patients endure, but there is no substitute for personal experience. We should not hesitate to bring our personal experiences to use, being mindful, of course, of not overstepping boundaries.

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Empathy training a must for physicians

Kudos to *Canadian Family Physician* for bringing the issue of empathy to the foreground,[1,2] and to Lussier and Richard for emphasizing the need to distinguish between empathy and sympathy.[1]

I discuss the importance of empathy when teaching physicians about that most invisible of conditions: chronic noncancer pain. I show learners a photograph of a trauma patient in the emergency department and ask them how they feel. I share that I feel overwhelmed, horrified, and helpless, while emergency and advanced trauma life support–trained colleagues have said that they feel "pumped" because they know how to help this victim. I point out that technical skills help physicians to maintain their boundaries and to remain effective in uncomfortable situations.

Then I discuss chronic noncancer pain, which is underrepresented in most medical school curricula, leaving physicians with minimal knowledge on the approach to diagnosis and treatment. I discuss the fact that functional magnetic resonance imaging studies have shown that observing someone in pain "activates similar neurons as if the observer were feeling pain himself."[3] Authors of these studies go on to state that "[it is important to] differentiate the observer's sense of knowing the other's personal experience and his/her personal affective response to this [experience]. When unsuccessful in differentiating, the observer may get overwhelmed by distress [leading to] further distress and helplessness in both."[3]

Studies have shown that empathy declines in medical students as they proceed with their training, yet empathy is a crucial element in the therapeutic encounter and the linchpin of narrative medicine.[4,5] Training is required for both technical skills and emotional balance. Without this, physicians remain at risk of becoming overwhelmed and helpless in the face of suffering—or, even worse, cold, detached, and disbelieving.

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Rebuttal: palivizumab for the prevention of respiratory syncytial virus infection

In the article on palivizumab for the prevention of respiratory syncytial virus infection,[1] Rogovik et al summarized current literature on palivizumab safety, efficacy, use, and cost-effectiveness. The primary objectives were to determine the indications for the use of palivizumab and whether it can be used in the treatment of respiratory syncytial virus (RSV) infections.

Although the recommendations for palivizumab use from the Canadian Paediatric Society[2] are summarized, the discussion largely focuses on recommendations by the American Academy of Pediatrics,[3] which is disappointing given the substantial research contributions to this field by the Pediatric Investigators Collaborative Network on Infections in Canada (PICNIC) and other Canadian investigators. As mentioned in the Canadian guidelines, there are important differences between the 2 position statements owing to unique epidemiology, geography, and practice settings, in addition to different health care systems and drug costs. Recommendations for infants at a gestational age (GA) of 32 to 35 weeks are the most divergent, with Canadian guidelines recommending localized policies in each province and territory, considering risk factors and the available risk-scoring

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tool.[4,5] These recommendations are omitted from the authors' summary table, and the differences between Canadian and American indications and rationale for the use of palivizumab in this specific subpopulation are not discussed. This is important, as this cohort of infants are at a risk similar to that of infants with a GA of less than 32 weeks with respect to RSV hospitalization rates, incurred morbidities during their hospital stays, and subsequent health care resource use.[6-10] Moreover, the authors quote the use of 1 risk factor and a maximum of 3 doses for infants with a GA of 32 to 35 weeks born 3 months before or during the RSV season. There is ample evidence that more than 1 risk factor determines RSV hospitalization in this group of infants[4,11-13]; further, the use of 1 to 3 doses of palivizumab during an entire RSV season is a strategy untested in randomized controlled trials[14,15] and that is not supported by the pharmacokinetics and therapeutic efficacy of the drug, as evidenced in the earlier phase 1 and 2 and IMpact trials.[14,16]

The authors include a brief overview of palivizumab cost-effectiveness analyses. However, their survey of the literature is limited to only 1 paper, a UK-specific analysis,[17] which is discussed in detail. Analyses of the cost-effectiveness of palivizumab might have limited generalizability among countries, as health care costs and cost-effectiveness standards can differ.[18] None of the available Canadian analyses[19-22] is included in the discussion of cost-effectiveness or risk factors. Additionally, the variation in results and indications, even among the analyses cited, is not addressed. For example, Nuijten et al concluded that palivizumab is cost-effective for preterm infants and those with bronchopulmonary dysplasia or chronic heart disease,[23] while Reeve et al only examined a group of infants of low birth weight and concluded that it was not cost-effective.[24] A recent

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comprehensive review of the literature demonstrated that although results vary among countries and indications, palivizumab is often cost-effective for use in high-risk populations, especially those with multiple environmental risk factors.[22]

Furthermore, a big issue in Canada, which merits further attention, is the use of palivizumab in aboriginal populations. Palivizumab has been shown to be cost-effective for term Inuit infants in remote Northern communities[21] owing to especially high rates of RSV infection and hospitalization costs.[20] The number needed to treat in the Nunavut settlements of Igloolik, Arctic Bay, Grise Fjord, and Hall Beach[20] varied from 2.5 to 3.7, unlike that of the IMpact randomized controlled trial. The Canadian Paediatric Society has also recognized the need for research in remote First Nations and Métis communities.[2] Although Inuit infants are included in the summary of usage guidelines, the authors do not discuss aboriginal infants in the text or mention the important possible risks of RSV infection in this population.

In summary, the information in this article is incomplete and key Canadian references have been excluded. A comprehensive overview of the indications for which palivizumab is effective and cost-effective that includes Canadian data and focuses on guidelines published by the Canadian Paediatric Society for our urban and rural populations would be far more beneficial and informative for family physicians.

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