who requires care away from home can easily be accommodated. Specialists are paid by the hospitals. Opting out is permitted.

I wonder whether the British aren't showing us the future as we quarrel over the division of the pie, with little regard for waste and accountability. I also wonder whether the US system, in which the American dream (read millionaire) extends even to medicine and which permits blatant self-promotion, can ever rediscover the ideals of professionalism and service.

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## Future for new MDs

The excellent article "Future looks bleak for new MDs as practice limitations become national issue" (*Can Med Assoc J* 1993; 148: 2175–2180), by Lynne Sears Williams, is an insightful and broad-reaching review of the controversy.

The article's discussion of the legal aspects of physician restrictions seems to indicate that the basic rights of new physicians have been violated. In a given practice area two physicians doing the same job would be paid different fees. One might argue that senior physicians should be rewarded for years of experience, but recent changes in examination and licensure have assured that graduates are fully trained and competent. The licensing bodies do not require young physicians to have further exposure to clinical situations, and thus seniority and experience should not be factors.

The Newsbriefs section of the same issue (*ibid:* 2173) reports that the CMA, the College of Family Physicians of Canada, the Association of Canadian Medical Colleges, the Canadian Association of Internes and Residents, the Federation of Medical Licensing Authorities of Canada and the Royal College of Physicians and Surgeons of Canada have united to oppose the fee disincentives for new physicians. Don't the members of these organizations also belong to the medical associations that support the new restrictions?

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## Drug patent law reform and shortages

In the recent debate about Canadian drug patent law reform the issue of supply security has received relatively little attention. In June and July 1993 there was an interruption in the supply of intramuscular loxapine, which was caused by a change in the manufacturer of the drug vials (Habiba Kassam, Lederle Cyanamid Canada Inc.: personal communication, 1993). Since loxapine is currently under patent, no other source of the medication was available.

Loxapine is the only dibenzoxazepine antipsychotic drug currently approved for use in Canada. It is useful in the emergency management of acute psychosis and agitation because it is available in oral (tablet and liquid) and parenteral forms.

In our experience the acutely psychotic patient may refuse the regular oral medication and thus require a parenteral dose. As well, if a patient becomes agitated and a pro-re-nata dose is required the drug may have to be given intramuscularly. To avoid polypharmacy during the loxapine shortage our patients were given other antipsychotic drugs that have intramuscular formulations.

Patients may respond more favourably to one antipsychotic drug than another, for obscure reasons.[1,2] Unfortunately, for some patients the change in therapy resulted in less-than-optimal responses. Some patients were started on drugs whose effectiveness was unknown in them,[3] and others had their medication changed, with the attendant risk of deterioration and prolonged hospital stay.

This raises the issue of the continued availability of important hospital material. Had the shortage been of some other drug (e.g., a parenteral antibiotic, an inotropic agent or an antirejection drug) the costs could have been far greater. It seems clear that a drug produced at a single facility controlled by a single company is inherently more vulnerable to the interruption of supply than a drug produced at multiple sites by multiple companies or subcontractors.

When considering legislative reform of drug patent laws, politicians, the public and the medical profession should weigh the impact such reforms may have on the supply of vital drugs and equipment.

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## Assisted reproductive technology

The article "Public attitudes in Edmonton toward assisted reproductive technology" (*Can Med Assoc J* 1993; 149: 153–161), by Drs. Stephen J. Genuis and Wei-Ching Chang, and Shelagh K. Genuis, was interesting, particularly in light of

the work I have been involved with as chair of the Royal Commission on New Reproductive Technologies.

Through surveys and focus groups the commission collected information on social values and attitudes in Canada related to new reproductive technologies, including assisted reproductive technology, from more than 40 000 Canadians. It conducted national surveys and surveys of specific groups, including patients in fertility programs and physicians. This information has been vital to the commissioners in their deliberations on how our society should deal with issues such as those mentioned in the article.

The results of these surveys will be published as part of the 16 volumes of research studies accompanying the commisson's final report. They will be available after November 1993 and will be of interest to all those working in the field of assisted reproduction.

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## Standards of aerosol therapy

Dr. Kenneth R. Chapman, in his editorial "Aerosol therapy in Canada: What are the standards?" (*Can Med Assoc J* 1993; 148: 735–738), is critical of the Drugs Directorate of the Health Protection Branch, Department of National Health and Welfare (now Department of Health), for issuing notices of compliance to the manufacturers of two generic salbutamol metered-dose inhalers before a final protocol was established to determine their equivalence to innovator inhalers. (The article inaccurately stated that the Bureau of Human Prescription Drugs of the Health Protection Branch issued the notices.)

The Canadian Food and Drug Regulations[1] require that the efficacy and safety of a drug be proven before a notice of compliance is issued. The Drugs Directorate determined, before the notices were granted, that data from clinical studies and extensive in-vitro testing assured their equivalence.

Chapman raises questions about the directorate's involvement in the development of guidelines for metered-dose inhalers and about consultations with experts. Indeed, recognizing the need to establish guidelines for equivalence the directorate has continually worked on this issue with external experts since the late 1980s. Draft guidelines, developed with input from three experts (who are nationally and internationally respected in their fields and affiliated with leading Canadian universities and professional associations), were presented at a workshop in Ottawa in February 1990. Representatives of the Canadian Thoracic Society (CTS), the US Food and Drug Administration (FDA) and innovator and generic manufacturers of inhalers were present. After further consultation, a second draft was prepared and discussed by the directorate's Expert Advisory Committee on Bioavailability and then distributed to industry and professional associations, including the CTS, for comment. The directorate is collaborating with the FDA to finalize these guidelines and will meet with the Drug Information Association, in Toronto, in October 1993, to discuss the safety, efficacy and regulations of metered-dose inhalers.

The regulations for establishing the safety and efficacy equivalence of metered-dose inhalers apply not only to generic products but also to second-entry innovator formulations such as those with replacements for chlorofluorocarbons.

Toward the end of the editorial, Chapman raises questions about the postmarketing performance of generic versus innovator inhalers. Reports of adverse drug reactions given to the Drugs Directorate indicate no difference between the two.

It is comforting that Chapman concludes his editorial by referring to some of the collaborations that the directorate has had with scientific and regulatory bodies. We continue to seek input from stakeholders interested in successfully solving important and complex issues and are proud of our commitment to providing Canadians with safe and effective drugs.

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## Family physicians in Quebec

I am happy to see the attention given to Bill 120, the Quebec law that penalizes new family physicians financially if they don't change their practices to fit certain guidelines, in the article "Young Quebec FPs say deal to force hospital-based work sacrifices them" (*Can Med Assoc J* 1993; 149: 201–203), by Fran Lowry. It is important to hear from the young family physicians about how this will affect them, rather than from the president of the Fédération des médecins omnipracticiens du Québec, Dr. Clément Richer.

I am a former colleague of the physicians mentioned who work in family medicine at Queen Elizabeth Hospital, Montreal. One look at my address will reveal how I dealt with the Quebec government's interfer-