168(2):178-9.
2. Ontario Expert Panel. *Colorectal cancer screening: final report of the Ontario Expert Panel*. Toronto: Cancer Care Ontario; 1999 Apr. Available: www.cancercare.on.ca/colorectal.pdf (accessed 2003 Mar 3).
3. National Committee on Colorectal Cancer Screening. *Recommendations for population-based colorectal cancer screening*. Ottawa: Health Canada; 2002. Available: www.hc-sc.gc.ca/pphb-dgspsp/publicat/nccs-cndcc/index.html (accessed 2003 Mar 3).

Drug supply and drug abuse

The article by Evan Wood and colleagues[1] suggesting that the seizure of 100 kg of heroin made no difference to heroin abuse in Vancouver is interesting, but its conclusions are open to doubt and its implications are cause for concern.

In Australia over the past 2 years, there has been a significant decrease in heroin overdoses (and subsequent deaths) in association with a decrease in reported abuse of heroin.[2] Over the same period, law enforcement authorities here have had a series of major successes in intercepting shipments of heroin and arresting those responsible.[2]

Wood and colleagues[1] admit that the Vancouver Injection Drug User Study was not designed to look at the effects of a large seizure of heroin on supply to addicts but rather was aimed at analyzing factors related to HIV in drug abusers. Hence, their article reports an incidental post hoc analysis. It is possible that neither the sample of drug abusers they interviewed nor the time frame in which the interviews took place was appropriate for determining changes in drug abuse after a large seizure of heroin. For example, it might be that large shipments of illicit drugs are usually stored for months before being distributed (to help avoid linking importation with subsequent distribution), so that the impact of a seizure on abuse would take months to appear.

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References
1. Wood E, Tyndall MW, Spittal PM, Li K, Anis AH, Hogg RS, et al. Impact of supply-side policies for control of illicit drugs in the face of the AIDS and overdose epidemics: investigation of a massive heroin seizure. *CMAJ* 2003;168(2):165-9.
2. Weatherburn D, Jones C, Freeman K, Makkai T. Supply control and harm reduction: lessons from the Australian heroin "drought." *Addiction* 2003;98(1):83-91.

[Three of the authors respond:]

We thank Michael Copeman for his interest in our study.[1] While Weatherburn and associates[2] speculated that interdiction efforts might have led to a heroin drought in Australia in early 2001, they also found no reduction in crime and a concomitant rise in cocaine injection. It is also noteworthy that others[3] have speculated that the drought may have been due to factors other than interdiction.

In our study we moved beyond speculation and looked retrospectively at interviews with addicts regarding the availability of heroin after a record seizure.[1] Instead of this post hoc analysis being a limitation, as suggested by Copeman, our approach reduced the potential for bias because the subjects and interviewers were blinded to this eventual use of the data.

With regard to the time frame of our analyses, Fig. 1 of our original study[1] presents data as far ahead as 3 months after the seizure. Furthermore, even if storage were a factor, basic economic theory predicts that any significant impact on supply should immediately affect price, regardless of storage.[4]

We believe that the ideal case study of interdiction and enforcement efforts comes from the United States, where the resources directed to this approach dwarf what is spent in other nations such as Australia and Canada. For instance, in the United States the number of nonviolent drug offenders in prison exceeds by 100 000 the total incarcerated population in the European Union (EU), despite the fact that the EU has 100 million more citizens.[5] Nevertheless, US drug supply and purity have reached an all-time high.[1,6]

We agree that the implications of our study are of concern, especially since the vast majority of resources spent on the drug problem continue to be directed to enforcement.[1] We hope that the politicians charged with protecting public health take a closer look at the wealth of studies showing the failure of this approach[1-3,5-7] and at the evidence supporting more effective alternatives.[8,9]

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References
1. Wood E, Tyndall MW, Spittal PM, Li K, Anis AH, Hogg RS, et al. Impact of supply-side policies for control of illicit drugs in the face of the AIDS and overdose epidemics: investigation of a massive heroin seizure. *CMAJ* 2003;168(2):165-9.
2. Weatherburn D, Jones C, Freeman K, Makkai T. Supply control and harm reduction: lessons from the Australian heroin 'drought.' *Addiction* 2003;98(1):83-91.
3. Dietze P, Fitzgerald J. Interpreting changes in heroin supply in Melbourne: droughts, gluts or cycles? *Drug Alcohol Rev* 2002;21(3):295-303.
4. Lipsey R, Chrystal A. *Principles of economics*. 9th ed. Oxford (UK): Oxford University Press (Academic); 1999.
5. Schiraldi V, Holman B, Beatty P. *Poor prescription: the cost of imprisoning drug offenders in the United States*. Washington: Justice Policy Institute; 2000 Jul. Available: www.drugpolicy.org/docUploads/PoorPrescription.pdf (accessed 2003 Feb 21).
6. Bluthenthal RN, Lorvick J, Kral AH, Erringer EA, Kahn JG. Collateral damage in the war on drugs: HIV risk behaviours among injection drug users. *Int J Drug Policy* 1999;10:25-38.
7. Best D, Strang J, Beswick T, Gossop M. Assessment of a concentrated high-profile police operation: no discernible impact on drug availability, price or purity. *Br J Criminol* 2001;41:738-45.
8. Rydell CP, Caulkins JP, Everingham SE. Enforcement or treatment? Modeling the relative efficacy of alternatives for controlling cocaine. *Oper Res* 1996;44(5):687-95.
9. Rehm J, Gschwend P, Steffen T, Gutzwiller F, Dobler-Mikola A, Uchtenhagen A. Feasibility, safety, and efficacy of injectable heroin prescription for refractory opioid addicts: a follow-up study. *Lancet* 2001;358(9291):1417-23.

Emergency docs or family physicians?

I am concerned that Benjamin Chan's research letter[1] dealing with the practice patterns of physicians with emergency medicine certification (CCFP [EM]) from the College of Family

Physicians of Canada is based on the assumption that family medicine is a discipline defined by setting. Chan gives the impression that family medicine cannot be practised anywhere but within the confines of a clinic with strictly scheduled patient visits. The notion that family physicians hang up their family medicine knowledge, skill set and principles at the door when they enter an emergency department is at best naive.

In 1980 the College recognized that emergency medicine is a core part of family medicine and that a formal training and certification program should be provided to those wishing to practise both family medicine and emergency medicine or full-time emergency medicine.[2] Indeed, the considerable overlap between these disciplines makes clear the need for physicians certified in both. Through its residency and certification programs in emergency medicine across the country the College has done an outstanding job in fulfilling its mandate to "provide family physicians the opportunity to bring enhanced skills in emergency medicine to their communities."[3] Graduates of CCFP(EM) programs certainly use their family medicine background to provide high-quality medical care in emergency departments and other practice settings. Thus I strongly disagree with Chan's conclusion that his study demonstrates "an incongruity between the CCFP(EM) program's objective and the practice choices of its graduates."

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References

1. Chan BTB. Do family physicians with emergency medicine certification actually practise family medicine? *CMAJ* 2002;167(8):869-70.
2. Rice DI. Certification in family medicine/emergency medicine. *Can Fam Physician* 1980;26:909-10.
3. *Standards for accreditation of residency training programs*. Mississauga (ON): College of Family Physicians of Canada; 2002.

[The author responds:]

Family medicine can of course encompass multiple settings outside the office, including the emergency department, case room and hospital ward. Yes, family physicians bring important knowledge and skills to these environments. However, when a family physician restricts almost all of his or her practice to an emergency setting, that individual resembles not a family physician but a specialist. He or she does not bring to these settings the perspective of long-term relationships with patients, as are cultivated in the physician's office, and is not as well positioned to act as a bridge between the office and hospital environments. The emergency department performs many important functions, but continuing care, preventive services and chronic disease management — all core functions of family medicine — are not among them.

No one disputes that physicians with CCFP(EM) certification who do full-time emergency medicine are providing an essential service, and my paper[1] suggests many plausible reasons why these physicians would choose such a career path. Nonetheless, this study has raised some important questions about the CCFP(EM) certification program. Do we want our community hospital emergency departments to be staffed by full-time emergency physicians? If yes, is 2 years of family medicine plus 1 year of emergency training appropriate, or should there be more emphasis on the latter? If no, then are the candidates selected for the CCFP(EM) program people who want to do family medicine, rather than those looking for the fastest route to full-time emergency practice? Have we inadvertently created a culture where family physicians without this certification are made to feel unwelcome or underskilled for work in the emergency department? All of these questions merit careful consideration.

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Reference

1. Chan BTB. Do family physicians with emergency medicine certification actually practise family medicine? *CMAJ* 2002;167(8):869-70.

Reference-based refinements

The claim by Sebastian Schneeweiss and colleagues[1] that "between 1995 and 1997, when [reference-based pricing] was actively expanding, increases in PharmaCare's costs were contained" disagrees with data published by the Canadian Institute for Health Information[2] (CIHI). According to CIHI, BC PharmaCare's expenditures increased from $329 million in 1995 to $410 million in 1997, a 25% increase in 2 years. Over the same period, total provincial and territorial spending on public pharmaceutical benefits for the rest of Canada decreased by 2%, from $2720 million to $2668 million.[2] Furthermore, Schneeweiss and colleagues' failure to observe negative health consequences from reference-based pricing may result from the fact that only 5353 of 37 362 subjects switched from a restricted to a reference angiotensin-converting enzyme (ACE) inhibitor when the policy was established. The majority chose to pay the difference in cost themselves or received exemption through special authority. The resulting lack of statistical power meant that a 19% increase in hospital admissions for "switchers" in the 2 months after implementation of reference-based pricing for ACE inhibitors was considered insignificant because the confidence interval was –1% to 42%.[3] Therefore, the argument that reference-based pricing was not associated with negative health outcomes is unconvincing.

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Competing interests: The Fraser Institute has received charitable donations from a number of pharmaceutical manufacturers; these donations make up less than 3% of the Institute's budget. Mr. Graham has received travel assistance and an honorarium from one of these companies.

References

1. Schneeweiss S, Maclure M, Dormuth C, Avorn J. Pharmaceutical cost containment with reference-based pricing: time for refinements [editorial]. *CMAJ* 2002;167(11):1250-1.