In it for profit?

Your article "Stand and Declare"[1] made me sit up with pride and feel more hopeful about the future of family medicine in Canada. It takes vision, critical thought, and courage to go forth on the path that you have laid out in your article, and I commend you and others involved in this mission.

As a practitioner, I continue to watch industry and the drive for profit erode the practice of family medicine. I hear from allied health care providers and patients alike that "the medical model" is mostly a recipe book of algorithms and pharmaceuticals being dished out in 5- to 10-minute increments known as "office visits." Practices such as these have replaced compassionate, reflective practice styles, which involved more time and more meaningful human contact. I believe we have lost our perspective on what is indeed normal and normative about the development of human beings. We have grown reliant on technology and taxonomy (eg, DSM-IV) to pigeonhole patients to the extent that they have been dehumanized. In this process we ourselves have grown more desensitized and more distant and detached from ourselves, our families, and our patients.

Clinical guidelines quickly become the expected standard of care. This occurs without any analysis of economic effects, population health, or disease prevalence in primary care, and without any meaningful discourse between specialists and primary care practitioners. Moreover, as pointed out by Dr Sanderson, a UK-based family doctor,[2] there have been catastrophic results when these "standards" have been implemented along with pay incentives for family doctors to practise them (pay-for-performance practice). I understand that this is an exploration of incentive-based practice; however, I am unable to rid myself of the image of a donkey with a carrot just beyond its reach.

Critical appraisal skills are important as we evolve as practitioners and grow more knowledgeable about our collective effect on population health. The very evidence that we are critically appraising, however, is flawed from the outset, owing to research and publication-related practices that you describe so succinctly in your editorial.

This has to change! The profession has been corrupted by these insidious influences. I have read that if you throw a frog into a pot of boiling water, it will react by jumping out. In order to successfully boil the frog to death, you have to put it in a pot of cold water and slowly turn up the temperature so that it does not even notice that it is being boiled to death.

Thank you for pointing out how hot the water has become!

—Dr Ajantha Jayabarathan, MD, FCFP
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by e-mail

References

1. Kelsall D. Stand and declare. Opportunity and challenge of clinical trial registration. *Can Fam Physician* 2005;52:1189-90 (Eng), 1194-6 (Fr).
2. Sanderson A. Pay-for-performance programs in family practices in the United Kingdom. *N Engl J Med* 2006;355(4):375-84.

Clarifying hormone terminology

I am writing to save myself from tearing out any more hair over the epidemic of careless use of certain terminology related to hormones. I hope you can help by printing this plea directed at your contributors and readers alike: please, please, please review your basic chemistry and pharmacology and get it straight in your minds once and for all that there is a critical difference between the word "progesterone" and words like "levonorgestrel," "norethindrone acetate," and "medroxyprogesterone acetate."

You see, these aren't just words. These are the names of different molecules with different structures and profoundly different effects on our bodies, regardless of what the pharmaceutical industry would like us to believe. I was quite mortified to read the Pediatric Pearls article entitled "Emergency contraceptive options available for adolescents."[1] The third paragraph references "progesterone-only" emergency contraceptives and goes on to explain that "The combined pill, commonly known as the 'morning-after pill' contains ethinyl estradiol (estrogen) and levonorgestrel (progesterone)." I'll grind the ethinyl estradiol–estrogen axe some other time. Right now, I need to grind the progesterone axe. If levonorgestrel and progesterone are synonymous, as the article avers, then all interested readers should ask themselves what a hormone critical for the maintenance of pregnancy (ie, progesterone) is doing in a product designed to prevent pregnancy. Levonorgestrel is a progestogen. It is not progesterone. Neither are any of the other synthetic progesterone look-alikes. The following link gives a fairly concise explanation of the difference: **http://en.wikipedia.org/wiki/Progestogen**.

Synthetic progestogens definitely interact with progesterone receptors, but the effects can be both weaker and stronger than that of progesterone itself, on an equimolar basis. The synthetic progesterone look-alikes also interact more strongly (compared with progesterone itself) with other receptor families, including glucocorticoid receptors and androgen receptors. These nonphysiologic interactions give rise to many of the side effects associated with synthetic progesterone look-alikes, and also contribute to the bad rap that the synthetics have vis-à-vis risk of breast cancer (when given in conjunction with estrogens). Researchers in countries outside North America[2] seem to understand the distinction between these various molecules (and words!). Why can't we?

Ayn Rand once said, "A is A, reality is final and the truth is true." Similarly, I wish that for the benefit of our

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patients, we in North America would learn that progesterone is progesterone, physiology is final, and the truth is that synthetic progestogens are not appropriate substitutes for our own progesterone.

—George Gillson MD, PhD, CCFP
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by e-mail

References

1. Gupta V, Goldman RD. Emergency contraceptive options available for adolescents [Pediatric Pearls]. *Can Fam Physician* 2006;52:1219-20.
2. Campagnoli C, Clavel-Chapelon F, Kaaks R, Peris C, Berrino F. Progestins and progesterone in hormone replacement therapy and the risk of breast cancer. *J Steroid Biochem Mol Biol* 2005;96(2):95-108.

Important role in emergency contraception

I was happy to see the attention given to the importance of emergency contraception (EC) in the October 2006 Pediatric Pearls article, "Emergency contraceptive options available for adolescents" by Gupta and Goldman.[1] One concern about the 2005 approval of nonprescription status for the emergency contraceptive Plan B® is that family physicians might feel they have less of a role in providing it. As the primary care providers for most adolescents, family physicians are important to promotion of healthy sexuality in teens. This includes ensuring that they know about EC and how to get it. Although Plan B® is available in pharmacies without a prescription, teens need to be aware that they have to request it at the pharmacist's counter. This could pose a barrier for some, and family physicians can assist this group by reviewing alternative methods for obtaining EC (eg, sexual health clinics) or providing prescriptions for EC or doses to keep on hand "in case." Although it is slightly less effective and more likely to cause nausea than Plan B, the Yuzpe regimen is another option, and doses can be made from office stocks of common oral contraceptive samples (eg, Alesse,® 2 doses of 5 tablets each taken 12 hours apart). When EC has been provided in advance of need, it is used appropriately and has not resulted in lower use of regular contraception.[2]

Gupta and Goldman cite the higher risk of pregnancy after EC among women who have intercourse again within a few days of treatment. Family physicians should keep this in mind. For women who need ongoing contraception, EC alone is not enough. Those who want to use oral contraceptives can start them on the day following EC, but should be instructed to use a backup method until the pill has been taken for 7 consecutive days.[3] This provides women with effective contraception for emergencies and long-term. The very small risk of failure of EC can be managed by performing a pregnancy test if women fail to have withdrawal bleeding when expected.

The authors mention the higher rates of sexually transmitted infections among teens. A request for EC

should be an indication for sexually transmitted infection screening in teens. Unprotected intercourse, which necessitated EC, also puts them at risk for sexually transmitted infections.

Finally, the authors indicate that the regimen for Plan B is 1 pill taken as soon as possible and another taken 12 hours later. A simpler regimen of taking the 2 pills at the same time provides the same efficacy and avoids the problem of forgetting the second dose.[3]

Family doctors have an important role in prevention of negative health outcomes. In a world where 40% to 50% of teens are sexually active by grade 11[4] and 50% of pregnancies are unplanned, emergency contraception is a preventive therapy with the potential for huge effect.

—Sheila Dunn, MD, CCFP(EM), FCFP
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by e-mail

References

1. Gupta V, Goldman RD. Emergency contraceptive options available for adolescents. *Can Fam Physician* 2006;52:1219-20.
2. Gold MA, Wolford, JE, Smith KA, Parker AM. The effects of advance provision of emergency contraception on adolescent women's sexual and contraceptive behaviors. *J Pediatr Adolesc Gynecol* 2004;17:87-96.
3. Dunn S, Guilbert E, Lefebvre G, Allaire C, Arneja J, Birch C, et al; Clinical Practice Gynaecology and Social Sexual Issues Committees, Society of Obstetricians and Gynaecologists of Canada. Emergency contraception. *J Obstet Gynaecol Can* 2003;25:673-9, 680-7.
4. Council of Ministers of Education, Canada. Canadian youth, sexual health and HIV/AIDS Study. Factors influencing knowledge, attitudes and behaviours. Toronto, Ont: Council of Ministers of Education, Canada; 2003. Available from: **http://www.cmec.ca/publications/aids/CYSHHAS_2002_EN.pdf**. Accessed 2006 Dec 11.

Correction

Dans l'article intitulé «Consensus guidelines for primary health care of adults with developmental disabilities» (*Can Fam Physician* 2006;52:1410-8.), l'expression «affections congénitales invalidantes» a été utilisée incorrectement. L'expression correcte est «déficience intellectuelle». *Le Médecin de famille canadien* s'excuse de cette erreur.

Make your views known!

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