



Possible patient overlap in studies

I read with great interest the article by Sandra Dial and colleagues, in which they reported an increased risk of *Clostridium difficile*-associated disease with exposure to proton pump inhibitors.¹ The cases in this study were recorded in the United Kingdom General Practice Research Database (GPRD) between Jan. 1, 1994, and Dec. 31, 2004. The authors claim that there was no overlap between the cases in this study and those in a study they published previously.² Interestingly, in the previous study conducted by Dial and colleagues, data were derived from the same database over the same time period.² The cases included in that study were instances of a first occurrence of *C. difficile*-associated disease defined on the basis of a positive *C. difficile* toxin assay or a clinical diagnosis by a general practitioner. How is it possible that the patients in the current study are not the same ones who were previously studied? It seems very likely that any of the patients treated with oral vancomycin who were included in the current study either would have had a positive *C. difficile* toxin result or would have received a clinical diagnosis of *C. difficile*-associated disease during the study period.

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[Two of the authors respond:]

We conducted our *CMAJ* study¹ using cases defined by prescription for oral vancomycin therapy in response to the criticism of the clinical diagnosis case definition that we used in our earlier paper published in *JAMA*,² as well as in response to the issues raised by van Staa and colleagues concerning changes in recording.³ We wished to tighten the case definition by looking at patients who received a prescription for oral vancomycin for whom the only indication was treatment of *Clostridium difficile*-associated disease.

We found that for about 90% of patients for whom a *C. difficile* toxin assay was performed, the result was not entered in the laboratory results section of the database. We also found that there were 2 different coding systems for medical diagnoses: OXMIS and READ. In practices using the OXMIS coding system, there was no medical diagnostic code for *C. difficile*-associated disease, so these practices may have been missed in our original study. We believe that the laboratory results and clinical diagnosis may have been included in the free-text section of the database, to which we did not have access. In addition, if the test was done but no results were entered into the database, these patients were excluded from our original study if they did not have a clinical diagnosis,² and thus we possibly missed cases.

We believe that by defining cases by prescription for oral vancomycin in the present study, we were able to find patients from practices using the OXMIS coding system and possibly patients

whose toxin assay results or clinical diagnoses might have been entered only in the free-text section of the database. As we indicated in our *CMAJ* article, when cases were defined on the basis of a prescription, the results were less likely to be affected by changes in data entry and recording over time.³ Finally, as we demonstrated several times in the article, the cases in the 2 studies did not overlap.

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Health science research in Hungary

We read with great interest the paper by Judith Hall and associates on interdisciplinary health research in Canada.¹ In the 1990s, Canada contributed significantly to the development of education and research in the health sciences in Hungary after the social and political changes that occurred in Eastern Europe at the beginning of the decade. With the establishment of a health care management training centre in Dobogókő with the assistance of McGill University, Hungarian health care leaders were able to acquire modern management skills. With the help of Douglas College (New Westminster, BC), bachelor's and master's level programs in nursing

were introduced in Hungary. Canadian experts also provided valuable support in introducing health technology assessment.² In 2006, a new milestone was reached with the establishment of a doctoral program in health sciences at the University of Pécs.

In Hungary, the the definition of health sciences is broader than the 6 basic disciplines discussed by Hall and colleagues; we include some subjects related to economics and management. This broader definition results in a greater possibility for interdisciplinary research in health economics and health services.^{3,4}

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The 1% solution

I read with interest *CMAJ's* list of health-related charities to which one could make donations as an alternative to buying Christmas gifts.¹ Most physicians I know will readily give \$20 for a worthwhile cause (for example, they will buy not-so-good chocolate bars that the neighbour's kid is selling to fund his trip to a South American polo tournament), but how many go all the way and donate the "recommended dose" of 1% of their pre-tax annual salary (see

www.pledgebank.com/justonepercent)? Such a commitment would require one to write quite a few \$500 cheques year after year to one's favourite charities; this is the very least we should do.

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Please slow down the CanMEDS express

Louise Samson, President of the Royal College of Physicians and Surgeons of Canada, recently wrote about a planned revision of the entire medical education curriculum at the Université de Montréal based on the CanMEDS competency categories.¹ She indicated that the "success of the project lies in a sound faculty development program that aims to upgrade and adjust professors' teaching skills" and that "the response to date has been very positive;" however, only 70 of about 2000 educators have become involved.

I have been on the receiving and delivering ends of medical education since 1978. I have watched as educational reforms have been introduced. Problem-based learning spread worldwide in various forms despite persistent reservations about its efficacy.^{2,3} The use of interviews in the medical school admission process was intended to improve our ability to select the best future doctors, but the validity of this technique remains unclear.⁴

Competency-based education, which appeared in the 1970s and is the root of the CanMEDS framework, is not a proven approach. Brown University School of Medicine introduced a competency-based curriculum in 1996, but judging by the few published reports it remains a work in progress.⁵ Leung wrote, "We should be cautious of adopting the competency based ap-

proach universally across stages of medical training for which well defined and validated competencies are unavailable."⁶

Although I agree with the ideals of the CanMEDS competency framework, I have found that implementing the framework can be difficult. More distressingly, I have found that the requirements for documentation are so rigorous that my time is consumed by paperwork. As a consequence, my enthusiasm for actually teaching anything is drained.

I predict that wholesale introduction of CanMEDS-based reform will be costly, time-consuming and frustrating. I hope that other medical schools in Canada will wait several years to see how the implementation goes in Montréal before doing the same thing. Let us use evidence-based information in our medical education as well as in our medical practice.

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Inspired by Banting and Best

The reprinting of the first page of the original report on the use of pancreatic extracts in the treatment of diabetes mellitus by Banting and Best, with the wonderful accompanying commentary by Cathy Younger-Lewis,¹ gave me much joy, along with