

Canadian faculties of medicine not in denial

In their Sept. 7, 2010 editorial, Hébert and colleagues touch on a critical subject: the complicated relationship between industry and medical education.¹ The authors rightly point out that in many medical schools, “future generations of students are [being] taught by some expert faculty who receive funds from the pharmaceutical industry.” They go on to say that “it is time for medical faculties and academic physicians to stop burying their heads in the sand.”

Far from burying their hands in the sand, the Board of Directors of the Association of Faculties of Medicine of Canada (AFMC), which comprises all 17 deans of medicine and 4 public members, voted to endorse the principles contained in the Association of American Medical Colleges report on industry funding of medical education that the authors reference.² There can be no clearer signal that the senior leadership of our faculties of medicine is taking action. All of our faculties have reviewed their codes and guidelines relating to conflict of interest and many have made, or are making, substantial advances.

Three important issues must be acknowledged. First, despite the fact that the authors focus exclusively on the pharmaceutical industry, concerns about conflict of interest apply to medical device companies, biotech firms and many other private-sector industries.

Second, AFMC agrees that “medical students deserve a bias-free education.” But bias and conflict of interest are not the same thing. Conflicts of interest do not inherently lead to bias, and bias can certainly exist without conflicts of interest.

Third, guidelines, policies and procedural frameworks must be developed in all settings and contexts in which medical students and faculty function. Conflicts of interest must be addressed

collectively by our faculties, affiliated hospitals and research institutes, practice settings, home universities, associations such as the CMA, specialty societies and industry.

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Five steps for ruling out coronary artery disease in general practice

Brook's idea for creating an acronym¹ for Bösner and colleagues' prediction rule² is commendable. It would certainly facilitate the use of the score in daily clinical practice. But perhaps the acronym would be easier to remember if it was associated with the cardiovascular system — something like the PEVAsC score:

P: pain not reproducible by palpation
 E: exercise-related pain
 V: known vascular disease
 As: age/sex (men > 55, women > 65)
 C: patient assumes pain is of cardiac origin

Careful assessment of clinical probability (estimation of the prediction score) together with other diagnostic tools (i.e., resting electrocardiogram) allows one to exclude coronary origin of chest pain with a much greater confidence than either history and physical examination or electrocardiogram alone. When differentiating chest pain in general practice, it is important that primary care physicians consider serious diseases such as acute coronary syndromes, pulmonary embolism and

pneumonia, in addition to more common (but not life-threatening) conditions such as pain in the chest wall, gastroesophageal reflux disease and panic disorder.³ Existing prediction scores are valuable complementary measures that may help clarify many of these diagnoses.^{1,4-6}

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Better by a marathon's distance than shoes

There is no question that barefoot running will go a long way toward preventing injuries.¹ Having come across a suggestion in a book on marathon running to add to one's training repertoire an occasional barefoot run on grass or similar soft ground, I gave it a try.

This was in 1987, and I was what one could call an addict, fitting in two lengthy runs per day, most days. Pushing over 150 km per week, I was frequently injured, with hamstring tears, Achilles tendon problems and other complaints. So I chose a shorter, 10-km route for my initial barefoot run.