

private and public drug plans. That's good public policy.

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References

1. Emergency contraception moves behind the counter [editorial]. *CMAJ* 2005;172(7):845.
2. The Society of Obstetricians and Gynaecologists of Canada (SOGC): pioneers in the struggle to provide emergency contraception access to Canadian women [press release]. 20 Apr 2005. Available: www.sogc.org/sogcnet/documents/emergency_contraception_morningafterpill.pdf (accessed 28 Apr 2005).
3. Soon JA, Levine M, Osmond BL, Ensom MHH, Fielding DW. Effects of making emergency contraception available without a physician's prescription: a population-based study. *CMAJ* 2005;172(7):878-83.

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A recent *CMAJ* editorial¹ expresses concern that the reclassification of levonorgestrel 0.75 mg (Plan B) as a "behind the counter" product represents a "needless barrier to access."

The National Association of Pharmacy Regulatory Authorities strongly believes that incorporating pharmacists' counselling in the provision of emergency contraceptives benefits women and the health care system. Pharmacists can play a key role in educating women on the risk of infection associated with unprotected sex, the correct use of barrier and hormonal contraception and the management of side effects of this medication. Women will have the option of visiting a physician or a pharmacist and thus will be able to make their own decision on the initial point of care.

Given the experience in British Columbia² of a "dramatic rise" in the total use of emergency contraceptives "resulting mainly from pharmacy dispens-

ing" (to quote the *CMAJ* editorial), it is difficult to understand how consultation with the pharmacist presents a barrier to access. Licensed pharmacists possess the knowledge, skills and professionalism needed to sensitively supply emergency contraception.

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References

1. Emergency contraception moves behind the counter [editorial]. *CMAJ* 2005;172(7):845.
2. Soon JA, Levine M, Osmond BL, Ensom MHH, Fielding DW. Effects of making emergency contraception available without a physician's prescription: a population-based study. *CMAJ* 2005;172(7):878-83.

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Physicians and advocacy

It is evident that providing responsible advocacy for patients, individually and collectively, is an obligation for Canadian physicians, as was discussed in a *CMAJ* editorial¹ earlier this year. The College of Family Physicians of Canada has distributed a Declaration of Commitment, dated Nov. 25, 2004, that states "we are a resource to our practice populations — promoting health to prevent illness, providing and explaining health information, collaborating with and facilitating access to other caregivers, and advocating for patients throughout the health care system." The Educating Future Physicians for Ontario project identified "advocate" as one of the roles patients expect from their physician. Similarly, the Royal College of Physicians and Surgeons of

Canada's CanMEDs roles include the role of "advocate."

Even if such advocacy makes administrators uncomfortable, physicians must judge what is in the best interests of their patients and behave accordingly. We must strive for communication within institutions that ensures that medical staff can make good judgments about how best to exercise their responsibility for advocacy, but we must never stifle their voices. There are too many historical examples of suppression of information when patients would have benefited from prompt disclosure.

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Reference

1. Physicians and advocacy [editorial]. *CMAJ* 2005; 172(11):1413.

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A novel mutation in a patient with pantothenate kinase-associated neurodegeneration

Pantothenate kinase-associated neurodegeneration is an autosomal recessive disorder characterized by accumulation of iron mainly in the basal ganglia.^{1,2} In about half of these cases, patients have an identifiable mutation in the *PANK2* gene.¹

We previously described a 13-year-old boy who showed the "eye of the tiger" sign on a T_2 -weighted magnetic resonance (MR) image³ that is highly specific not only for this disease but also for a mutation in the *PANK2* gene.¹ Here we report on our screening for mutations of the *PANK2* gene conducted on the genomic DNA of the patient and his family (Fig. 1).

DNA was isolated from peripheral blood using a phenol-chloroform reference protocol. All exons of the gene were amplified by polymerase chain reaction (PCR),⁴ and the amplified prod-