Update from the Canadian Dyspepsia Working Group

In our recently published *CMAJ* supplement on the management of uninvestigated dyspepsia in the era of *Helicobacter pylori*,[1] we (on behalf of the Canadian Dyspepsia Working Group) made a very cautious statement about the use of cisapride, given the increasing number of publications that have recently described rare but potentially serious cardiac consequences associated with use of this drug. Cisapride was listed as a third option in the mini-management schema for gastroesphageal reflux disease (Fig. 3)[1] and was also listed as a third option in the treatment schema for patients who have a negative result of noninvasive diagnostic testing for *H. pylori*. Given the cardiac side effects of cisapride use, both the Health Protection Branch and the US Food and Drug Administration have decided that cisapride should be withdrawn from the market and only released following special authorization for selected individuals. Given these recent changes in the availability of cisapride, the Canadian Dyspepsia Working Group feels that we can no longer recommend this medication for the treatment of gastroesophageal reflux disease or for the treatment of dyspepsia that is *H. pylori* negative.

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A parent and a doctor

The recent article by Bibiana Cujec and colleagues highlighted several important factors relating to lifestyle and general life satisfaction within medicine.[1] The accompanying commentary also raised a number of important issues.[2] I was disturbed, however, by the statement that "women sacrifice productivity to parenting (or vice versa)."[2] This suggests that parenting is a nonproductive activity.

It is true that for women the pursuit of any career is often filled with stress and guilt, and these feelings also occur when women choose to remain at home with their children. Statements suggesting that parenting work at home is nonproductive only serve to increase those feelings.

I was much more encouraged by the recent suggestion by Barbara Lent and colleagues that, in relation to parental leave, all employers "should be encouraged to facilitate the efforts of both women and men to balance work and family responsibilities."[3]

We should not be focusing on encouraging (and sometimes pushing) women to leave the home and go into the workplace. Instead, our challenge is to encourage both men and women to be all they can be and want to be. The aspirations of parents may include pursuing a career outside of the home, but we should also encourage men and women to share responsibilities for our children, who often don't see enough of us.

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[Two of the authors respond:]

We agree wholeheartedly with Cornelius Woelk that parenting is rewarding and productive work and should be recognized as such. Parenting does have costs, such as limits to career advancement[1] and personal pursuits. Although ideally both parents are interested and equally involved in parenting, this is often not the case. Women bear the brunt of child-rearing responsibilities, whether by choice or by default.[2] Unfortunately, one cannot be everything to all people (oneself and one's children, spouse, patients, department heads, etc.).

Establishing goals and setting priorities at different stages of life should be the objective. The rise in the number of female physicians has forced the importance of parenting responsibilities to surface. These issues are of equal importance to men. Flexibility in practice settings and training programs is helpful to all physicians — parents or not.

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Battling opiate overdoses

I thoroughly enjoyed your recent articles on substance abuse in the June 13 issue of *CMAJ*, especially Kyle Stevens' essay.[1] I cannot help but think that if the narcotic antagonist naloxone was made readily available to heroin addicts and others as a harm reduction measure (perhaps as an expansion of a needle exchange program) there would be fewer deaths from opiate overdose. After all, most addicts would have little trouble subcutaneously or intravenously injecting naloxone into an unresponsive friend while awaiting a 911 response,[2] and the drug would certainly not be used for recreational purposes. Indeed, this idea is being seriously explored in the addiction literature.[3,4]

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You can't have one without the other

Did anyone else note the rather bizarre, if not macabre, juxtaposition of 2 articles in the July 11 issue?[1,2] One dealt with the prevention of motor vehicle injuries, whereas the other concerned improvements in organ donation rates. Seems to me you can't have it both ways!

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Attitudinal problems facing international medical graduates

T.B. MacLachlan's recent letter illustrates the attitudinal problems Canadian citizens who graduate from schools outside Canada face when they attempt to obtain licensure in Canada.[1]

The article on British Columbia's experience with the licensing program for international medical graduates (IMGs) showed that the program had a 100% licensure and in-country retention rate at a much lower cost than that of training a physician from scratch.[2] The program also eliminates the possibility of having newly minted, Canadian physicians ending up paying taxes to Uncle Sam after having had several hundred thousand taxpayer dollars spent training them in Canada.[3]

Instead of seeing such programs as cost-effective, short-term solutions to the oft-reported Canadian physician shortage,[4] people quibble about the "significant cost" or about whether such programs really meet the needs of *all* IMGs in Canada.

When faced with the possibility that IMGs might have to be considered for practice in Canada, Canadian doctors — at least the ones who have written to CMA publications — react by enacting rules to exclude them[5] or faulting them for having to study abroad.[6] This is done despite reports about the need for more physicians[7] and about how hard it is to get into medical school in Canada.[8]

Being a Canadian citizen and an IMG who has at least US$400 000 worth of postgraduate medical training in the United States, I find myself having to head back to the United States to join other Canadian citizens who are also IMGs, after being unsuccessful in my attempts to obtain licensure here. I knew I would have a hard time trying to get medical training here but I didn't know how hard it would still be after I received accredited training in the United States.

Canadians deserve the best medical care in the world, but are they getting it when doctors feel so overworked they take job action to get funding for additional manpower, as physicians have done in British Columbia?

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Be careful how you report survey results

I read with great interest a recent Pulse column in *CMAJ*.[1] However, I have several major concerns with Lynda Buske's reporting of the survey of residency program directors concerning job opportunities in their specialties over the next 5 years.

While the statement that a majority of program directors in 4 specialties (occupational medicine, neurosurgery, pediatrics and community medicine) thought that job opportunities in their specialties would either remain constant or deteriorate over the next 5 years is technically correct, it is misleading.

A detailed review of the CaRMS survey report shows that respondents were asked to specify if they believed job opportunities in their specialty would (1) improve, (2) remain constant or (3) deteriorate over the next 5 years. For these 4 specialties the results of the survey were as follows: 100% (2/2) of occupational medicine program directors felt that job opportunities would remain constant; 22% (2/9) of neurosurgery program directors felt that job opportunites would improve, 44% (4/9) felt that they would remain constant and 33% (3/9) felt that they would deteriorate; 46% (6/13) of pediatrics program directors felt that job opportunities would improve and 54% (7/13) felt that they would remain constant; and 50% (2/4) of community medicine program directors felt that job opportunites would improve and 50% (2/4) felt that they would remain constant.

By choosing to group "remain constant" and "deteriorate" together, Buske presented a distorted view of the results. Imagine how the article would have read if she had chosen to group "constant" and "improve" together. I would suggest that in only 1 of these specialties — neurosurgery — is it true that program directors thought job opportunities would deteriorate over the next 5 years. In the other 3 the survey results indicate that opportunities are expected to either remain constant (occupational medicine) or actually improve (pediatrics and community medicine) over that time period.

Unfortunately, this article has misinformed the journal's readers, particularly medical students who depend on sources such as *CMAJ* to make difficult career decisions.

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1. Buske L. Where do medicine's job opportunities lie? *CMAJ* 2000;162(13):1865.

[The author responds:]

Bart Harvey's points are well taken. The detailed results of the survey of program directors conducted by the Canadian Resident Matching Service in 1999 are shown in Table 1. I hope this will clear up the confusion caused by the presentation of the survey results in my *CMAJ* Pulse column.[1]

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Canadian Medical Association

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Table 1: Responses of Canadian program directors surveyed by the Canadian Resident Matching Service to the following question: Please speculate as to how job opportunities in your specialty will change in the next 5 years

	Response (%)		
	Increase	Remain constant	Decrease
Family medicine	73	27	0
Internal medicine	92	8	0
Obstetrics and gynecology	83	8	8
Anesthesia	77	23	0
Radiology	100	0	0
Psychiatry	62	38	0
Pediatrics	46	54	0
Laboratory medicine	82	9	9
Dermatology	75	25	0
Emergency medicine	70	30	0
Neurology	85	15	0
Physical medicine and rehabilitation	67	33	0
Community medicine	50	50	0
Medical genetics	100	0	0
Nuclear medicine	50	25	25
Occupational medicine	0	100	0
General surgery	100	0	0
Cardiac surgery	71	29	0
Neurosurgery	22	44	33
Opthalmology	67	33	0
Orthopedic surgery	67	25	8
Otolaryngology	86	14	0
Plastic surgery	86	14	0
Thoracic surgery	100	0	0
Urology	67	33	0
Overall	74	23	3