few exceptions, male urology patients are obviously anxious when I enter the room. Their response is tri-phasic: first, a look of terror; next, an embarassed and intent gaze at the floor; and finally, the smirk of shame as his gaze returns to me and he beings to descibe his urologic condition. Once this tri-phasic hurdle is crossed, the interview proceeds as almost any other medical encounter. I contend that male patients do not need to be spared the anxiety and discomfort that female patients have long dealt with out of necessity; in fact, they might benefit from the interaction. They learn that they will not be shamed when talking about their most intimate concerns (erectile dysfunction, for example) with a woman, and this realization may improve their ability to communicate with female partners.

I met my educational goals during this rotation, and I think I learned to address sensitively the concerns of the patients in whose care I was privileged to be involved. Unfortunately, many of my female colleagues have not had the opportunity to acquire the skills they are expected to have. One of the urologists I worked with commented, "Female physicians aren't very skilled at investigation of men's urologic conditions." Quelle surprise! If all medical schools make urology a mandatory rotation, not only would future physicians benefit, but the change would also confer an equal importance to medical conditions of the male and female genotourinary systems, and would be another step toward achieving equality of men and women in the teaching and practice of medicine.

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Meta-analysis and adverse drug reactions

Evelinde Trindade and colleagues raise a number of important issues regarding meta-analysis and the reporting of adverse drug reactions in their article on adverse effects associated with selective serotonin reuptake inhibitors (SSRIs) and tricyclic antidepressants.[1]

Although meta-analysis has become an accepted method for statistically pooling outcome measurements, the results of such analyses may not uniformly predict the clinical outcomes of randomized controlled trials[2] and must be interpreted with caution. Limitations depend upon the selection of articles combined, the outcome criteria chosen, the heterogeneity of the studies included, the statistical technique used to pool the data, duplicate publication and interpretation of results.[3,4]

Furthermore, meta-analysis was developed primarily to examine treatment efficacy, not safety. Trindade and colleagues report crude occurrence rates of adverse events for 2 classes of antidepressant medications. They found that SSRIs cause significantly more serotonergic events and tricyclic antidepressants more anticholinergic events. Did this outcome warrant the use of meta-analysis? Although the presentation of overall event rates may be useful,[5] meta-analysis comparing the adverse events of treatments with widely different side effect profiles is unnecessary, as there is no conflict to resolve.

In addition, meta-analysis results are restricted to published clinical trials which, although they are ideal for examining efficacy in controlled environments, are not appropriate for comprehensive investigations of adverse events. The clinical trials used in the analysis by Trindade and colleagues had small samples and thus had sufficient power only to detect common adverse events. Moreover, clinical trial designs examine the effect of treatments in "ideal" patients, typically men and women between the ages of 18 and 65 years, who are otherwise healthy and not taking other medications. The effects of the medication in different populations, such as elderly people, adolescents and people with comorbidity, are thus not evaluated. As a result, uncommon and potentially serious adverse events may go unnoticed. We published a large case-series analysis of hyponatremia and the syndrome of inappropriate antidiuretic hormone (SIADH) associated with SSRI use.[6] We identified 736 spontaneous reports of SIADH to adverse-event reporting agencies and pharmaceutical manufacturers, of which 30 were published. Most of the cases occurred in elderly people. Yet despite the large number of case reports, this adverse event remains relatively unknown and unrecognized. A recent review found 35 additional published case reports since our original publication (12 of these published during the period between manuscript submission and publication). Only 4 case reports referenced the comprehensive case-series analysis. Given the serious nature of the event, we are troubled by the failure to recognize epidemiological or post-marketing surveillance study designs as valid sources for adverse event information.

Investigators who, like Trindade and colleagues, use meta-analysis in isolation may miss important, serious adverse events. Approaches that incorporate both clinical trial information and epidemiological and post-marketing surveillance research, including case reports, case series, and cohort and case–control studies, are necessary and appropriate to evaluate a complete, clinically relevant safety profile of therapeutic interventions.

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Privacy policy

Dr. Donald J. Willison's article on health services research, privacy and new legislation[1] does a good job of addressing, on a general level, the complex challenges created by new information technology. In the current environment, how can physicians maintain their role as "stewards" of their patients' confidential personal information? Because this problem has essentially been created by technological innovation, perhaps the answer to balancing the needs of insurers and government and those of our patients must come from the same source (for example, through encryption). It is no wonder that one of the most notable defenders of privacy rights has been a group of academics in the computer sciences known as Electronic Frontier Canada,[2] who caution that government legislation to control encryption technology will pose a substantial threat to the only technological means of defending privacy of individuals.

Willison presents a good synopsis of the balance needed between patients' interests and the needs of the state. However, as physicians and stakeholders, we also have our own privacy rights to consider. For example, what will be the impact of physician profiling and data mining technologies on the day-to-day practice of medicine? Furthermore, the issue of privacy is perhaps more fundamental to the profession of medicine than to other professions, given the obligations we accept when we take the Hippocratic oath.

Willison's article is a wake-up call to do more to make legislators aware of our concerns. Our challenge is to safeguard privacy and limit its potential to become a commodity in the information market. Privacy once lost can never be regained, and the recent trend toward commodifying privacy simply because this is possible could change the practice of medicine in unforeseen ways. It is surprising that organizations such as the Canadian Institute for Health Information, which did over $13 million of business in 1997 selling health information, does not have a single practising physician on its board of directors.[3]

Organized medicine must participate in this debate. The CMA's recent privacy code[4] is a step in the right direction, but individual physicians must also take responsibility for explaining to their patients the risks associated with information technology. To do that, we must understand those risks ourselves. In considering issues of privacy, we should ask ourselves whether breaching confidences is necessary for optimal patient care, whether there is evidence that it will improve outcomes, and how our patients feel about it. Once we address such issues, we may be able to meet Willison's challenge of ensuring "the confidentiality and security of information used for health policy analysis and health services research."

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