Drug marketing priorities

I appreciated *CMAJ*'s recent editorial on drug marketing,[1] but I wish to highlight here a major medical education issue that is usually overlooked, in part because of the influence wielded by the pharmaceutical industry through its funding of speakers. My concern is the relative lack of "marketing" for effective psychotherapeutic regimens that often result in the patient discontinuing the use of medication.

Well-established psychotherapeutic regimens have been empirically validated, and their cost-effectiveness has been demonstrated.[2] For example, brief dynamic regimens have been empirically validated not only for anxiety disorders, depression and personality disorders, but also for a range of physical conditions such as irritable bowel syndrome.[3] There is a body of data for these treatments showing that they reduce physician visits and admissions to hospital. In one case series, in which 89 patients were treated with short-term dynamic psychotherapy in 1996–1997, a total of $402 000 was saved in the first year of treatment because of reductions in the number of physician visits, medication costs, disability costs and hospital costs.[4] Sixty-three (71%) of the patients in this series were able to stop their medications, and a further 13 (15%) reduced their dosages.[4]

But how well known is this type of data? What educational institutions dependent on industry money would disseminate such information? What industry representative would endorse a treatment in which a positive outcome is the discontinuation of medication?

This problem speaks to the need for "firewalls" in our journals and educational institutions to prevent pharmaceutical companies from controlling information about treatments and to thus ensure appropriate balance in medical education. Somehow, we must guarantee that the whole picture of human pathology, including emotional dysfunction, is evenly represented and addressed.

Allan Abbass
Director, Centre for Emotions and Health
Dalhousie University
Halifax, NS

References

1. Drug marketing: Unsafe at any dose? [edito *CMAJ* 2002;167(9):981.
2. Lazar SG, Gabbard GO. The cost-effectiv of psychotherapy. *J Psychother Pract Res* 1997;6: 307-14.
3. Anderson E, Lambert M. Short-term dyn cally oriented psychotherapy: a review and meta-analysis. *Clin Psychol Rev* 1995;15:503-14.
4. Abbass A. Intensive short-term dynamic chotherapy in a private psychiatric office: clinical and cost effectiveness. *Am J Psychother* 2002;56: 225-32.

CANM endorsement of densitometry guidelines

The Canadian Association of Nuclear Medicine (CANM) is a national body representing the nuclear medicine specialists of Canada. Members of our organization have been involved in performing and interpreting the results of bone mineral densitometry for 22 years.

The CANM has reviewed the bone densitometry recommendations recently published in *CMAJ*,[1] and we are pleased to endorse them.

The members of our organization look forward to continuing to assist our colleagues in the management of patients with suspected or proven osteoporosis.

Christopher J.M. O'Brien
President
Canadian Association of Nuclear Medicine
Ottawa, Ont.

Reference

1. Khan AA, Brown JP, Kendler DL, Leslie WD, Lentle BC, Lewiecki EM, et al. The 2002 Canadian bone densitometry recommendations: take-home messages. *CMAJ* 2002;167(10):1141-5.

Protection after medical error

In one of many recent articles on *Building a Safer System*, the report of a steering committee formed by the Royal College of Physicians and Surgeons of Canada, Barbara Sibbald[1] focused on the fear of litigation associated with reporting complications in medicine and the protection offered by

Submitting letters

Letters may be submitted via our Web site or by mail, courier, email (pubs@cma.ca) or fax. They should be no more than 250 words long and must be signed by all authors. Letters written in response to an article published in *CMAJ* must be submitted within 2 months of the article's publication date. Letters are subject to editing and abridgement.

eLetters

We encourage readers to submit letters to the editor via the eLetters service on our Web site (www.cmaj.ca). Our aim is to post by the next business day correspondence that contributes significantly to the topic under discussion. eLetters will be appended to the article in question in *eCMAJ* and will also be considered for print publication in *CMAJ*. To send an eLetter, click on the "Submit a response to this article" at the top right-hand side of any *eCMAJ* article.

provincial evidence acts. The tone of this and similar articles suggests that the entire Canadian medical community experiences medical incidents and errors and that none of these problems is reported or analyzed because of fear of litigation.

This implication is incomplete and perhaps untrue. I cannot speak for other provinces, but in British Columbia the Evidence Act[2] protects from disclosure any reports and investigations of committees such as hospital morbidity and mortality committees.

Similarly protected by designation under the Act is the British Columbia Anesthesiologists' Society Critical Incident Reporting Service.[3] This service is a patient safety and quality assurance program offered by BC anesthesiologists, the existence of which seems to have been overlooked by the authors of the original report.

I do not see fear of litigation as a barrier to establishing specific patient safety programs. Rather, there is a need to establish a supportive environment in which overly busy clinicians can reflect upon and analyze the quality and results of the care they provide. Such support will necessarily involve not only education on the value of self-analysis but also appropriate support facilities, with funding, staff, and access to tools and information. Such an undertaking will not be inexpensive.

Richard N. Merchant
Chairman, Patient Safety Committee
British Columbia Anesthesiologists' Society
Vancouver, BC

References

1. Sibbald B. Reducing medical error: "People doing their best is not enough." *CMAJ* 2002;167(9):1047.
2. Evidence Act. R.S.B.C. 1996, c. 124. Available: www.qp.gov.bc.ca/statreg/stat/E/96124_01.htm (accessed 2002 Dec 2).
3. Patient safety: BCAS Critical Incident Reporting Service [online]. Burnaby, BC: British Columbia Anesthesiologists' Society; [no date]. Available: www.bcanesthesiologists.ca (accessed 2002 Dec 2).

[The author responds:]

I agree that it is incomplete and, indeed, untrue, to suggest that none of Canada's incidents and errors is reported or analyzed because of fear of litigation. However, the fact remains that medical error is underreported in Canada.[1] The question is why. There are myriad reasons: the lack of a supportive environment is one, fear of legal reprisal is another. The Canadian Medical Protective Association has stated that people reveal medical errors at their legal peril because "there is no privilege [exemption from legal action] following disclosure."[2] Evidence acts come under provincial and territorial jurisdiction and therefore differ substantially. Changing this legislation would be an easier — and less expensive — approach to alleviating this problem, at least when compared with instituting supportive environments. Let's hope it's only the first of many steps.

Barbara Sibbald
Associate News Editor
CMAJ

References

1. Sibbald B. Reducing medical error: "People doing their best is not enough." *CMAJ* 2002;167(9):1047.
2. Sibbald B. Ending the blame game key to overcoming medical error. *CMAJ* 2001;165(8):1083.

Neuroradiologists and stroke

Stephen Phillips and colleagues[1] are to be congratulated for organizing and developing an acute stroke unit in Halifax and for describing the contributions that such units can make to the care of stroke patients. Halifax is well served by its unit, which is an example for Canada and the world.

However, the article omitted mention of one important group of medical specialists. Neuroradiologists have participated in stroke management in Canada for decades, and skilled neuroradiologists and the neuroimaging they perform are integral to the management of stroke, both acute and chronic. Up-to-date diagnostic and interventional neuroradiology procedures and well-trained neuroradiologists are needed for stroke care as we now know it, including the care of patients in acute stroke units.

Phillips and colleagues[1] list the important contributions of 13 professional groups to their model stroke unit. This list mentions food and nutrition services, research assistants and spiritual care, but not neuroradiology. Perhaps neuroradiologists have come to be appreciated in the same way as an institution's walls and its plumbing — absolutely necessary, always available, excellent and reliable.

Allan J. Fox
Department of Neuroradiology
Sunnybrook and Women's College Health Sciences Centre
Toronto, Ont.

Reference

1. Phillips SJ, Eskes GA, Gubitz GJ, on behalf of the Queen Elizabeth II Health Sciences Centre Acute Stroke Team. Description and evaluation of an acute stroke unit. *CMAJ* 2002;167(6):655-60.

[Two of the authors respond:]

We regret that some radiologists may feel slighted because their specialty was not explicitly listed among the members of our acute stroke team.[1] We agree that radiologists, and neuroradiologists in particular, play an important and expanding role in the diagnosis and treatment of stroke.

We are pleased to have a close working relationship with the radiologists in our department of diagnostic imaging. Radiologists have been helpful in improving our ability to deliver care in a timely manner. Although waiting for a scan may be a rate-limiting step in the administration of tissue plasminogen activator, our protocol specifies that any candidate for such treatment is next in line for CT. We also have a rapid carotid Doppler ultrasonography service, so patients can be scanned immediately if they present to the emergency department during the day (the next day, including weekends, if they present after hours).

Our interventional neuroradiologists, in collaboration with neurosurgery and neurology specialists, treat aneurysms and arteriovenous malfor-