of resuscitation status or do-not-resuscitate orders for patients who want to forego resuscitation, and there has been no decrease in the number of attempted resuscitations at the time of death since the Patient Self Determination Act became effective in the United States.[1] However, revisions in 2006 to the US Uniform Anatomical Gift Act have added new barriers to appropriate end-of-life care for terminally ill patients who are resuscitated without explicit consent or with advance documentation of do-not-resuscitate wishes.

The Uniform Anatomical Gift Act was revised to increase the procurement of organs for transplantation from terminally ill patients on life support.[2] The revised sections 14(c) and 21(b) permit the continuation of all medical measures (including the use of life support) necessary to maintain organ viability until procurement personnel have determined whether the patient is suitable to be an organ donor.[2] These revisions were introduced to override patients' advance directives that life support systems be withheld or withdrawn at the end of life. The revised Act has added new barriers to appropriate end-of-life care for terminally ill patients, who will now be resuscitated without their explicit consent or contrary to their do-not-resuscitate wishes documented in advance directives.[2]

The real impact of the revised Uniform Anatomical Gift Act on the quality of palliation and end-of-life care for terminally ill patients in US intensive care units and their families is still unknown.[3] Health care providers have expressed concerns about the possibility of euthanasia for organ procurement after life support is withdrawn from dying patients.[4] Nevertheless, the revisions to the Act have been enacted in over 20 US states and may exacerbate the current crisis in which scarce intensive care resources are being used ineffectively and medically futile care is being delivered at the end of life. These revisions will pose new challenges to the Congressional Budget Office when it addresses the rising costs of health care in the United States.[5]

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DOI:10.1503/cmaj.1070171

MedsCheck: an opportunity missed

In 2007 the Ontario Ministry of Health and Long-Term Care, in collaboration with the Ontario Pharmacy Council and the Ontario Pharmacists' Association, launched the MedsCheck program, which targets Ontario patients with chronic diseases who take 3 or more prescription medications daily. As of May 22, 2007, more than 28 600 patients had received a MedsCheck review.[1]

The prophylactic identification of potential drug-related events (e.g., interactions, prescribing errors) is a significant element of comprehensive, high-quality care for this at-risk patient population. However, we believe the MedsCheck program as currently structured is flawed.

Contrary to the information in Sylviane Duval's *CMAJ* news piece,[2] family physicians have not been formally included in the program. According to the MedsCheck website (www.medscheck.ca), there is no requirement for pharmacists to provide a copy of the medication review to the patient's family physician. Given that the Ontario government is compensating pharmacists on a flat-rate basis ($50 per consultation, irrespective of time spent), it is unlikely that the extra time will be taken to ensure, as a matter of routine, that the family physician is fully and promptly informed of the review and its findings.

Research has shown that multilevel, multi-faceted interventions are more effective at improving the quality of health care. In view of the growing focus on interprofessional care, it is curious that this new program appears to have been conceived, designed and implemented in the absence of formal collaboration with Ontario's family physicians. We believe this represents a significant missed opportunity to foster meaningful team-based care for those most in need, namely patients with complex chronic diseases.

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Competing interests: None declared.

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2. Duval S. Pharmacists to red flag risky drug interactions. *CMAJ* 2007;177:1171.

DOI:10.1503/cmaj.1070172

Corrections

In the Jan. 1 issue, a news story on the physician complaints process[1] should have stated that if a complaint reaches a disciplinary hearing and the committee overseeing the process rules that the physician was at fault, his or her name is published in only 6 provinces: British Columbia, Alberta, Manitoba, Newfoundland and Labrador, Ontario and Quebec. The websites of the colleges in New Brunswick, Nova Scotia and Saskatchewan display the results of disciplinary hearing decisions but do not name the doctors.

REFERENCE

1. Howell, E. Canvassing the Canadian complaints landscape. *CMAJ* 2008;178:14-16.

DOI:10.1503/cmaj.080043

A Teaching Case Report in the Jan. 1 issue about facial contact dermatitis[1] should have listed John Luo as the first author.

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1. Bercovitch L, Luo J. Cellphone contact dermatitis with nickel allergy. *CMAJ* 2008;178:23.

DOI:10.1503/cmaj.080087