ADRs and smart health cards

The commentary by Paula Rochon and colleagues[1] highlights the importance of information technology in drug safety. In recent years medication error has received considerable attention, because it causes substantial mortality and morbidity and leads to additional health care costs. This source of preventable harm to hospital patients represents an area where information technology will have a positive impact.

The use of computerized physician order entry and online alerts to reduce medication errors are common elements of medication safety policy. We have implemented an automated alert system for drug–drug interactions in Taipei Municipal Wanfang Hospital (which is managed by Taipei Medical University). This system alerts the clinician in real time if a drug–drug interaction is detected for prescriptions given at our hospital. However, it is common for patients to be taking drugs from different hospitals or clinics at the same time. Now, our system is able to detect drug–drug interactions for prescriptions from different hospitals by checking the electronic prescription records on the patient's National Health Insurance (NHI) integrated circuit (IC) card. These cards have been in use since July 2003 and have fully replaced paper cards since January 2004. Hospitals must be able to use and support the IC cards to provide medical services for insured patients.

Four types of information are stored on the NHI IC card: personal information, NHI-related information, medical service information (e.g., drug allergies, long-term care prescriptions, ambulatory care prescriptions, and certain medical treatments) and public health information (including personal immunization records and willingness to donate organs). The electronic prescription records on the NHI IC card are a valuable way to detect drug–drug interactions between prescriptions from different hospitals.

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«Oui» à l'indépendance éditoriale, «non» à l'ingérence politique

L'autonomie éditoriale est garante de la liberté d'expression et de l'intégrité d'une revue scientifique, dont la réputation et la crédibilité dépendent en grande partie de l'adhésion à ce principe. En congédiant sans motif valable une équipe éditoriale de renommée mondiale, le *JAMC* agit non seulement contre l'intérêt public, mais nuit à sa propre réputation. En effet, une fois que l'intégrité scientifique d'une revue est teintée par des intérêts politiques, elle perd toute crédibilité. Il devient très difficile de persuader des chercheurs de grand renom de publier des articles dans une revue dont la réputation a été entachée par la transgression de l'autonomie éditoriale. Les visées d'une revue scientifique de haut calibre sont inconciliables avec celles d'un véhicule d'opinion au service des membres d'une association médicale.

Nous croyons que seule l'indépendance éditoriale peut garantir aux médecins et aux autres professionnels de la santé, aux chercheurs et à la société en général, que le *JAMC* demeure une source rigoureuse et impartiale d'information scientifique sur la santé. L'AMC ne devrait pas censurer l'information à des fins politiques, stratégiques ou corporatives, mais au contraire, protéger la liberté et l'indépendance éditoriales du *JAMC*.

Toutes les revues scientifiques sérieuses — comme les médias d'ailleurs — sont appelées un jour ou l'autre à publier des articles pouvant diverger des intérêts idéologiques ou commerciaux de leurs propriétaires.

Letters submission process

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Letters written in response to an article published in *CMAJ* are more likely to be accepted for print publication if they are submitted within 2 months of the article's publication date. Letters accepted for print publication are edited for length (usually 250 words) and house style.

Ceux-ci ne devraient pas réagir à de telles situations par la censure, mais plutôt fonder leurs décisions sur des considérations plus globales témoignant d'une vision à long terme, les amenant ainsi à générer d'authentiques débats intellectuels, professionnels et sociaux autour de questions et d'enjeux importants pour la santé.

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Au nom des membres suivants de la communauté scientifique et de santé publique du Québec, rattachés aux universités de Montréal, McGill, Laval et Sherbrooke ainsi qu'aux départements des centres hospitaliers universitaires de Montréal, McGill et Québec (dans l'ordre alphabétique) : Alix Adrien, Ginette Beaulne, Michèle Beaupré Bériau, Pierre Bergeron, Luc Boileau, Anne-Marie Bourgault, John Carsley, Christine Colin, Richard Côté, Suzanne DeBlois, Philippe DeWals, Bernard Duval, Patricia Goggin, Maryse Guay, Nicole Hébert-Croteau, Pierre Joubert, Mylène Kosseim, Marie-Claire Laurendeau, Dominique Lesage, Patrick Levallois, Réal Morin, Josée Morisset, Gilles Paradis, Robert Perreault, Raynald Pineault, Léo-Roch Poirier, Yvonne Robitaille, Denis A. Roy, Jocelyne Sauvé, Julio Soto, Marc Steben, Jean-Philippe Weber.

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Accountability in *CMAJ*

One of the questions arising from the recent firing of *CMAJ*'s editor and senior deputy editor is "To whom should the Journal and its editorial board be accountable?"[1]

If the *CMAJ* is directly accountable to its publisher, CMA Media Inc., then it effectively does not have editorial independence, despite claims to the contrary. However, I believe that *CMAJ* should not be directly accountable to any one organization, even its owner. The *CMAJ* is accountable to CMA Media to prepare a journal for publication every 2 weeks — that is all. In fact, it is CMA Media and the Canadian Medical Association that are responsible to Canadian physicians, the Canadian public, the world medical community and medical scholarship in general to ensure that we have an independent medical journal.

The *CMAJ* should first and foremost be accountable to its principles, and these principles must be clearly stated. In addition to articles on research and clinical medicine, the journal should be committed to publishing news and commentary about trends in Canadian and world medical practices and policies, as well as environmental issues and international health. The intersection of arts, medicine and life is also a relevant topic.

CMAJ should also be accountable to its readers, especially CMA members (after all, it is "our" journal), to the Canadian public, and to the community of world medical scholarship and publications.

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Chronic fatigue

Jacques Cornuz and colleagues,[1] in Box 2 of their case report, list 11 initial laboratory tests for patients with prolonged or chronic fatigue. Given that hypocortisolism is one of the most frequently reported abnormalities of patients with chronic fatigue syndrome,[2–5] it is surprising that none of the available tests for assessing cortisol production[2–5] was included. The importance of this assessment is especially evident in light of the virtually complete recovery of patients with chronic fatigue who are treated with low-dose hydrocortisone.[6]

Another rationale for assessing cortisol production in patients with chronic fatigue is the fact that this condition shares 43 clinical features with Addison's disease,[7,8] including hypocortisolism, chronic fatigue, and all of the symptoms listed in the diagnostic criteria for chronic fatigue.[7] This impressive clinical overlap between 2 distinctly named diseases suggests that in practical terms, chronic fatigue should be regarded as a mild form of Addison's disease.[7]

Although Cornuz and colleagues, in Table 1 of their paper, correctly mention Addison's disease as one of the major underlying causes of fatigue, they should have remarked that "pigmentation in skin creases, scars and buccal mucosa"[1] is far from being a constant feature of Addison's disease.[9,10] Therefore, the absence of such pigmentation in patients with chronic fatigue should not mislead general practitioners to exclude hypocortisolism as a possible cause of that unremitting symptom.

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Recent reports indicate that in addition to viral infections,[1] chronic bacterial infections may also lead to chronic fatigue syndrome. For example, chronic fatigue syndrome has been di-