## Inaccessibility of drug reports

When new drugs are launched, physicians must have access to the randomized controlled trials that evaluated their efficacy and safety.

I wrote to 12 Canadian pharmaceutical companies, all subsidiaries of multinational companies, who released a total of 16 new drugs from 1990 to 1999. I asked them to supply me with a list of the randomized controlled trials on the primary indication for each product that were published in English and that were available to physicians at the time the product was first marketed in Canada. A second letter was sent to all companies that did not respond after 5 weeks.

Two of the 12 companies did not respond and one said it was unable to compile the necessary data. Of the others, only GlaxoSmithKline accurately complied with my request, sending material on one study for one of its products (it was asked to provide information on 3 products in total). Other companies sent extraneous material, including studies that had been published in other languages, studies published after the product had been marketed and studies evaluating uses of the product other than that for which it was primarily marketed. Interested readers can contact me for a complete list of these studies and drugs. This variability in the responsiveness of pharmaceutical companies is not a new phenomenon.[1]

All of the companies in question are members of Canada's Research-Based Pharmaceutical Companies (Rx&D). Although neither the *Code of Advertising Acceptance*[2] of the Pharmaceutical Advertising Advisory Board nor Rx&D's *Code of Marketing*[3] covers requests from health care professionals for information not connected with advertising and promotion, such information can be vital to the physicians to whom these new drugs are being marketed.

I strongly urge Canadian pharmaceutical companies to make available to practising physicians the reports of all randomized controlled trials on new drugs being marketed in Canada, at the time of the Canadian launch. They could easily do this by placing the information on their Web sites. If the companies won't do this voluntarily, then the matter should be regulated through a change to the Food and Drugs Act.

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## Onomastic bias

I wish to report a potential onomastic bias, or alternatively a potential onomastic methodologic error, in the work of Rebecca Pollex and colleagues on celestial determinants of success in research.[1] The authors' efforts, although stellar, led to their conclusion that "Gemini produces persons of greater intellect and more powerful invention and genius than any other sign in the zodiac." I noted that 2 of said authors are Scorpios; however, the first author's surname suggests possible onomastic bias, no doubt innocent but subtle, toward their twin-favouring conclusion. "Pollex" is obviously a postmodern adaptation of the name of one of history's most famous twins and the first-magnitude star named after him in the constellation Gemini. If that's too obtuse, look up, and look it up.

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## Treatment of attention-deficit hyperactivity disorder

Benedetto Vitiello's thoughtful commentary[1] on 2 recent articles on the short-term effectiveness of methylphenidate corrects the omission of the very important MTA study[2] from the meta-analysis by Howard Schachter and colleagues.[3] Vitiello's question concerning the impact on long-term outcomes of reducing the symptoms of attention-deficit hyperactivity disorder cannot be considered in isolation from the multiple comorbidities that accompany attention-deficit hyperactivity disorder and that are not affected directly by medication. Behavioural, educational, substance use and family psychopathologic issues call for a comprehensive multimodal management approach.

One important message of the MTA study is that for the vast majority of children with attention-deficit hyperactivity disorder, effective treatment begins with a well-monitored medication trial that opens the door for other management approaches. The MTA study also demonstrated that routine community trials of stimulants are not as effective as carefully monitored trials that follow research protocols. For example, we do not have good data on how community physicians monitor trials of methylphenidate. Indirect information from teacher surveys[4] suggests that physicians do not routinely enlist teachers' help in monitoring the effect of medications in the classroom. Teachers should fill out rating scales on an ongoing basis; this easy, if time-consuming, task is an essential component of any adequate trial of treatment with stimulants.

Vitiello's point concerning the lack of data on whether or not treatment with stimulants decreases the risk of accidental trauma is timely. The literature on attention-deficit hyperactivity disor-

der has demonstrated a significantly increased risk of driving problem behaviours in people with attention-deficit hyperactivity disorder. This issue is addressed in the latest edition of the CMA's recommendations to physicians concerning medical fitness to drive.[5] Recent clinical reports have examined the subjective and objective benefits of stimulant medications for driving performance in adults diagnosed with adult attention-deficit hyperactivity disorder.[6-8]

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## Catholic bioethics

Hazel Markwell and Barry Brown state that certain matters concerning reproduction viewed from a natural-law perspective would be seen as intrinsically evil, but that they might be regarded as justifiable from a proportionalist perspective.[1]

Proportionalism is an ethical theory that holds that there is no such thing as an act that is intrinsically evil, and also that any act may be justified by the intention for which it was chosen or the totality of the foreseeable consequences of that act for all persons concerned.

I would like to point out that this thesis was rejected and condemned by Pope John Paul II in his encyclical *The Splendor of Truth*.

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## Responsible drug disposal program in North Vancouver

Lions Gate Hospital (LGH) in North Vancouver has an ecological footprint of 739 times its actual size.[1] This means the hospital requires an area of land 739 times its actual size to supply the resources it requires and absorb the waste it produces. Waste from items including paper, latex, plastic, medications, and packaging has placed a burden on the environment. Currently, LGH is the only hospital that has had its ecological footprint measured; thus comparisons to other hospitals cannot be made.

In Nov. 2001, physicians and patients were invited to bring to the hospital any unused or expired medications for incineration and proper disposal. All drug products were accepted, including samples, prescription and nonprescription items.

Forty-seven kilograms of medications were collected from 25 people over 2 days. The wholesale cost of identifiable products totalled more than $20 350. Medications that were unidentifiable or no longer available were not included in the total cost. The majority of drugs (87% of total cost) were from physician samples; many of the products collected were cardiovascular medications or items used in women's health (see the accompanying charts to this letter at www.cmaj.ca).

Samples collected from 12 physicians alone valued in excess of $17 000. If this number was extrapolated to approximately 250–300 physicians in the hospital, the wastage would be well over $350 000–$425 000. This cost is borne ultimately by the consumer or third-party payer. The issue of accepting and providing medication samples is beyond the scope of this letter.

The proper disposal of medications is important for preserving our environment. Findings from a recent US Geological Survey have reported pharmaceutical contaminants in US streams, including nonprescription drugs in 81% of their streams, antibiotics (48%) and other prescription drugs (32%).[2] Though the clinical relevance of these findings awaits further studies, proper disposal of medications may ease the burden placed on our environment.

Health Canada announced in Sept. 2001 that new legislation will be developed requiring products regulated under the Food and Drugs Act to also meet environmental assessment standards[3] (see News, p. 1326). According to their Web site, "Health Canada and Environment Canada will create a scientific expert panel to provide a technical foundation for the development of the regulatory framework ... . After September 13, 2001, companies seeking approval to import and manufacture new products regulated under the Food and Drugs Act will need to notify the Minister of the Environment under the New Substances Notification Regulations of the new Canadian Environmental Protection Act (CEPA)."

In our community, 3 end users of medications contribute to waste: pharmacies, patients and physicians' offices. For pharmacies, expired or unused medications are either returned to the manufacturer or incinerated. For patients in British Columbia, the collection of medication waste from patients falls under the Post-Consumer Residuals Stewardship Program Regulation[4] and is funded by the pharmaceutical manufactures. Participating community pharmacies will accept expired or unused medications, for proper disposal, at no cost to the patient. Similar programs