Letters
Correspondance

Is there room in medicine for the family man?

What a pleasure it was to see attention being paid to important family- and career-satisfaction issues in our national medical journal.[1] It is disappointing but not surprising to see that satisfaction is lowest among residents. Although we have come a long way in supporting the learning environment for them, it is clear we have more to do.

I agree strongly with Susan Phillips that if we are to enhance parenting and career satisfaction we must equalize the psychological and time commitment to parenting between the sexes.[2] But what will it take to do this? She calls for action, not further study.

Although women have been shown repeatedly to take on the larger proportion of family responsibilities, we must stop making this a women's issue. Even though women are blocked from career satisfaction and advancement by assuming these responsibilities, men (knowingly or not) are being counter-blocked from playing larger family roles by societal structures and values.

We must make both boys and girls aware of the value of caring for the family. We must fundamentally change society so that boys are encouraged to do this, taught how to do it and valued for doing it. We must remove the subtle, demeaning language that creeps into conversations about men's roles in family life. Not only should it not be tolerated but also we must act to encourage boys and men to take on these roles. Why can't we move beyond federal legislation that permits parental leave for men to a point where salaries are topped up for men, supported by the employer? Without this, fathers will almost never make this choice because it places the whole family at a financial disadvantage.

We must make our work environments supportive of men who play these roles. Flexible work hours, interrupted career paths and recognition that family responsibilities must take precedence at times should be fostered.

For academics, we have to dispel some myths and change some policies. For those who wish to have both a career and active involvement in family life, we have a lot of work to do to convince people that nontraditional career paths to success do exist. Just because you have not published extensively or received large national grants in the first 5 years does not mean you will never be successful. Although the literature does not support this thesis,[3] this work is retrospective and based on structures that support only one model of career development. Let's be more flexible and work together to make our profession a more satisfying place for those with families.

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Halifax, NS

References

1. Cujec B, Oancia T, Bohm C, Johnson D. Career and parenting satisfaction among medical students, residents and physician teachers at a Canadian medical school. *CMAJ* 2000; 162(5):637-40.
2. Phillips SP. Parenting, puppies and practice: juggling and gender in medicine. *CMAJ* 2000; 162(5):663-4.
3. Bland C, Schmitz C. Characteristics of the successful researcher and implications for faculty development. *J Med Educ* 1986;61:22-31.

Training aboriginal health care professionals in Manitoba

Malcolm King, chair of the Aboriginal Health Careers Program, says that the University of Alberta has graduated the highest number of aboriginal physicians in Canada.[1] This is incorrect.

The University of Manitoba has graduated 21 self-identified aboriginal physicians, and 20 of the 21 have graduated since 1987. Another 14 aboriginal students (First Nations [status and non-status], Métis and Inuit) are currently enrolled in our medical school, with 3 of them graduating this spring.

Our success is due in large part to the success of the Special Premedical Studies Program (SPSP) and its continuation, the Professional Health Program (PHP). Sixteen of the 21 Aboriginal physicians who have graduated in Manitoba participated in these programs.

SPSP was established in 1979 by the university and the provincial and federal governments. It is designed to help Aboriginal students meet the requirements for medical school admission and also includes preparation for other professional health careers such as dentistry and nursing.[2]

PHP is a natural extension of that program. In Manitoba, most of the professional health faculties are located on a downtown campus, kilometres away from the main campus. PHP helps to provide aboriginal health professionals with a less isolated environment and continues to provide support and resources in the academic, personal, financial and professional-development areas.

The faculties of medicine, dentistry and medical rehabilitation have long shown support for training aboriginal students. Medicine, dentistry, pharmacy, occupational therapy and dental hygiene all have a special category stream of admission, which includes aboriginal applicants. The physiotherapy program allocates up to 10% of its admission slots for SPSP students, and the medical school has supernumerary positions for these applicants.

The recruitment strategies of the Manitoba and Alberta program differ substantially. Manitoba creates a "pipeline" of potential aboriginal physicians by recruiting and supporting (mainly) Manitoba students interested in a career in health care early in their undergraduate studies and at the high school level. These potential professionals may not have had the resources or academic qualifications to achieve this goal prior to joining our program. Alberta recruits Canada-wide from a pool of aboriginal students who have already met the necessary requirements for applying to medical school.

Many aboriginal physicians and other health care professionals work in underserviced areas and within aboriginal communities after graduation.[3] Programs such as those in Manitoba and Alberta need to continue to promote medicine and other health careers for aboriginal people; in Canada, for instance, aboriginal physicians are still underrepresented when compared with the general population. Mentorship and support for premedical and medical students, and provision of academic, financial and counselling resources that are culturally appropriate, are of paramount importance to the continued success of these programs.

Gilles Pinette
Coordinator, SPSP/PHP
Randy Herrmann
Director, Access/SPSP/PHP
Brian Hennen
Dean
Faculty of Medicine
University of Manitoba
Winnipeg, Man.

References

1. Kent H. U of A proving popular with native students. *CMAJ* 2000;162(4):550.
2. Krause RG, Stephens MCC. Preparing aboriginal students for medical school. *Can Fam Physician* 1992;38:1187-93.
3. Stephens MC. The Special Premedical Studies Program — review of ten years of experience. *Circumpolar Health 90: Proceedings of the 8th International Congress on Circumpolar Health*; 1990 May. Winnipeg: University of Manitoba Press; 1991. p. 134-7.

Studying medicine abroad

The Canadian Federation of Medical Students receives regular requests for membership from Canadians studying medicine abroad.[1] As Canadians, they are anxious to return home to practise in the country that they know and love. However, even though they are Canadians they were turned away from receiving a medical education in Canada because the funding was not available. It is widely recognized that, on a per capita basis, the number of positions available for medical training is far lower in Canada than in other developed countries.

It is a shame that so many talented and worthy young Canadians have been forced to leave this country at a time when we need physicians so crucially, and that so many of them may never return. In fact, if the number of students who leave Canada to train in international locales is included in the brain-drain equation, I imagine that the loss for Canada is much higher than estimated.

The solution is to retain students before they are lost to international medical schools. If we begin to create enough positions to train doctors in this country, we won't have to deal with the dilemma of luring them back when they have finished their training. In the meantime, however, if repatriation is to be considered, it will have to be approached in a very thoughtful and careful way that remains respectful of the global community.

Tara Mastracci
President
Canadian Federation of Medical Students
Ottawa, Ont.

Reference

1. Sullivan P. Shut out at home, Canadians flocking to Ireland's medical schools — and to an uncertain future. *CMAJ* 2000;162(6):868-71.

If something seems too good to be true . . .

On Apr. 13, 2000, I received a letter from a Nigerian philanthropic foundation informing me that I had been awarded an unsolicited research grant worth US$125 000 (see www.canmed.net/fraud/). There was also an option for a 50% bonus following submission of a satisfactory progress report on my research. The letter added that a detailed accounting of how the money would be spent would not be necessary, although it was not to be used for military research or for human cloning studies. I also had to agree to present an expenses-paid lecture on my research at a Nigerian university and to return 2% of any licensing fees generated from the sale of my research results. All I had to do was send 4 passport-size photographs, along with a handwritten letter of acceptance. I was also to provide my CV and complete a detailed form indicating my address, passport and driver's licence numbers and other information.

The RCMP's Commercial Fraud Division confirmed my suspicion that this was a scam, although it had an interesting twist because it was aimed at medical researchers, not business people. In my case, the passport photos and detailed personal information would likely be used to assume my identity in some fraudulent transaction, perhaps passport fraud. In similar scams originating in Nigeria and carried out with business people and lawyers, an individual would receive a letter indicating that someone needed the recipient's assistance to get money out of the country and to help launder it. The recipient would receive a generous commission for his or her efforts. Later, the person would be asked for a substantial sum to pay for taxes or bribes, after which the money would be able to leave the country. The explanation offered would always be plausible. Of course, that would be the last the dupe would hear.

Not everyone I showed my letter to recognized it as a scam; many people even offered me hearty congratulations. Undoubtedly, the people sending the letters are hoping plenty of naïve researchers will regard the offer as genuine.

Investigator beware!

D. John Doyle
Department of Anesthesia
Toronto General Hospital
Toronto, Ont.

Advertisement for Relenza

Print ads for Relenza (zanamivir) that have appeared in *CMAJ* recently state clearly that "patients should be advised of the conditional nature of the market authorization for this indication." However, the patient information booklet on influenza published by Glaxo Wellcome does not mention

this. If patients should be advised of something, wouldn't the patient information pamphlet be the place to advise them? When I explain to patients my refusal to prescribe it prophylactically they are sceptical because no advisory on the conditional nature of the authorization appears in the patient brochure.

Deena Ages
Family physician
Toronto, Ont.

[Glaxo Wellcome responds:]

Deena Ages notes that the patient information pamphlet for Relenza does not include the statement in the advertisement in *CMAJ* that reads "patients should be advised of the conditional nature of the market authorization for this indication." This statement is a reference to the fact that Relenza was granted a Notice of Compliance with Conditions in November 1999 by the Therapeutic Products Program of Health Canada. The statement appears at the front of the product monograph for Relenza and is directed at health care professionals; it is meant to serve primarily as an instruction to physicians.

The subject of conditional approval is complex and is very unlikely to be meaningful to a patient in the absence of an appropriate explanation from a health care professional. We believe that by instructing the prescriber to address this matter with patients, the message will be more effectively communicated and a patient's understanding will be greatly improved.

Finally, for the benefit of readers who may misinterpret Ages' reference to prophylactic use, we feel it is important to clarify that Relenza is currently approved by Health Canada only for the treatment of acute influenza, and not for influenza prevention.

Michael D. Levy
Senior Vice-President, Research and Development
Chief Medical Officer
Glaxo Wellcome Inc.
Mississauga, Ont.

Electronic wonderland

Peter Singer laid out a very intriguing scenario in his article on the future of medical journals.[1] Certainly many of the developments he outlined are here or will come true in the foreseeable future for some users of medical literature. The key words, however, are "future" and "some users." In many ways we are not into the dawn of a new information millennium in terms of equitable access to electronic medical literature. With health care and library budgets being continuously cut, the costs of the ever-changing technology are often beyond the means of many. Knowledge may be a great leveller, but access to information is not always equal.

Singer shows some naïveté in stating that everyone — authors, publishers, advertisers and subscribers — will be "delighted" with the new electronic publishing medium. Vested interests and economic imperatives are not that easily shifted by the glimmer of technology. And to state that subscribers will be grateful to pay $200 per year for a journal shows a singular lack of understanding of the current pricing realities of periodical publishing. One doubts that the major publishers will just roll over and forsake the accumulation of profit in the interests of humanity. With due regard for his refreshing sense of hope, I might suggest that Singer pay equal attention to the increasingly dire situation in many of our academic and hospital libraries. Budgets decrease annually in relation to the real cost of delivering ever-growing amounts of information by increasingly sophisticated and often costly means. Let's get the basic methods of knowledge transfer down pat before going off on an enthusiastic tangent about the electronic wonderland that awaits us.

John Tagg
Health Disciplines Library
West Park Hospital
Toronto, Ont.

Reference

1. Singer PA. Medical journals are dead. Long live medical journals. *CMAJ* 2000;162(4):517-8.

I write in response to Peter Singer's article on the future of medical journals.[1]

It's the year 2015. With the exception of trauma specialists, doctors no longer exist. As research findings are immediately available to the public via the Internet and the news media, everyone knows what pills to take. Pharmacists are allowed to dispense medications directly to an informed public.

The process of delicensing the occupation of physician began when doctors started making treatment decisions on the basis of abstracts found in MEDLINE rather than after reading and evaluating complete articles for themselves. From there, the capsule comments and notations provided by e-publishers became the sum total of doctors' reading, making them basically equivalent to the general public. As a superior intellect and vast medical knowledge were no longer necessary to practise medicine, universities decertified most medical programs, with the exception of surgery — although there are now electronic resources guaranteed to provide a lay person with enough knowledge and guidance to perform creditably in any cyber-equipped operating room.

Everyone is happy — although there is some suspicion that this may be the result of the pills everyone is now taking for general well-being as found on the Net.

Gord Lindsay
Toronto, Ont.

Reference

1. Singer PA. Medical journals are dead. Long live medical journals. *CMAJ* 2000;162(4):517-8.

[The author responds:]

I thank John Tagg and Gord Lindsay for responding to my article[1] in which I sketched a vision of the future of medical publishing — only time will tell how unrealistic or naïve it is. I don't expect publishers to roll over, as Tagg suggests, although I predict publishers who do not innovate will be bowled over by the tsunami of elec-

tronic publishing bearing down upon them. Despite the parody in Lindsay's letter, the vision of a public informed and active in health matters is a good one. Lindsay and Tagg neglect the key point in my article: there is a terrible inequality in medical knowledge around the world, and we need to find innovative ways to remedy this in the interests of global peace and justice.

Peter A. Singer
University of Toronto Joint Centre for Bioethics
Toronto, Ont.

Reference

1. Singer PA. Medical journals are dead. Long live medical journals. *CMAJ* 2000;162(4):517-8.

Do the right thing

Charlotte Gray's report on Canada's hospital emergency department crisis[1] showed that we must take off our blinkers. As Gray reported, this was done in major hospitals in Alberta and Saskatchewan, where staff anticipated the arrival of the annual flu season in order to avoid emergency department overcrowding. Far too often, planning like this is anathema to solo practitioners, both specialists and FPs, who act as if they are running a corner store.

Surely medicine is not only a business but also a public service. That, and the responsibility to care for individual patients, should lead to 24/7 service. Why is this not the universal standard? Why is it not a moral as well as a legal requirement of medical practice? The hospital emergency department is not a substitute for continuity of practice, and it is the next best thing to a cop-out to use emergency departments as an alternative to the doctor's office.

As a pathologist, I was part of a group that provided such service at night and on weekends. I am sure that evening and weekend coverage by a physician as part of a formal or informal group is the least the public can expect. Being on call once in 7 nights or weekends is all that would be required in most cases.

Communication systems can now be used to route calls to the person on call without redialing, to provide at least a triage consultation. Medical bodies, such as the provincial colleges, should consider making such coverage obligatory and subject to disciplinary action. Come on, colleagues. Let's do the right thing for our patients!

J.V. Frei
Pathologist (retired)
Toronto, Ont.

Reference

1. Gray C. Hospital crisis? What crisis? *CMAJ* 2000;162(7):1043.

We protest!

You recently published an article regarding Paras Naik and reported that "at age 22 he will become the youngest Canadian to hold a medical degree."[1]

I wish to report that Pamela Veale graduated from the University of Calgary Faculty of Medicine in 1993 at the age of 21. I am certain of these facts because I was a classmate of hers and am now her husband. By the way, another classmate of mine, Earl Campbell, obtained his MD at age 22.

Alan C. Tiessen
Anesthesiologist
Calgary, Alta.

Reference

1. Sullivan P. Paras Naik, MD: how Scotland produced Canada's youngest physician. *CMAJ* 2000;162(6):870.

Paras Naik is a remarkable young man but he is not the youngest Canadian to hold a medical degree.1 He may hold that honour in the year 2000, but not historically.

My father, Douglas J. Patchell, graduated from the University of Toronto in 1946 at age 20 and began practising in Hillsdale, Ont., at age 21. Bette Stephenson, a past president of the CMA, also graduated from medical school at age 20, if my memory serves.

Paul Patchell
Coldwater, Ont.

Reference

1. Sullivan P. Paras Naik, MD: how Scotland produced Canada's youngest physician. *CMAJ* 2000;162(6):870.

As I am rapidly sliding into advancing middle age, I must protest about an issue dear to my heart. I graduated from the University of Toronto in 1968 at age 21, 4 months shy of my 22nd birthday. I can't claim to be the youngest U of T graduate, but I'm sure there were also others younger than 22. So I must take exception to hearing Paras Naik[1] described as Canada's youngest doctor, because he isn't!

Compulsively yours,

Irena C. Szparaga
Family physician
Weston, Ont.

Reference

1. Sullivan P. Paras Naik, MD: how Scotland produced Canada's youngest physician. *CMAJ* 2000;162(6):870.

[The news and features editor responds:]

The article was meant to refer to Paras Naik's status in the year 2000 only. We were well aware, for instance, that during the war years the compressed medical curriculum meant that Canada was producing many doctors who were barely out of their teens. However, these letters did raise another question among *CMAJ*'s aging editors. Does anyone know how old Canada's oldest medical graduate was when he or she graduated?

Patrick Sullivan