We agree that the transfusion of 3 units of packed red blood cells in this case was most likely unnecessary and deviated from the published Red Blood Cell Transfusion Guidelines. Our patient, who did not speak English or French, was sent to the hospital after an on-call family physician was notified by the community laboratory of critical results. Hospital consultant physicians were faced with a newcomer to the Canadian health system, an Arabic-speaking patient without prior Canadian health records. We suspect communication challenges contributed to their aggressive management approach.

The literature is full of examples of ethnic minorities receiving suboptimal health care because of various challenges associated with communication, unfamiliar disease patterns, physician practice patterns, and disempowered or underinformed patients.[1,2] We also would like to highlight the need for well coordinated health services for migrant patients,[3] with which we continue to struggle. We hope our case study and the ensuing discussion will raise awareness of these issues and contribute to improved care for migrant patients.

Intestinal helminths play an important role in mild-to-moderate anemia in the developing world and are often found in corresponding immigrant subgroups.[4] As part of our preventive care program for arriving refugees, we screen all patients for ova and parasites; this patient's stool test results were negative. We thank Dr Moore for highlighting this important omission.

—Kevin Pottie, MD, MCLSC, CCFP, FCFP
—Patricia Topp, RN(EC), MSCN
—Frances Kilbertus, MD, CCFP, FCFP
Ottawa, Ont
by e-mail

References

1. Mayberry RM, Mili F, Ofili E. Racial and ethnic differences in access to medical care. *Med Care Res Rev* 2000;57(Suppl 1):108-45.
2. Smedley BD, Stith AY, Nelson AR, editors. *Unequal treatment: confronting racial and ethnic disparities in health care.* Washington, DC: National Academies Press; 2003.
3. DuPlessis HM, Cora-Bramble D; American Academy of Pediatrics Committee on Community Health Services. Providing care for immigrant, homeless, and migrant children. *Pediatrics* 2005;115:1095-100.
4. Stauffer WM, Kamat D, Walker PF. Screening of international immigrants, refugees, and adoptees. *Prim Care* 2002;29:879-905.

Whose pen is in your pocket?

I whole-heartedly concur with the sentiment of Dr C. Sikora's article, "Whose pen is in your pocket?" in the March 2006 *Canadian Family Physician*.[1] Dr Sikora refers to the Canadian Medical Association guidelines for our interactions with the pharmaceutical industry. These guidelines allow physicians to judge for themselves the accuracy of information provided to them by the industry.

How well do family doctors adhere to these guidelines? Are the guidelines specific or strict enough? Dr Sikora refers to a common interaction where perhaps we don't do well enough: talking to pharmaceutical representatives in our offices. We let these salespeople wine us and dine us. Until recently we would get the odd golf game out of them or maybe even a weekend away with the family. We let them leave behind various promotional items, barely disguised as patient-education tools. And all the while we claim to maintain our objectivity. But do we?

It seems to me that the pharmaceutical industry spends millions on us for one reason; it works. It sells their product. A "drug rep" visiting you is responsible ultimately to the shareholders of their company, not to the health of your patients. We are as likely to receive objective information from these people as to have a Toyota salesperson recommend a Honda! So why do we subject ourselves to this? And what would our patients say to this influence on our prescribing practices?

Why don't we have the fortitude as a profession to admit that listening to these salespeople is not in the best interest of our patients?

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Reference

1. Sikora C. Whose pen is in your pocket? *Can Fam Physician* 2006;52:394.

I was heartened to read Dr Sikora's Residents' Page[1] about the detrimental effects of pharmaceutical advertising on "...the basic tools of our trade,"[1] including pens and notepaper, on the patient-physician relationship.

This resident's opinion stands in stark contrast to the recent developments at the Medical Society of Nova Scotia (Doctors Nova Scotia). The Society announced in the February 2006 issue of its magazine[2] that the pharmaceutical company "AstraZeneca has become the educational sponsor of the Doctors Nova Scotia electronic bookshelf. The sponsorship agreement is valued at $125 000 for a 1-year term."[2] The article continues, "The electronic bookshelf, on doctorsNS.com, is the most accessed feature on the website." In return for the funding, the electronic bookshelf will carry the AstraZeneca logo. Dr Sikora's patient would have even greater justification for being suspicious of the advice doctors give if she became aware of this development.

It is ironic that our residents can clearly identify conflicts of interest while the establishment chooses to ignore the dangers of intimacy with the pharmaceutical industry.

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References

1. Sikora C. Whose pen is in your pocket? *Can Fam Physician* 2006;52:394.
2. Doctors Nova Scotia. AstraZeneca becomes educational sponsor of electronic bookshelf. *Doctors NS* 2006;4:5.

The burden of paperwork

Time required for paperwork has been increasing to the detriment of other aspects of physicians' work.[1]

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