

when, as Dr Rich puts it, sexual intercourse is "off the menu."

Penis-in-vagina intercourse and orgasm through sexual intercourse alone is, however, difficult to achieve without an erection. This is the point of the statement in trying to help guide medical management for men dealing with physical causes of erectile dysfunction that are associated with cardiac disease. For much of non-coronary artery heart disease (such as hypertension and atrial fibrillation), sildenafil is considered safe. It would be doing our patients a disservice if we denied them a therapeutic option because of a misperception of risk.

If a man has *ever* used nitrates or is carrying prophylactic nitroglycerin, he should *never* take sildenafil. For men who fall in the third category of "maybe," such as those taking medica-

tions, such as amiodarone, or having a grade IV ventricle, treatment with sildenafil truly needs to be individualized. Potentially causing fatal hypotension needs to be weighed against reducing sexual anxiety of both men and their partners. As I pointed out in my accompanying editorial,¹ even with end-stage heart disease, sex remains an important concern for most men. At this point, a conversation between patient, cardiologist, and family physician would be fitting to weigh the benefits as well as the risks. Sometimes, helping couples explore other options than medication-induced sexual intercourse is the appropriate treatment.

The goal of treating sexual concerns is to help individuals and couples improve their emotional and physical intimacy, independent of their capacity for sexual intercourse. There is a four-letter word for intercourse: it is called "talk." Helping couples discuss their sexual concerns together and with their physicians can best lead to integration of appropriate psychological and medical therapies.

—Stephen Holzapfel, MD, CCFP, FCFP
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Reference

- Holzapfel S. Viagra and broken hearts [editorial]. *Can Fam Physician* 2000;46:257-9 (Eng), 267-9 (Fr).

Anecdotal evidence "impressive"

I am always interested in reading "Prescrire: Evidence-based drug reviews," and having read the one¹ in the February issue on olanzapine, I wish to mention an adverse drug reaction that occurred to a patient of mine taking olanzapine.

After several months of receiving 5 mg bid, this 49-year-old woman

complained of muscle cramps in her neck, shoulders, and thighs. The medical student who examined her recommended a creatinine phosphokinase test be done. The result was 1572 U/L. The symptoms subsided, and her creatinine phosphokinase levels returned to normal 2 weeks after olanzapine was discontinued—admittedly anecdotal evidence but impressive, nevertheless.

—Ralph Scandiffio, MD, CCFP
Gloucester, Ont
by e-mail

Reference

- Prescrire. Evidence-based drug reviews. Olanzapine. Keep an eye on this neuroleptic. *Can Fam Physician* 2000;46:321-6 (Eng), 330-6 (Fr).

Family physicians and maternity care

The March issue featured two papers^{1,2} looking at the role of family physicians in maternity care. Using different types of data, both Kaczorowski and Levitt (administrative data) and Reid et al (survey data) paint a consistent picture of decreasing involvement of our colleagues in maternity care. The patterns are consistent over time with the slope of the decrease in involvement varying from province to province.

Despite this distressing trend and the paragraph entitled "Potential crisis" in Reid et al's paper, a subsequent paragraph states: "All these signs are encouraging for the future.... The CFPC will have to continue to work with other organizations to prevent the potential crisis...."

I suggest the crisis is already upon us. The trends are clear. The crisis is not the absence of family medicine from the maternity suite but the trend that will lead to this absence. I do not share Reid et al's optimism about the future or their confidence in the ability of the College of Family Physicians of Canada (CFPC) to reverse the trend.



The nature of what we do as family physicians is changing rapidly as evidenced by the maternity care statistics quoted in these two papers, the spread of hospitalists across Canada, and the growth of the walk-in industry. These changes strike at the heart of family practice: the patient-physician relationship. Our failure to address these fundamental challenges to our discipline adequately will result in its ongoing evolution (a process well established) without the thoughtful guidance of its proponents.

I have watched our health care system evolve in this haphazard fashion for some time. Our role in caring for the health of Canadians is following the same poorly charted course. I suggest that the faith and optimism expressed by Reid et al are both misplaced and irresponsible. We cannot afford to be passive observers of these trends. While the CFPC successfully responded to the recent remarks by Health Minister Allan Rock in defending us against imposed salaried positions, the CFPC must be much more proactive in addressing the scope of practice issues that threaten our relationship with our patients.

—Alan Katz, MD, CCFP, FCFP
Winnipeg, Man
by e-mail

References

1. Kaczorowski J, Levitt C. Intrapartum care by general practitioners and family physicians. Provincial trends from 1984-1985 to 1994-1995. *Can Fam Physician* 2000;46:587-97.
2. Reid A, Grava-Gubins I, Carroll J. Family physicians in maternity care. Still in the game? *Can Fam Physician* 2000;46:601-11.

Response

I appreciate Dr Katz's comments on the maternity care crisis. I admit my optimism for the future is, perhaps, misplaced given the ongoing trends of abandonment of intrapartum care. However, we have been hearing about a "crisis" in maternity care for about

15 years now, and so far, it has been avoided or postponed by the changes in practice patterns that were mentioned. Nevertheless, it is quite possible that the crisis will overtake us very soon, as I stated in the article, if maternity care is not carefully nurtured.

My optimism comes from the fact that more than 60% of family medicine graduates are now women, and of the women younger than 35 years in our study, 23% were doing intrapartum care. And these women attend far more births, on average, than men. So at least we have a cohort of active caregivers. Second, I believe the CFPC's Committee on Maternal and Newborn Care has actively promoted obstetrics among family physicians, cooperating with the Society of Obstetricians and Gynaecologists of Canada, the Society of Rural Physicians of Canada, and midwives and modifying the Advanced Life Support in Obstetrics (ALSO) course for Canada. The plan to hold a national maternity caregiver conference later this year is an example of this work.

Third, I believe we have the tools to address the lifestyle, malpractice, and educational issues. They include promoting group obstetrics practices, signing out, continued governmental support for malpractice fees, and more access to ALSO and Advances in Labour and Risk Management (ALARM) courses. Solutions to lifestyle issues especially need to be actively promoted in residency training, discussed at professional meetings, and modeled by respected family physicians. Lobbying for better fees might also help. I bet that, if you doubled or tripled the fee for a birth, you might find more graduates looking at obstetrics with some interest.

Although the Kaczorowski and Levitt article paints a grim picture, I still believe the Janus Project gives a useful perspective and one that is not entirely hopeless.

—Tony Reid, MD, MSC, CCFP, FCFP
Scientific Editor,
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How advertisements have changed

Dr Lexchin's article¹ on the changes in how drug companies advertise, while accurate, missed the point. The key reason for the shift from the older to the newer style of ads has little to do with truth in advertising or PAAB codes. It has everything to do with the syntax of public discourse.

As a society, we have shifted from a typographic syntax, where people communicate using words and ideas, to a televised syntax, wherein the image is paramount. The difference is profound. In speech and writing, in order to make a point, one has to make a defined statement. The claim might be true or false but, in either case, is open to challenge. In the syntax of television and image-based advertising, all that is required is an association.

I challenge the readership of *Canadian Family Physician* to ask the following questions when looking at any of the advertisements they see (in *Canadian Family Physician* or elsewhere):

- Is there a definite claim being made in the large text?
- If yes, is the statement being made directly relevant to the specific product rather than the class of products?
- If yes, can the claim be argued against or is it an irrelevant truism?
- Is the image directly related to the product?
- What emotional response is the image designed to trigger?
- Does the emotional response support an emotional text rather than a rational claim?
- Do the emotional responses engendered by the image undermine any logical argument you might have considered against using the product?

If you can challenge the claim in an ad, do so, if only in your own mind. The process is both educational and liberating. It is educational in that it