ephedrine and/or phenylpropanolamine) among American adolescent students. They concluded there was little distortion in their estimates of stimulants due to the marked decline in the US of the annual prevalence of the use of diet pills (from 20% in 1982 to 9.6% in 1998), in the presence of an increasing trend in amphetamine use.[1] Also, regarding male–female methylphenidate ratios, the gap between males and females has been narrowing.[2] Safer and Krager showed a narrowing of the ratio from 1:12 in 1981 to 1:6 in 1993 in middle school.[3] Robison and colleagues reported a narrowing of the male–female ratio for children aged 5 to 18 years, from 5.4:1 in 1990 to 3.1:1 in 1995.[4]

Safer and Zito state that the prevalence of stimulant treatment in our study was 50% higher in 10th grade than in 7th grade. The estimate of past-month medical stimulant use, which is more likely to be accurate, shows no significant difference in the prevalence of medical stimulant use in 7th compared with 10th grade ($p > .05$). Of note, Zito and colleagues found that the largest increase in methylphenidate utilization had occurred among high-school aged youth of 15 to 19 years.[2] Our item on past-year medical use was analyzed primarily to determine the relationship between medical and nonmedical stimulant use. The medical and nonmedical drug use items, symmetrical by design, date back to 1991 in the Nova Scotia Student Drug Use Survey and earlier in the case of the Ontario Student Drug Use Survey. Due to the 12-month recall period and discontinued therapeutic regimens and trials of therapy, the past-year prevalence estimate can be expected to be less accurate than the past-month estimate. However, this should not invalidate the association between past-year medical and non-medical stimulant use. In effect, our study revealed a relationship between medical and non-medical stimulant use based on several indicators, including the past-year use items.

Finally, marked geographic variability has been observed in methylphenidate utilization.[2,5,6] Whereas the Nova Scotia Prescription Monitoring Program provides some insight into methylphenidate utilization in Nova Scotia, we do not have comparable information for the other 3 Atlantic provinces. We do know significant differences exist in prevalence of use of several substances among adolescent students in the 4 provinces.[7,8] Clearly, many factors could have influenced the age and gender ratios observed in our study.

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Provincial drug benefit programs

I hope that Andreas Laupacis' essay on provincial drug benefit programs will start an overdue debate on the decision-making processes involved in these programs.[1] As a rheumatologist practising in Ontario, I have often been frustrated by the inadequacy of limited use criteria for drugs that I wish to prescribe, for example, certain bisphosphonates. Even more frustrating is the slowness with which the program deals with new and important agents such as etanercept, for which, at the time of writing, special requests still have to be made under Section 8. For drugs in this category, physicians must submit a written request to the Drug Programs Branch of the Ministry of Health and Long-Term Care indicating the reason why the drug is required for a particular patient.

If the Therapeutics Committee of the Ministry of Health and Long-Term Care makes its decisions from a societal perspective, then it should welcome transparency and conduct open meetings. It must, at least, request the views of interested parties other than of just the pharmaceutical companies when considering submissions. We would all like to see better evidence that the committee usually makes reasonable decisions.

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Obstetrics in family medicine

I applaud Dr. Godwin and colleagues[1] for advancing our knowledge in this area of importance to the discipline of family medicine and to the provision of obstetrical services to our population. The findings of this study are congruent with what our group found several years earlier[2] and with results of the Janus Project[3] of the National College of Family Practice of Canada.

I would like to highlight several aspects to this issue that are critical in moving forward. One is the gender difference found in all above studies, with a preponderance of female practitioners intending to practise obstetrics on