this. If patients should be advised of something, wouldn't the patient information pamphlet be the place to advise them? When I explain to patients my refusal to prescribe it prophylactically they are sceptical because no advisory on the conditional nature of the authorization appears in the patient brochure.

Deena Ages
Family physician
Toronto, Ont.

[Glaxo Wellcome responds:]

Deena Ages notes that the patient information pamphlet for Relenza does not include the statement in the advertisement in *CMAJ* that reads "patients should be advised of the conditional nature of the market authorization for this indication." This statement is a reference to the fact that Relenza was granted a Notice of Compliance with Conditions in November 1999 by the Therapeutic Products Program of Health Canada. The statement appears at the front of the product monograph for Relenza and is directed at health care professionals; it is meant to serve primarily as an instruction to physicians.

The subject of conditional approval is complex and is very unlikely to be meaningful to a patient in the absence of an appropriate explanation from a health care professional. We believe that by instructing the prescriber to address this matter with patients, the message will be more effectively communicated and a patient's understanding will be greatly improved.

Finally, for the benefit of readers who may misinterpret Ages' reference to prophylactic use, we feel it is important to clarify that Relenza is currently approved by Health Canada only for the treatment of acute influenza, and not for influenza prevention.

Michael D. Levy
Senior Vice-President, Research and Development
Chief Medical Officer
Glaxo Wellcome Inc.
Mississauga, Ont.

Electronic wonderland

Peter Singer laid out a very intriguing scenario in his article on the future of medical journals.[1] Certainly many of the developments he outlined are here or will come true in the foreseeable future for some users of medical literature. The key words, however, are "future" and "some users." In many ways we are not into the dawn of a new information millennium in terms of equitable access to electronic medical literature. With health care and library budgets being continuously cut, the costs of the ever-changing technology are often beyond the means of many. Knowledge may be a great leveller, but access to information is not always equal.

Singer shows some naïveté in stating that everyone — authors, publishers, advertisers and subscribers — will be "delighted" with the new electronic publishing medium. Vested interests and economic imperatives are not that easily shifted by the glimmer of technology. And to state that subscribers will be grateful to pay $200 per year for a journal shows a singular lack of understanding of the current pricing realities of periodical publishing. One doubts that the major publishers will just roll over and forsake the accumulation of profit in the interests of humanity. With due regard for his refreshing sense of hope, I might suggest that Singer pay equal attention to the increasingly dire situation in many of our academic and hospital libraries. Budgets decrease annually in relation to the real cost of delivering ever-growing amounts of information by increasingly sophisticated and often costly means. Let's get the basic methods of knowledge transfer down pat before going off on an enthusiastic tangent about the electronic wonderland that awaits us.

John Tagg
Health Disciplines Library
West Park Hospital
Toronto, Ont.

Reference

1. Singer PA. Medical journals are dead. Long live medical journals. *CMAJ* 2000;162(4):517-8.

I write in response to Peter Singer's article on the future of medical journals.[1]

It's the year 2015. With the exception of trauma specialists, doctors no longer exist. As research findings are immediately available to the public via the Internet and the news media, everyone knows what pills to take. Pharmacists are allowed to dispense medications directly to an informed public.

The process of delicensing the occupation of physician began when doctors started making treatment decisions on the basis of abstracts found in MEDLINE rather than after reading and evaluating complete articles for themselves. From there, the capsule comments and notations provided by e-publishers became the sum total of doctors' reading, making them basically equivalent to the general public. As a superior intellect and vast medical knowledge were no longer necessary to practise medicine, universities decertified most medical programs, with the exception of surgery — although there are now electronic resources guaranteed to provide a lay person with enough knowledge and guidance to perform creditably in any cyber-equipped operating room.

Everyone is happy — although there is some suspicion that this may be the result of the pills everyone is now taking for general well-being as found on the Net.

Gord Lindsay
Toronto, Ont.

Reference

1. Singer PA. Medical journals are dead. Long live medical journals. *CMAJ* 2000;162(4):517-8.

[The author responds:]

I thank John Tagg and Gord Lindsay for responding to my article[1] in which I sketched a vision of the future of medical publishing — only time will tell how unrealistic or naïve it is. I don't expect publishers to roll over, as Tagg suggests, although I predict publishers who do not innovate will be bowled over by the tsunami of elec-

tronic publishing bearing down upon them. Despite the parody in Lindsay's letter, the vision of a public informed and active in health matters is a good one. Lindsay and Tagg neglect the key point in my article: there is a terrible inequality in medical knowledge around the world, and we need to find innovative ways to remedy this in the interests of global peace and justice.

Peter A. Singer
University of Toronto Joint Centre for Bioethics
Toronto, Ont.

Reference

1. Singer PA. Medical journals are dead. Long live medical journals. *CMAJ* 2000;162(4):517-8.

Do the right thing

Charlotte Gray's report on Canada's hospital emergency department crisis[1] showed that we must take off our blinkers. As Gray reported, this was done in major hospitals in Alberta and Saskatchewan, where staff anticipated the arrival of the annual flu season in order to avoid emergency department overcrowding. Far too often, planning like this is anathema to solo practitioners, both specialists and FPs, who act as if they are running a corner store.

Surely medicine is not only a business but also a public service. That, and the responsibility to care for individual patients, should lead to 24/7 service. Why is this not the universal standard? Why is it not a moral as well as a legal requirement of medical practice? The hospital emergency department is not a substitute for continuity of practice, and it is the next best thing to a cop-out to use emergency departments as an alternative to the doctor's office.

As a pathologist, I was part of a group that provided such service at night and on weekends. I am sure that evening and weekend coverage by a physician as part of a formal or informal group is the least the public can expect. Being on call once in 7 nights or weekends is all that would be required in most cases.

Communication systems can now be used to route calls to the person on call without redialing, to provide at least a triage consultation. Medical bodies, such as the provincial colleges, should consider making such coverage obligatory and subject to disciplinary action. Come on, colleagues. Let's do the right thing for our patients!

J.V. Frei
Pathologist (retired)
Toronto, Ont.

Reference

1. Gray C. Hospital crisis? What crisis? *CMAJ* 2000;162(7):1043.

We protest!

You recently published an article regarding Paras Naik and reported that "at age 22 he will become the youngest Canadian to hold a medical degree."[1]

I wish to report that Pamela Veale graduated from the University of Calgary Faculty of Medicine in 1993 at the age of 21. I am certain of these facts because I was a classmate of hers and am now her husband. By the way, another classmate of mine, Earl Campbell, obtained his MD at age 22.

Alan C. Tiessen
Anesthesiologist
Calgary, Alta.

Reference

1. Sullivan P. Paras Naik, MD: how Scotland produced Canada's youngest physician. *CMAJ* 2000;162(6):870.

Paras Naik is a remarkable young man but he is not the youngest Canadian to hold a medical degree.1 He may hold that honour in the year 2000, but not historically.

My father, Douglas J. Patchell, graduated from the University of Toronto in 1946 at age 20 and began practising in Hillsdale, Ont., at age 21. Bette Stephenson, a past president of the CMA, also graduated from medical school at age 20, if my memory serves.

Paul Patchell
Coldwater, Ont.

Reference

1. Sullivan P. Paras Naik, MD: how Scotland produced Canada's youngest physician. *CMAJ* 2000;162(6):870.

As I am rapidly sliding into advancing middle age, I must protest about an issue dear to my heart. I graduated from the University of Toronto in 1968 at age 21, 4 months shy of my 22nd birthday. I can't claim to be the youngest U of T graduate, but I'm sure there were also others younger than 22. So I must take exception to hearing Paras Naik[1] described as Canada's youngest doctor, because he isn't!

Compulsively yours,

Irena C. Szparaga
Family physician
Weston, Ont.

Reference

1. Sullivan P. Paras Naik, MD: how Scotland produced Canada's youngest physician. *CMAJ* 2000;162(6):870.

[The news and features editor responds:]

The article was meant to refer to Paras Naik's status in the year 2000 only. We were well aware, for instance, that during the war years the compressed medical curriculum meant that Canada was producing many doctors who were barely out of their teens. However, these letters did raise another question among *CMAJ*'s aging editors. Does anyone know how old Canada's oldest medical graduate was when he or she graduated?

Patrick Sullivan