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Training aboriginal health care workers

Perhaps I let my pride in our program and its achievements carry me away when I told your writer that the University of Alberta has graduated the largest number of aboriginal physicians in Canada.[1] It was not my intention to demean the Professional Health Program at the University of Manitoba, nor its success in training aboriginal health professionals.[2] I should have qualified my statement by noting that although we have graduated the largest number of aboriginal physicians in the shortest time — 20 since 1993 — the University of Manitoba program, with its longer history, has a larger number of aboriginal graduates overall.

At the same time, I'm sure that the University of Manitoba did not intend to reduce the achievements of our program to a single sentence. Far from selecting only qualified applicants nationally, we have offered positions to out-of-province students who did not qualify for admission to medical schools that have no admissions policies for aboriginal Canadians, as well as to applicants who qualified in the general pool. Nor have we found our national recruitment policy incompatible with developing a strong aboriginal applicant pool in Alberta. In the 1999/2000 academic year, 8 of the 12 aboriginal students enrolled in our medical program were Albertans.

However, rather than launching a debate about numbers, we need to talk more with our sister medical schools and other health professional training programs, particularly those that have not been as active in training aboriginal health professionals. In its 1996 report, the Royal Commission on Aboriginal Peoples identified a need for 10 000 aboriginal health professionals in Canada. This would include about 1000 physicians — roughly 10 times the current number — to bring the ratio close to that for the general population.

Despite the best efforts of both our programs, we are far from being on track to achieve this goal. We need a concerted effort from all 16 medical schools, coordinated through the Association of Canadian Medical Colleges and the Canadian Association for Medical Education, to develop plans to achieve these targets.

Malcolm King
Chair, Aboriginal Health Care Careers Committee
Anne-Marie Hodes
Coordinator, Aboriginal Health Care Careers Program
University of Alberta
Edmonton, Alta.

References

1. Kent H. U of A proving popular with native students. *CMAJ* 2000;162(4):550.
2. Pinette G, Herrmann R, Hennen B. Training aboriginal health care professionals in Manitoba [letter]. *CMAJ* 2000;162(12):1661-2.

Hepatitis B and medical students

Because of hepatitis B virus (HBV) infection and other infectious diseases, several Canadian medical schools have created controversial admissions policies that have led to ethical debates about the rights of students and their future patients.

One prevention strategy requires students to provide evidence of vaccination before clerkship or face training and career restrictions, thus making successful immunization a condition of employment. To minimize high-risk encounters, most schools steer HBV-positive students into community medicine, administration, laboratory medicine, psychiatry and research. Only one school permits students to enter family medicine or certain subspecialties, with the understanding that they are not to perform any elective obstetric or invasive procedures. To allow students to make informed decisions regarding career goals and preferred training locations, all Canadian medical schools should be reading off the same song sheet.

Given the perception of exposure risk, public disclosure of (future) physicians' serologic status would have devastating effects on their livelihood and invade their right to privacy. A delicate balance must be struck between a patient's right to informed decision-making and the potential harm caused by disclosure. Physicians and ethicists must make a "best-interest judgement" and determine the risk that a reasonable person in the patient's position would be willing to take. Unlike medical students, who agreed to a certain level of risk upon entering medicine, it may not be right to assume that patients also agree.

The principles of biomedical ethics do not point to a clear course of action but provide conflicting guidance. In the meantime, schools must inform (prospective) students of the risk of training-related disability, offer appropriate counselling services and provide options for income security through meaningful work or retraining.

The debate over the suitability of potentially infectious students raises legal, ethical and individual issues. Voluntary testing, coupled with an intensive public health initiative to vaccinate the entire population, may be the most respectful of solutions. Nevertheless, patients must come first. Students performing "exposure-prone" procedures have a moral and ethical obligation to

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know their HBV status. However, students should be free from unwarranted immunologic discrimination based on remote risks that are generally tolerated within society, such as those seen in noninvasive medical procedures. But how much risk is acceptable?

Robert Colistro
Fourth-year medical student
University of British Columbia
Vancouver, BC

Antismoking documents now available on Web site

I wish to clarify our position on claims made in a recent *CMAJ* article.[1] Your reporter stated that British Columbia is withholding internal tobacco industry documents (the Guildford documents) collected to support the government's lawsuit to recover health care costs associated with smoking-related disease.

That is not the case. To avoid any suggestion that government action might influence the outcome of a constitutional challenge to the legislation upon which the lawsuit was based, the province temporarily withheld publishing the Guildford documents until a decision in the constitutional challenge was rendered. After the decision was handed down, the documents were made public on Apr. 18 (www.health.gov.bc.ca/tobacco). These 15 000 pages of documents concerning British American Tobacco and its Canadian associate, Imperial Tobacco Ltd., were retrieved by BC from the Guildford document depository in Guildford, England. These documents were first made available at the depository as part of the settlement of Minnesota's lawsuit against tobacco companies. Another 5000 documents have recently been received from Guildford and will be added to our Web site shortly.

The documents provide inside information on the tobacco industry, including its marketing and promotional strategies. With them, health organizations and governments interested in tobacco reduction can find information about business practices within the industry.

Andrew Hazlewood
Assistant Deputy Minister
Public and Preventive Health Services
BC Ministry of Health
Victoria, BC

Reference

1. Sibbald B. Physicians fight for access to tobacco info, hope to show criminal negligence. *CMAJ* 2000;162(10):1468.

Licensing international medical graduates

Rodney Andrew and Joanna Bates recently reported on an attempt to manage the significant problems surrounding the licensing of international medical graduates (IMGs) in British Columbia.[1] The financial burden must be significant, yet this solution only accommodates 6% to 8% of eligible applicants. It will not satisfy the BC applicants who are not selected, nor the many more scattered across the country.

It should be no surprise that none of the successful candidates has left Canada for the United States, since this is becoming more difficult these days. The fact that only 4 candidates were recognized to have attitudinal difficulties is not surprising either. Most faculty give only lip service to this topic, and avoid it if possible.

I found parts of the report unclear. If, as they say, "No passing grades are set; IMGs compete against each other at each step …," how are the top 2 candidates selected? The assumption would be that a bell curve was created from the grading system and a cut-off determined. If the selection is based on subjective evaluation, BC may face appeals by those not chosen. How is this eventuality avoided?

Finally, the federal government has created this problem, since immigration is a federal authority. IMGs

Submitting letters

Letters may be submitted by mail, courier, email or fax. They must be signed by all authors and limited to 300 words in length. Letters that refer to articles must be received within 2 months of the publication of the article. *CMAJ* corresponds only with the authors of accepted letters. Letters are subject to editing and abridgement.

Pour écrire à la rédaction

Prière de faire parvenir vos lettres par la poste, par messager, par courrier électronique ou par télécopieur. Chaque lettre doit porter la signature de tous ses auteurs et avoir au maximum 300 mots. Les lettres se rapportant à un article doivent nous parvenir dans les 2 mois de la publication de l'article en question. Le *JAMC* ne correspond qu'avec les auteurs des lettres acceptées pour publication. Les lettres acceptées seront révisées et pourront être raccourcies.

Note to email users

Email should be addressed to **pubs@cma.ca** and should indicate "Letter to the editor of *CMAJ*" in the subject line. A signed copy must be sent subsequently to *CMAJ* by fax or regular mail. Accepted letters sent by email appear in the Readers' Forum of *eCMAJ* (**www.cma.ca/cmaj**) promptly, and are published in a subsequent issue of the journal.

Aux usagers du courrier électronique

Les messages électroniques doivent être envoyés à l'adresse **pubs@cma.ca**. Veuillez écrire «Lettre à la rédaction du *JAMC*» à la ligne «Subject». Il faut envoyer ensuite, par télécopieur ou par la poste, une lettre signée pour confirmer le message électronique. Une fois une lettre reçue par courrier électronique acceptée pour publication, elle paraîtra dans la chronique «Tribune des lecteurs du *JAMC*» du *JAMCél* (**www.cma.ca/cmaj**) tout de suite, ainsi que dans un numéro prochain du journal.

should be clearly informed about the licensing problems they will face before they arrive in Canada. The federal government decides who is allowed to immigrate to Canada and knows the professional status of immigrants. It should either be prepared to tell the IMGs that most of them will be unable to practise in Canada, or it should pay the total cost of the selection process and the training required.

The BC Human Rights Commission's ruling involving 5 foreign-trained physicians must be appealed.[2] The commission seems to be unaware of the provincial college's role in protecting the Canadian public.

T.B. MacLachlan
Obstetrician (ret'd)
Saskatoon, Sask.

References

1. Andrew R, Bates J. Program for licensure for international medical graduates in British Columbia: 7 years' experience. *CMAJ* 2000;162(6):801-3.
2. Kent H. College to appeal discrimination ruling. *CMAJ* 2000;162(6):854.

[The authors reply:]

T.B. MacLachlan comments on the method of selection of the 2 candidates[1] and whether this may be perceived as unfair and open to challenge. The initial examinations by the Medical Council of Canada are externally set and validated, and the objective structured clinical examination has demonstrated reliability in psychometric evaluation. During the 6-week clinical evaluation, skills are evaluated by clinical faculty with extensive experience. The director of the international medical graduate (IMG) program remains at arm's length from candidates, grants no interviews and plays no personal role in the evaluation. IMGs who have participated in the process indicate that it is as fair as possible, although senior and experienced IMGs feel that the process is demeaning.

The financial costs are considerable, given that so few residents are produced. The evaluation component could be expanded at relatively low cost to produce more residents, but the largest part of the cost is residents' salaries. Still, the cost of producing a licensable physician from the IMG pool is much lower than the additional cost of 4 years of medical school incurred by Canadian graduates.

We agree that many IMGs arrive here with scant knowledge of the requirements that must be met to enter medical practice. Many of our candidates comment on the extreme hardship involved in acquiring a licence and the considerable barriers to residency training. Many are so daunted that they never do practise medicine here.

Canada's colleges of physicians and surgeons have a crucial role in ensuring that only competent physicians gain the right to practise here. Our experience is that, with appropriate evaluation and residency training, many more IMGs could make a contribution to the health care of Canadians.

Rodney Andrew
Joanna Bates
Department of Family Practice
University of British Columbia
Vancouver, BC

Reference

1. Andrew R, Bates J. Program for licensure for international medical graduates in British Columbia: 7 years' experience. *CMAJ* 2000;162(6):801-3.

Emergency contraception

I found a recent letter[1] offensive because of its suggestion that the provision of emergency contraception is unrelated to providing a service to patients or to reducing violence against abortion providers.

Why is it easier for young people to buy street drugs than to get emergency contraception? Why had none of my friends in high school ever even heard of the morning-after pill? A 2-dose regimen of levonorgestrel is more effective and better tolerated than the traditional Yuzpe regimen.[2–4] If women were better informed and had better access, a lot fewer therapeutic abortions would be performed in Canada.

Safe abortions are an essential service. I am grateful to all physicans and nurses who have chosen to put themselves at risk in the name of justice, and I long for the day when all physicians act as patient advocates: pro-children and pro-choice.

Madeleine Cole
Family physician
Iqaluit, Nunavut

References

1. Gutowski WD. Access to the morning-after pill in BC [letter]. *CMAJ* 2000;162(11):1554.
2. Task Force on Postovulatory Methods of Fertility Regulation. Randomised controlled trial of levonorgestrel versus the Yuzpe regimen of combined oral contraceptives for emergency contraception. Task Force on Postovulatory Methods of Fertility Regulation. *Lancet* 1998; 352:428-33.
3. Glasier A, Thong KJ, Dewar M, Mackie M, Baird DT. Mifepristone (RU 486) compared with high-dose estrogen and progestogen for emergency postcoital contraception. *N Engl J Med* 1992;327(15):1041-4.
4. Task Force on Postovulatory Methods of Fertility Regulation. Comparison of three single doses of mifepristone as emergency contraception: a randomised trial. *Lancet* 1999;27(353):697-702.

Oldest at graduation

I'm responding to your request for information on the oldest age at graduation among Canadian physicians.[1] I think I must have been one of the oldest medical graduates. I graduated from the University of Toronto medical school in 1995 at the age of 49. One of my son's high school classmates was a classmate of mine in medical school.

I now practise family medicine in the Hamilton area and am forever grateful to the admissions people at the University of Toronto who took a chance on me.

Rachelle Sender
Family physician
Hamilton, Ont.

Reference

1. Sullivan P. We protest! [letter]. *CMAJ* 2000: 162(12):1664.

You wanted to know who among Canada's physicians was the oldest at graduation.[1] A good friend of mine,

Anne Draginda, graduated from the University of Alberta at age 48. At the time, she was a mother of four and grandmother of two. I don't know whether she was Canada's oldest medical graduate, but she may hold the unique distinction of being the only grandmother to graduate from medical school.

J.B. Hunter
Edmonton, Alta.

Reference

1. Sullivan P. We protest! [letter]. *CMAJ* 2000; 162(12):1664.

Not fade away

At my age — I retired 8 years ago — I find the Deaths section of *CMAJ* interesting and informative. In your May 2 issue,[1] I noted the passing of Douglas Harvie, who followed my dad in his practice in Chapleau, Ont., in 1927. I also noted the names of John Simpson, an old student friend, and Woodie Woodsworth, whom I valued as a teacher of anesthesia. Woodie's father founded the Cooperative Commonwealth Federation, the forerunner of the New Democratic Party.

I am writing to congratulate *CMAJ* for inviting readers to submit brief death notices, but in particular to comment on the death of Donald Williams, also announced in your May 2 issue. He was an outstanding teacher and practitioner of dermatology, and I believe he headed the Canadian army's venereal disease program during World War II. The story of how he became interested in dermatology is in itself a great one. As is the case with many of your death notices, more needs to be told about him.

It is unfortunate that few readers have responded to your request to supply more information. As others have discovered, physicians are an endless source of fascinating detail within the web of Canadian history, and their contributions are not limited to the confines of medicine.

Perhaps we should have a permanent file to remember physicians upon their death. Too many of them fade away quietly.

William M. Brummitt
Anesthesiologist (ret'd)
Carrying Place, Ont.

Reference

1. Deaths. *CMAJ* 2000;162(9):1387.

St. John's wort and schizophrenia

In recent years St. John's wort has become a popular natural medicine for the treatment of depression[1] and general symptoms such as tiredness and lack of energy. Unfortunately, the potential harmful effects of St. John's wort have not been fully recognized. It inhibits monoamine oxidase[2] and the reuptake of serotonin and norepinephrine.[3,4] Such mechanisms of action underlie the therapeutic effects of antidepressants. Like antidepressants, St.

John's wort may induce mania and hypomania.[5,6] Antidepressants may exacerbate psychosis in patients with schizophrenia;[7] this raises the possibility that St. John's wort may have a similar adverse effect. To our knowledge this has not been previously described. We report 2 cases in which patients with schizophrenia experienced psychotic relapse that was temporally associated with the consumption of St. John's wort.

The first patient had been admitted to hospital because of schizophrenia at age 26. Following complete remission, perphenazine therapy was stopped and the patient remained well without medication for 3 years. Five months before her relapse she purchased a bag of St. John's wort herbs from a natural food store, and once or twice a week she placed some of the herbs in tea and consumed it. Two months before her relapse she consumed the herbs daily. She became acutely psychotic with paranoid delusions, ideas of reference and loosening of associations. Her psychosis responded to olanzapine. She did not take street drugs. On occasion she had taken other herbal products, but not regularly.

The second patient was first treated for a paranoid psychosis at age 34. He rapidly responded to treatment with risperidone. After 6 months the medication was stopped. He did well without any medication for another 7 months, at which time he experienced an abrupt recurrence of persecutory delusions, ideas of reference and bizarre behaviour over a 2-week period. His schizophrenic episode responded to risperidone. Two to 3 months before his relapse he had purchased St. John's wort at a health food store and had been taking it daily.

It was only after the condition of these patients improved that information was elicited on their use of St. John's wort; they were unable to provide details beyond the information described here. These 2 cases do not establish a cause–effect relation, but they do raise the possibility that relapse was associated with taking St. John's wort. Given our current knowledge about the pharmacological properties of St. John's wort it is important that physicians ask their patients whether they take natural products and caution them about potential harmful effects.

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References

1. Deltito J, Beyer D. The scientific quasi-scientific and popular literature on the use of St. John's wort in the treatment of depression *J Affect Disord* 1998;51(3):345-51.
2. Bennett DA, Phun L, Polk JF, Voglino SA, Zlotnik V, Raffa LB. Neuropharmacology of St. John's wort (Hypericum). *Ann Pharmacother* 1998;32:1201-8.
3. Neary JT, Bu YR. Hypericum LI 160 inhibits uptake of serotonin and norepinephrine in astrocytes. *Brain Res* 1999;816:358-63.
4. Chavez ML, Chavez PI. St. John's wort. *Hosp Pharm* 1997;32:1621-32.
5. Nierenberg AA, Burt T, Mathews J, Weiss AP. Mania associated with St. John's wort. *Biol Psychiatry* 1999;46:1707-8.
6 Schneck C. St. John's wort and hypomania. *J Clin Psychiatry* 1998;59:689.
7. Kalinowsky LB, Hippius H. *Pharmacological, convulsive and other somatic treatments in psychiatry*. New York: Grune & Stratton; 1969.