Letters
Correspondance

Bias-free health care

Bravo to Dr Biron et al[1] and to Drs Steinman and Baron,[2] in the Commentary and Debates sections respectively, for bringing our attention to the pervasive and negative effects of the influence of the pharmaceutical industry on continuing medical education. I am disappointed that Dr Marlow[3] would use the guidelines in place as an argument that safeguards against undue influence are preventing this problem. One only has to attend a large continuing medical education conference (such as a Chapter meeting) and feel overwhelmed by the numerous booths hosted by pharmaceutical representatives to realize that something is wrong with the situation. We obviously are not being protected from undue influence by said guidelines.

I would also like to bring attention to another troubling issue—clear overpricing of many new drugs, such as monoclonal antibodies, which are proving useful against many cancers. When a drug such as rituximab costs $3000 per treatment, it clearly is out of reach for most of our patients. This creates a 2-tiered system when governments will not fund this drug. Clearly, profit is taking precedence over optimal care. The pharmaceutical industry must take responsibility for creating such a situation, and, clearly, governments need to address the regulation of drug pricing.

—Joel Weinstein MD CCFP FCFP
North York, Ont
by e-mail

References

1. Biron P, Plaisance M, Lévesque P. Pharmas-co-dependence exposed. Would it be time to say, "No thanks"? *Can Fam Physician* 2007;53:1635-7 (Eng), 1643-5 (Fr).
2. Steinman MA, Baron RB. Is continuing medical education a drug-promotion tool. Yes [Debate]. *Can Fam Physician* 2007;53:1650-3 (Eng), 1654-7 (Fr).
3. Marlow B. Is continuing medical education a drug-promotion tool. No [Debate]. *Can Fam Physician* 2007;53:1650-3 (Eng), 1654-7 (Fr).

Response

Dr Weinstein implies that the presence of booths hosted by pharmaceutical representatives biases the continuing medical education (CME) provided at the College of Family Physicians of Canada's annual scientific assemblies. As the Director responsible for the annual scientific assembly portion of the Family Medicine Forum, I can attest that this is not the case, owing to the guidelines we have in place.

The CME content comes primarily from a call for abstracts. The application process requires full disclosure of competing interests. The abstracts are then peer reviewed by a planning committee of College of Family Physicians of Canada members. A needs assessment is conducted beforehand and, if any gaps are identified, speakers are invited by the planning

committee to present identified topics. The speakers are instructed to provide full disclosure to their audience, and speakers with declared competing interests that are selected must provide full content of their presentations beforehand, which also undergoes peer review. Furthermore, sessions evaluations are monitored for perception of bias to ensure CME that is free from commercial influence.

The exhibit hall is entirely separate from our CME sessions. In our exhibit hall, only 30% of the booths are sold to the pharmaceutical industry. Recruiters, residency programs, medical associations, and not-for-profit exhibitors make up most of the booths. There are strict rules in place preventing sampling or giveaways, and exhibitors are allowed to distribute educational material only. Attendance at these booths is not part of accredited CME.

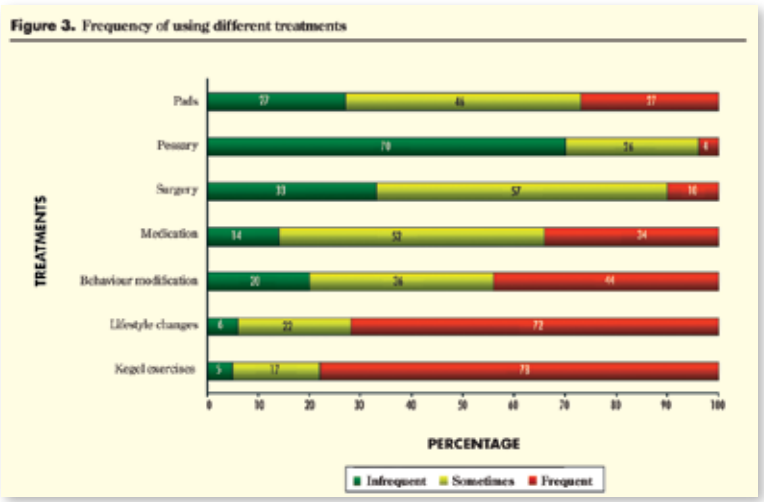
Again, I believe that the situation regarding industry-biased CME has changed dramatically in recent years and differs between Canada and the United States. The guidelines and review processes that we have in place at the College ensure that our accredited CME programs are not abused for commercial interests.

—Bernard Marlow MD CCFP FCFP
Director of Continuing
Professional Development
College of Family Physicians of Canada

Correction

It has come to my attention that **Figure 3** in our article "Urinary incontinence in Canada. National survey of family physicians' knowledge, attitudes, and practices" (*Can Fam Physician* 2002;48:86-92) contained an error. The correct figure appears below. I apologize for any confusion that might have arisen from this error.

—Graham Swanson MD MSc FCFP
Burlington, Ont
by e-mail



Labour pains

I read with interest the article by Minty et al describing the challenges of providing high-quality analgesia to women in labour in small community hospitals.[1]

The recommended combination of intrathecal (IT) opioids and local anesthetic is said to have a lasting effect of about 4 hours. Hence, if the duration of remaining labour exceeds this, then a period of untreated labour pain will follow. The doses of opioid and local anesthetic recommended in the article are conventional and are limited by side effects such as nausea and hypotension.

Whereas multiple adjuvant agents to prolong analgesia have been investigated (from IT opioids to local anesthetics), none have become widely used owing to side effects.[2] However, IT midazolam is unique among these. This agent has been in use for more than 20 years as part of either a single-shot or continuous spinal-infusion technique. It increases the duration and quality of IT opioid-mediated analgesia in the labour-pain model, with no reported increase in side effects.[3] Intrathecal midazolam has been used in the cesarean section model, where it not only increased the duration of analgesia as compared with IT bupivacaine, but also appeared to prevent nausea.[4] In the surgical model, IT midazolam shows a dose-sparing effect on local anesthetic agents.[5]

It is unfortunate that precise data on the duration of action of IT midazolam are hard to obtain. This is probably because when administered alone it has minimal (or no) detectable effects. Our knowledge is derived from other agents' increase in duration of analgesia. From my own experience and from the available literature, 6 hours of effects from a single dose is a conservative estimate. I have always had access to an epidural (as opposed to a single-shot spinal) for labour-pain relief service, and have only used spinal analgesia as part of a combined spinal-epidural technique or to obtain rapid pain control to facilitate siting an epidural catheter. Having tried many combinations of IT drugs, however, my spinal anesthetic of choice for cesarean section is heavy bupivacaine (9 to 10 mg), with morphine (75 mg), and midazolam (2 mg). I have not had the opportunity to test this in a trial setting but have found that this combination produces rapid onset spinal anesthesia, with minimal nausea and pruritus. I have found no need to include a drug from the fentanyl family, suggesting that the onset of action and prolongation of the effects of morphine are accelerated by the presence of midazolam. If this were true, in the drug combination recommended in the review article[1] sufentanil could be replaced by midazolam in spinal anesthesia for labour pain.