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Mandatory continuing medical education

To the editor: Being aware of the official stand of the Canadian Medical Association (CMA) against mandatory continuing medical education[1] I was surprised by the title of the article written by J.L. Chouinard (a staff member of the CMA) — "Compulsory continuing medical education: It's just around the corner" (*Can Med Assoc J* 122: 595, 1980).

The only official stand for mandatory continuing medical education in Canada has been taken by the council of the Manitoba College of Physicians and Surgeons, and to my knowledge such a measure has not yet been implemented. As for professional associations, the College of Family Physicians of Canada is the only one that seems to have reasons to require "credits" in continuing medical education for active membership.

Mr. Chouinard states that "continuing education courses are being considered as prerequisite for membership in medical and specialty societies, for specialty recertification, and for relicensure; these are all part of a movement toward mandatory continuing education in Canada in the 1980s" and that "the profession has, to a degree, accepted the apparent inevitability of mandatory continuing medical education — both in Canada and the United States." These claims are in need of stronger substantiation.

As far as our American confrères are concerned, the concept of mandatory continuing medical education is still far from being accepted. Recently, the profession rejected the original acceptance of recertification; specialty boards are now reconsidering their course of action (*American Medical News*, Mar. 30, 1979, pp 1, 13, 14).

Probably the synthesis of this new attitude can be found in the recently formulated position statements of the Alliance for Continuing Medical Education: "ACME should reaffirm its position in opposition to mandatory continuing medical education."[2]

American physicians, who witnessed with dismay how an initial "voluntary activity" can rapidly evolve toward the role of a mandatory life line for the licence to practise medicine, are now redefining the proper function of continuing medical education as an important adjuvant to maintaining competence, but not as a device for assessing incompetence. For once we do not need to follow their example and repeat the same frustrating experience: learning from the mistakes of others represents wisdom.

The stand taken by the CMA is a realistic one and should be supported.

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2. *ACME Position Statement. CME and Continued Physician Competence*, Alliance for Continuing Medical Education, Norwalk, Conn, Jan 20, 1980

To the editor: I agree with Dr. Gialloreto that the present CMA policy on mandatory continuing medical education is appropriate. The intent of my article was to explain the rationale behind this policy and to indicate that many Canadian physicians, with good reason, still believe that continuing medical education will become compulsory in the future.

Dr. Gialloreto may find that the original title of my article, "Compulsory continuing medical education: the continuing debate", which was changed during the editing process, was more suitable.

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Powassan virus encephalitis in southeastern Ontario

To the editor: Recently Drs. Michael S. Wilson, Brian A. Wherrett and M.S. Mahdy described a case of Powassan virus encephalitis in Kingston, Ont. (*Can Med Assoc J* 121: 320, 1979). This was the 14th case reported in the world literature and the 3rd recognized in Ontario. We report here another case from Kingston.

Case report

A 7-year-old boy was admitted to Kingston General Hospital Dec. 15, 1979 with a 3-day history of fever, vomiting, increasing lethargy and headache. Six hours after admission he lapsed into coma with deviation of his eyes to the right and weakness of the left arm and leg. The next day he had a diffuse, erythematous rash on the upper body and face that lasted a few hours. He remained comatose for 4 days with fluctuating levels of consciousness, fluctuating neurologic signs and fever. He slowly recovered but severe expressive aphasia and spastic quadriplegia persists up to the time of writing.

Investigations during the acute phase of the illness revealed a blood leukocyte count of $12.6 \times 10^9/l$ (71% neutrophils, 22% lymphocytes, 3% band forms, 3% monocytes and 1% basophils). At lum-

bar puncture the cerebrospinal fluid had an opening pressure of 250 mm H_2O; the protein and glucose concentrations were 28 and 63 mg/dl respectively, the erythrocyte count was 3×10^6/l and the neutrophil count was 53×10^6/l. Tests for liver function, blood glucose levels and serum ammonia concentrations yielded normal results. Computer-assisted tomography of the brain gave normal results and an electrocardiogram showed diffuse δ-wave activity.

Antibodies to Powassan virus, echovirus and coxsackieviruses and to the viruses causing eastern and western equine encephalitis, California encephalitis and St. Louis encephalitis were absent from the first serum sample (obtained Dec. 16, 1979), but in the second sample (obtained Feb. 7, 1980) the hemagglutinin inhibition titre of antibodies to Powassan virus had risen to 1:80; the titre remained at that level in two subsequent samples.

Comment

This case is of interest for two reasons. First, the child's illness was "out of season", as all but two of the previous cases of Powassan virus encephalitis occurred in the summer, the exceptions occurring in October. Second, our patient lived within 8 km of the patient in the previous report. We may have a reservoir for Powassan virus in the Kingston area, or we may be more aware of the disease following recognition of the first case. The source of the infection in our patient has not yet been identified.

We would like to reinforce the point made by Dr. Wilson and his colleagues that Powassan infection should be looked for in any undiagnosed case of encephalitis. Serum antibodies should be sought for up to 6 weeks after the onset of symptoms, as a rise in antibody titre may not be detected any earlier.

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Some odd patterns of psychotropic self-medication

To the editor: We may be dismissing too readily any modification by our patients of a strictly prescribed chemotherapeutic regimen as noncompliance. Caught in the struggle to overcome our patients' resistance to psychopharmacotherapy, we tend to perceive all such interference as nonsensical, if not dangerous.

Recently, we have started to realize the need for individual tailoring of the dosage[1,2] owing to the tremendous differences in the bioavailability of drugs.[3] Our patients have been telling us this for a long time. The same applies to preferences for a particular brand, although we used to consider them all strictly interchangeable. Some of us may have laughed at our patients' claims that fixed drug combinations did them more good than the identical combination taken separately, and vice versa. We may still have doubts, but we certainly don't laugh any more, since the astounding complexities and intricacies of metabolism and interactions of drugs[1] are coming to light one after another. We have only started to analyse the possible influence of biologic rhythms on the effects of drugs, but our patients have been experimenting with the timing of their medication all along. Maybe they do know something we don't know. They are the only parties in the psychopharmacotherapeutic relationship that experience the effects of psychotropic medication on their subjective well-being.

Having run repeatedly into a few odd patterns of self-medication, or self-adjusted medication, I decided to listen to what my patients had to say. I learned, for example, that the renowned appetite stimulant cyproheptadine hydrochloride is an excellent hypnotic for some patients. Its apparent misuse in such a way may well make sense neurophysiologically. Bedtime use of benzodiazepine tranquillizers has been condoned, and even encouraged as an alternative to other hypnotics.[4] It is from my patients, too, that I've learned about the daytime use of the benzodiazepines and other nonbarbiturate hypnotics (e.g., methypry-