Confirming proper use of medication: more than one way

Dr Philip G. Winkelaar raises the issue of drug diversion by the father of a child being prescribed methylphenidate.[1] He correctly advises that assessment of the child's condition is one method of confirming proper use of the medication. A more reliable method would be to randomly test the child's urine, with parental consent, for the presence of methylphenidate. Absence of the drug in the child's urine sample would confirm that the child was not taking it and would strongly suggest improper use. Parental refusal to consent to random urine testing might constitute a reason to discontinue prescribing methylphenidate.

Finally, a written agreement or drug contract made with the parents before initiation of methylphenidate could have established random urine testing as a condition of treatment.

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Treating family members: call your doctor in the morning

I enjoyed the article[1] by Dr Mailhot very much, and I could not agree more with her approach. On this subject, I refer your readers to a most interesting study by Lapuma et al[2] in the *New England Journal of Medicine*.

In this work, the authors examined the circumstances under which doctors had treated their own family members. The study involved a survey of 691 physicians in a community hospital and they found, not surprisingly, that 99% of doctors reported requests from family members for medical advice, treatment, or diagnosis. The authors described many weird and wonderful things that doctors did to their families, including delivering one's own baby by cesarean section!

Several years ago in *The Medical Post*,[3] "What should a physician do if, in spite of the best laid plans of mice, men, mothers-in-law and medicine, relatives call at ungodly hours describing strange symptoms?," I suggested that physicians establish whether the medical situation is urgent and deal with it if it is. In most cases, however, physicians would be best to advise close family members to "take two aspirins and call *your* doctor in the morning."

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Education on abortion in medical schools appalling

I would like to comment on the excellent survey[1] of knowledge and interest in medical abortion among family doctors and residents.

Only a quarter of residents reported getting education on therapeutic abortion while in medical school. This is appalling. In my experience, the University of Calgary in Alberta (otherwise an excellent medical school) fit into the 75% that neglected to teach anything about abortion. A letter to our then dean (with copies to the heads of obstetrics and gynecology, and the Gender and Equity Committee) regarding this deficit got no reply.

Along with inadequate medical education, the fact that mifepristone (RU-486) is unavailable in Canada is another obstacle to women's health and choice. My reading about misoprostol and methotrexate tells me that, while it is usually effective, it is a labour-intensive treatment with injections, pills, and many ultrasound examinations and bloodwork.

While many therapeutic abortions are requested due to genuine contraceptive failure, many more are due to not using contraception and ending up with unwanted pregnancies. Education and access to birth control in Canada is inadequate. In my experience, this is particularly true in rural and aboriginal communities.

Publicly funded access to abortion services will always be necessary, but at 100 000 therapeutic abortions per year, we have missed the boat when it comes to primary prevention.

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