tutorials in clerkship. These should not be ignored, even if they do oppose the current COPS philoshophy. The most important principles to be adhered to are those that dictate a dedication to providing excellence in medical education and training. Dalhousie has taken a large step forward with COPS, however, it has yet to progress to finding the best system for medical education.

F Hassard, R Seth, C Naugler, April 1996

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LETTERS

Comments and letters, addressed to the editor at the publication office, are welcome.

CONGRATULATIONS

Dear Editors:

I think (but not well these days!) it was Arthur Miller, author-playwrite, who characterized the newspaper as a community talking to itself. The re-institution of the *Dalhousie Medical Journal* is timely, because it can act as a vehicle for communication among the student body which, in contrast to the time of my student days and editorship, is larger, geographically more spread out because of rotations and, therefore, less cohesive. At the same time, the decision making processes for, and the conduct of medical education, licensure and practice are much more complex for medical students today. These times may therefore dictate the Journal content. I hope it does, in part at least, because discussions and analyses of those processes would be productive self-talking and a source of ideas for feedback to decision-makers. Such an editorial policy might have as much, if not more, educational pay-off as one which emulates established medical journals.

Whatever direction you take, I congratulate the DMSS in reactivating the *Journal* and wish you every success with it, including proving that Arthur Miller was right!

David T. Janigan, MD
Professor and Senior Pathologist

Dear Editors:

All of us in the publications department of the Canadian Medical Association extend our heartiest congratulations to the editors and production staff on their impressive first issue of the revitalized journal. The issue is visually very attractive, and diverse and interesting articles set a very high standard for subsequent issues.

The future, of course, will not be easy, especially as you try to balance your academic work against the unceasing demands to honour deadlines and publish a journal of which you can be proud. However, your foresight in structuring the journal to provide opportunities for students at all levels of training will, we believe, create a continuing source of experienced and dedicated editors and production staff. Too often, medical school journals have faded away for lack of forward planning.

We at CMA publications send our very best wishes for the journal, and our sincere congratulations to all who have given their time, talent and energy to bring the *Dalhousie Medical Journal* back to life.

Sincerely yours,

Bruce P Squires, MD, PhD
Editor-in-Chief
Canadian Medical Association Journal

PHYSICIANS AND INDUSTRY

Dear Editors:

In the commentary by Donald MacIntosh on "Strategies for Decreasing Inappropriate Interactions Between Physicians and Industry" [Eds - DMJ Vol. 23, No 1, pp. 29-32] there is a very excellent discussion of interactions between

practising physicians and industry as well as between the medical school faculty and industry. You may be interested to know that Postgraduate Medical Education have also had a carefully developed policy on interactions between physicians in training and industry (which encompasses not just the pharmaceutical industry but also the surgical supply industry). Mr. MacIntosh's article has indicated that it is time to provide more publicity to this policy in order to assure that everybody fully understands it. It was accepted and endorsed by faculty a few months after the Continuing Medical Education policy and probably should be re-examined in order to heighten awareness of the policy. Thank you for drawing this to my attention.
Yours sincerely,

Jean Gray, MD, FRCP(C)
Associate Dean
Postgraduate Medical Education
Dalhousie University

Dear Editors:

I read with interest the issue of the Dalhousie Medical Journal dated November, 1995. I also read the article by Donald MacIntosh entitled "Strategies for Decreasing Inappropriate Interactions Between Physicians and Industry" [Eds - DMJ Vol. 23, No 1, pp. 29-32]. The article was excellent from the point of view of reiterating the current guidelines that have been put forth by the Canadian Medical Association. However, the tone of the article was fairly negative toward the pharmaceutical industry.

One must remember that most new compounds coming into clinical practice are designed and invented by the pharmaceutical industry. One must not forget that they indeed spend a lot of time and money in the development of these compounds and clinical trials. One of the main reasons why the cost of medication is so high in North America is our whole litigation process where patients can sue for millions of dollars for adverse effects of a medication. These are some of the points that the article did not address.

The pharmaceutical industry in the last decade has spent a lot of money in promoting continuing education for physicians at the community and the university level. This indirectly increases the cost of medication; however, in the long run benefits society as a whole. Often family doctors who practice in rural areas get information through representatives of pharmaceutical companies. This indeed is an anomaly in the system. Again, this problem has not been addressed in this article.

The other reason for the high cost of drugs, especially in North America, is the fact that even if a drug has a good clinical trial in Europe or any other part of the world, that trial has to be repeated in North America and this results in duplication of drug trials, which in turn increases the cost of medication. Unfortunately, the article does not address this problem.

In summary, the increased cost of medication is multifactorial and the few perks that the drug companies may be giving to physicians add only a minuscule amount to the cost of the drugs in general.

I wish Mr. MacIntosh's article was more balanced, as it does portray the pharmaceutical industry in a fairly negative light.
Yours sincerely,

JJP Patil, MB, BS, FRCP(C)
Physical Medicine and Rehabilitation
Halifax, Nova Scotia

BACK CLINICS

Dear Editors:

I read the article by Scott Bowen regarding the cost effective approach to acute low back pain in the November 1995 issue [Eds - DMJ Vol. 23, No 1, pp. 33-39]. This article indeed summarizes some of the problems that we face with respect to work related injuries to the lower back. The article recommends a "cook book approach to low back pain done by so-called multidisciplinary back clinics".

I have been in practice for more than 15 years and I well know that low back pain indeed is a complicated issue, especially when it is chronic. The protocol recommended does not completely address the issue of chronic low back pain, stress, underlying psychiatric conditions or other conditions that can increase the patient's perception of pain and magnify their pain experience. I am sure most of the readers are aware of the fact that pain is a personal experience which can be interpreted in terms of actual tissue or perceived tissue damage. One must not forget the definition as described by the International Association for the Study of Pain.

I have seen numerous patients who have gone through the mill of the multidisciplinary back pain clinics who have been inappropriately put into work hardening programs at the discretion of a bureaucratic, non-medical person from the Workers' Compensation Board.

I understand that we are trying to cut the cost of back pain to society but I think that the family physician should be closely involved in the process. We must also remember that we are not dealing here with machinery which can be put through an assembly line. We are dealing here with breathing, thinking, walking, talking human beings!

The other problem with the back pain epidemic is the fact that in North America, a labourer is expected to perform at the same level whether he be 25 or 65 years of age. This is utterly ridiculous and unphysiological. I strongly feel that as a person becomes older the physical demands should be decreased with their seniority. This again would prevent a lot of work-related pain which we see.
Yours sincerely,

JJP Patil, MB, BS, FRCP(C)
Physical Medicine and Rehabilitation
Halifax, Nova Scotia

THE AUTHOR RESPONDS

Dear Editors:

I thank Dr. Patil for his comments, a few of which I agree with. He proposes an interesting primary prevention measure whereby industry should incorporate age-appropriate physical demands on its laborers in an effort to prevent work-related back injuries. I am not aware that this has been studied yet; and I wonder if industry would gain more through primary prevention of back injuries than it may lose due to decreased productivity?

I also agree that, indeed, family physicians (Fps) must be involved in the management of these acute low back pain (LBP) patients; however, I feel that it should occur through close communication and guidance from the back clinic - i.e. the back authority. The literature clearly demonstrates the lack of adherence to published guidelines by physicians (generalists and specialists) regarding investigations, diag-

nosis, and management of acute LBP (1-3). A recent survey of Ontario Fps performed by the Ontario Institute for Work and Health (4) confirmed this statement revealing that only 41% of 814 respondents manage acute LBP according to published guidelines. I submit that, since already existing guidelines are not being followed, it would be more feasible to implement proper literature-guided management of acute LBP patients through a central multidisciplinary back clinic headed by one or more back specialists (orthopods or physiatrists, for example) than to bring about major change in Fps practices.

To clarify further, a multidisciplinary back clinic would not necessitate that patients see each member of the management team. The back expert would, by following proven protocols, coordinate proper investigations, consultations, and treatment through the judicious use of various allied health professionals - Fps, physio /occupational therapists, psychologists, social workers and perhaps ergonomists. For the majority of acute, activity-related mechanical back pain episodes, resolution occurs within two weeks and proven standardized approaches have been published (5).

Furthermore, the proposed approach would provide for the rapid identification of possible treatment failures who may progress through acute LBP to chronic LBP (organic or inorganic) and perhaps the chronic pain syndrome(6). Although the original article in the November issue of the journal did not completely address chronic back pain (it was written as an approach to acute LBP) the multidisciplinary back clinic would be perfect for the management of these few patients. This is of utmost importance since approximately 75% of the total compensation cost for spinal disorders is due to approximately 7% who are absent from work > 6 months (5). The various clinic personnel, each with his/her area of expertise, would contribute to the understanding that disability in chronic LBP is caused by physical impairment (50%) as well as psychological distress (20%), illness behavior (10%) and other factors (7,8). Through a concerted effort, the multidisciplinary team could provide a Functional Restoration Program consisting of the important elements described by Mayer (9) and Hazard (10): an exercise program with the purpose to increase function, not to reduce pain; vocational rehabilitation; and psychological and emotional support. In conclusion, one could hardly consider this a cook book approach to low back pain.

Sincerely,

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