Is Newfoundland's increased health spending part of premier's bid to become PM?

Newfoundland Premier Brian Tobin put more than just an accent on health care in his government's latest budget, which uses deficit financing and a roll of the dice to pump substantially more money into the province's hospitals and clinics.

Tobin — who in recent months has earned a national profile in his fight for increased medicare spending, using tactics that critics say have more to do with his own ambitions than with health reform — has been under considerable pressure to improve health delivery on his home turf.

To that end, overall health-care spending in last week's budget increased $136 million to about $1.2 billion. The total provincial budget is now $3.4 billion. "We have put our money where our mouth is," Tobin said on budget day, touting the plan as a wise reaction to demonstrated needs. He added that most other sectors of the government will hold tight to existing budgets because health is the top priority.

Tobin's gestures on health care at home are often derided by the political opposition, which says they are being motivated by his own career interests. Tobin is widely known to be interested in succeeding Jean Chrétien as Liberal party leader and as prime minister. A March Toronto Star poll of Liberals determined that Tobin ranks second only to Paul Martin as a potential successor to the prime minister.

Much of the extra money has been earmarked for one-time capital expenditures and hospital upgrading, including projects that were delayed in the belt-tightening 1990s.

The governors of the province's regional health care boards, which operate hospitals and nursing homes, have also been allotted extra money, but not enough to cover existing deficits. Moreover, they have been asked to find at least 1% of their budgets in cost-saving "efficiencies." Still, the extra financing was welcomed as a promising start by groups such as the Newfoundland and Labrador Medical Association.

The province is taking budgetary risks to bolster health care. After running consecutive budget surpluses, the province is forecasting a deficit this year of $34.7 million. As well, the reinvestment will consume all of Newfoundland's share of a one-time Canada Health and Social Transfer payment, announced in February's federal budget and amounting to about $43 million.

The disbursement could have been used over 4 years. Finance Minister Lloyd Matthews said he is "quite confident" that Ottawa will spend more on health care in coming years.

In an interview with *CMAJ*, Health Minister Roger Grimes remarked, "We're confident that our gamble is not going to be a gamble. We think the money will be there next year."

Part of the government's confidence is rooted in the turnaround in Newfoundland's economy. For the last 2 years, real economic growth in the province has led the rest of the country, and is forecast to do so again, thanks largely to offshore oil production and a diversified fishery.

Grimes said the provincial government has been under pressure to attend to health, in part because of frequent reports of inadequate access. He described such reports as "partially politically driven, partially based in reality."

Tobin himself had built high expectations for a budget focused heavily on better health care management. This winter, he gave several high-profile speeches across the country on the state of medicare. For instance, in Ottawa in January he described the "funding crisis in medicare" as a national "tragedy" and added his mission was to "issue a wake-up call." — *John Gushue*, St. John's

Making her stamp on the globe

Canada's medical missionaries, and in particular Dr. Lucille Teasdale, have been honoured with a new Canada Post stamp. Teasdale, who ran a hospital in Uganda with her pediatrician husband for more than 30 years, was one of Canada's first female surgeons. She and her husband converted a 45-bed clinic in Gulu, Uganda, into a 450-bed facility with surgical and pediatric wards and schools for nurses, laboratory technicians, health educators and physicians. Teasdale, who was born in Montreal, earned the Order of Canada, Order of Quebec and the CMA's F.N.G. Starr Award, as well as international acclaim. She died in Uganda in 1996 from complications relating to AIDS. The work of 5 Canadian physicians are celebrated in Canada Post's Millennium Collection.

Patient's choice: Doctor or nurse practitioner?

For the first time, Nova Scotia is to begin using nurse practitioners outside the tertiary care setting. The nurses are the cornerstone of new primary care projects about to begin in 4 rural communities.

Health Minister Jamie Muir stresses that nurse practitioners will work closely with doctors and will not be allowed to prescribe experimental or controlled drugs. "The pilot projects are going to be an integrated system. There will be a physician or a nurse practitioner, and other people as well. So it won't be like the nurse practitioner is in an office at one end of town and the physician is way down at the other end of town. The nurse practitioners are not going to be making profound diagnoses and then acting as though they were fully qualified medical doctors."

As well, patients who are uncomfortable with NPs can choose to see a physician instead, says Harriet McCready, director of primary care in the provincial Department of Health. "Nobody is going to force a patient to do one thing or another."

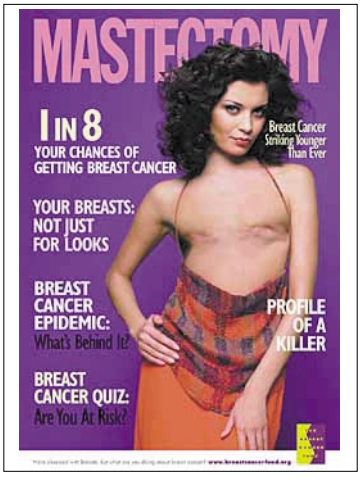
In addition, she notes, doctors and nurse practitioners can refer patients to each other, with problems beyond the scope of the nurse practitioner being addressed by a physician. Likewise, if there is a procedure that needs to be done and could be done easily by a nurse practitioner, the doctor might suggest this to a patient.

In order to allow for the use of NPs in Nova Scotia, the Pharmacy Act was amended to allow nurses to prescribe certain drugs, including birth control pills and blood pressure medication. The new legislation will remain in force for 3 years while the primary care pilot projects are running. If the projects prove successful, the Pharmacy Act could be amended to allow for the ongoing use of NPs in the province, the health minister says.

In addition to nurse practitioners, the four primary care projects, funded primarily by Health Canada at a cost of $2.85 million, involve developing new computerized information systems and new payment options for physicians. — *Donalee Moulton*, Halifax

Censoring breast cancer in San Francisco

San Francisco has been scandalized — by a health awareness campaign. The city, which barely flinched when the local zoo offered $40 "viewings" of mating animals on Valentine's Day, was rocked by bus shelter posters depicting provocatively posed women with mastectomy scars.



Transit authorities in Santa Clara County pulled all 17 advertisements there after receiving complaints in late January. Another 4 posters were removed in the East Bay. The company with exclusive rights to bus shelter advertising within the City of San Francisco initially agreed to accept the ads, but changed its mind when it saw them. "I looked away," the company's local director told the San Francisco Examiner, referring to a poster that parodied a Cosmopolitan magazine cover.

The ads were developed by the Breast Cancer Fund, an 8-year-old national nonprofit group (www.breastcancerfund.org) based in San Francisco, which has one of the highest breast cancer rates in the world. Designed to resemble a Cosmopolitan cover, a Victoria's Secret catalog and a Calvin Klein perfume ad, the posters all show professional models with mastectomy scars superimposed on their chests.

The scars belong to Andrea Martin, the Breast Cancer Fund's 53-year-old founder and executive director. "The models, advertising executive and photographer donated their time. I donated images of my mastectomy scars," says Martin, a former lawyer and restaurateur who underwent mastectomies in 1989 and 1991.

The ads are intended to depict America's obsession with breasts as symbols of nurture and sexuality, pointing out the deadly, disfiguring effects of breast cancer. By early March, the Breast Cancer Fund had received thousands of letters and emails about the campaign, 80% of which supported the ads, Martin said.

In Canada, the ads provoked mixed responses among breast cancer survivors contacted by *CMAJ*. Karen DeKoning, president of the Canadian Breast Cancer Network, found some of the ads objectionable. "Using a photo of a woman's scars to make a point is acceptable, but bringing sex into the picture to me is prostituting the woman for the cause," said DeKoning, who emphasized that she was speaking as a survivor, not on behalf of her group. A member of her board, Lynn Macdonald of Kelowna, BC, supported the ads. "Some people may be offended," Macdonald said, "but the realities of breast cancer, when they hit home, are severe, devastating and in some cases deadly."

While many of the bus shelter posters were removed, another outdoor advertising company offered free billboard space to the Breast Cancer Fund. — *David Helwig*, London, Ontario

First Canadian live-donor lung transplants performed in Winnipeg

Canadian medical history was made in Winnipeg last December with the first lung transplant that used healthy, single lobes from 2 living donors. A second live-donor lung transplant has since been performed by a team headed by Dr. Helmut Unruh, director of the Manitoba Lung Transplant Program at the Health Sciences Centre. The first patient has been discharged, but the second has since died of cardiac complications.

"Many of my colleagues wondered if [the transplant operation] was worth it," Unruh commented. "Does the outcome justify the risk to the donors? With a 5-year survival rate of 60% on lung transplant, does it warrant it? But any transplanted organ [has] a finite lifetime."

Unruh believes the procedure is worth the risk, given the lengthy waiting list for cadaveric donations and the condition of the patients involved. For the donors, the life-long outcome is a reduction of approximately 20% of their lung capacity, perhaps preventing them from marathon running but not restricting them from a generally active life.

Unruh said the procedure itself is similar technically to a cadaveric lung transplant. He said allowance must be made for smaller vessels because the transplanted lobe might not fill the entire thoracic cavity. This is one of the reasons why children and small adults are the primary candidates for live-donor lung transplants. The limited number of small cadaveric lungs available for transplantation also places them in the live-donor recipient category.

Although the procedure remains relatively new — about 60 of the operations have been performed worldwide — Unruh has advised other patients to start looking for possible live donors.

"There is no bank of [living] lung donors so the responsibility for procuring a donor is the patient's or the family's, or a coordinator appointed by them, depending on the complexity," said Unruh. "The hospital can't go and solicit lung donations."

Having live donors has added a new dimension to lung transplantation. Unruh said the team had to consider how to screen donors and consider their motivation. It would be advantageous, he suggested, to learn about psychological considerations in screening live donors.

As Unruh and his team pursue live-donor transplants as an option for some patients, centres in Toronto, Montreal and Vancouver are expected to start performing the procedure. Although Unruh's colleagues across the country are waiting to see the longer-term outcome, families of patients on organ transplant waiting lists may be looking to a new window of opportunity and hope. — *Jane Stewart*, Winnipeg

Courts' views on MDs' standards of practice changing, rural docs warned

It appears that the longstanding legal practice of lowering the standard of practice to accommodate the limited facilities and resources available to Canada's rural physicians is becoming a thing of the past.

Recent US decisions indicate that, because of advances in communication technology and access to larger centres of education and science, the courts no longer automatically adjust the standard of practice downward according to a physician's practice location. Instead, said Niels Ortved, managing partner McCarthy Tétrault, a Toronto law firm specializing in medicolegal cases, "appropriate allowances" are being made.

"Historically, the locality rule was often relied upon to recognize the differences between urban and rural medical practices," Ortved told about 150 surgeons attending a recent medicolegal course at the University of Toronto. "However, the advantages of modern communication and education have reduced the disparities between rural and urban practices."

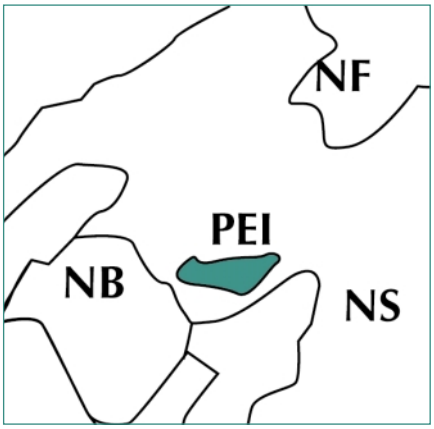
As a result, locality is merely one circumstance that is considered by the court in setting the standard of care imposed upon a physician when medical cases end up in court. He advises rural physicians to be "mindful of their access to information on tertiary care centres" and "be diligent to tap into these resources when appropriate."

In rural Manitoba, for example, a family physician was sued for failing to inform a patient about the side effect that a drug could have on her fetus. The doctor argued that his practice was in accordance with the standard of rural practitioners. The judge rejected his argument, saying that the doctor could have easily acquired more information.

In other words, said Ortved, "the court held that the doctor failed to conform with the basic standard of care to which all physicians must be held — regardless of the location of their practice — to make use of the tools available to them to obtain in a timely manner the facts and information on which to make an informed decision, which may include referring a patient to a tertiary care centre." — *Barbara Sibbald*, CMAJ

PEI spending $4.2 million to boost physician supply

The Prince Edward Island government is spending $4.2 million over the next 4 years to attract new doctors to the province. At the heart of the plan are



initiatives for sending local residents away to medical school on condition that they come home to practise. "New funding of $4.2 million will provide strong incentives for young Islanders to consider a career in medicine and return here to practise, while strengthening our current position in an increasingly competitive job market," says Premier Pat Binns.

The 12-point plan, developed in consultation with the Medical Society of PEI, the health regions and Island medical students, includes strategies to support existing physicians, as well as recruit new ones. "It contains a balance of immediate and longer-term strategies to ensure that Islanders have continued access to physician services," says Health and Social Services Minister Mildred Dover.

Under the plan, the government is purchasing 2 new medical school seats at Memorial University in Newfoundland for the exclusive use of PEI applicants. This brings to 8 the total number of seats set aside for Islanders (6 seats are allotted at Dalhousie University and 1 in Quebec).

More family practice training opportunities will also be created so that as many as 12 family practice residents can do at least part of their training in PEI each year. Family physicians who have practised in the province for a minimum of 2 years will have access to specialist training opportunities, while new medical trainee sponsorships will be put in place to help medical students and residents. They must agree to return to practise in the province for 1 year in exchange for each year they are sponsored.

The provincial government is also hiring a recruiter and allocating more resources for prospecting, advertising and marketing and host visits. In addition, location grants — on a par with those offered by larger provinces — will be provided to new doctors who agree to practise in specific communities for a set period. — *Donalee Moulton*, Halifax

Balancing controversy and intelligent debate in the media

The speaker at a recent seminar at McMaster University, which focused on ways to publish controversial evidence and stimulate an intelligent public debate while avoiding a media circus, was perfect. After all, *Lancet* editor Richard Horton is no stranger to controversial articles.

The most recent article involves the merits of breast cancer screening. He recounted that in early January, *The Lancet* published a paper concerning the analysis of randomized trials that investigated breast cancer screening. It revealed that the benefit of screening was only significant in those trials which were poorly randomized. "We felt this was a very technical inquiry into the details of randomization in these 8 trials, and that there needed to be some open debate about this, particularly because the Danish government had tried to suppress it," he said. Recognizing that the evidence was contrary to a decade of health policy, a commentary accompanied the paper; it noted that the trials were old and that the screening technologies were out of date.

Horton said media response in the UK was swift, with headlines declaring that breast cancer screening was a waste of time and that screening programs should be reconsidered. The hope of an intelligent debate was quickly lost: within days, media outlets determined that they couldn't decide one way or the other on the issue, and then ignored the report. In essence, Horton said, "2 days of debate and move on to the next scare story."

He experienced the same frustration with new variant Creutzfeldt-Jakob disease and beef consumption. While the media focused on the death of a new mother, the scientific debate was buried. He has come to appreciate, he said, the power the experience of an individual patient can have. The next step will be to determine "how one melds that narrative-based medicine, which fundamentally deals with the individual case, with other issues to do with more classical epidemiology."

As editor, Horton must evaluate whether instigating a public controversy is worth it. Based on his belief that medical science should aim for a refinement of debate, he continues to publish controversial evidence, although he has learned some hard-earned lessons. He says it is important to "work closely with the authors to try to get a proper and consistent message out." This may require participating in press conferences or even managing conflicts within a research team. Although not always successful, he now tries to anticipate and actively manage the spin that journalists may place on an issue. — *Wendy Wilson*, York, Ont.

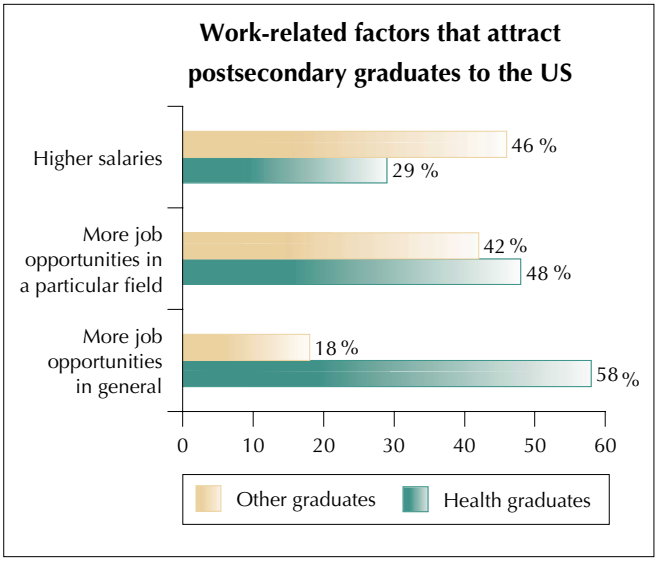
Pulse

The brain drain: a statistical snapshot

A Statistics Canada and Human Resources Development Canada study of postsecondary school graduates who moved to the US has determined that 1.5% of members of the 1995 graduating class had emigrated to the US by the summer of 1997.

Of the more than 4600 Canadians who graduated in 1995 and emigrated, 1300 (almost 30%) were graduates of health-related programs. At the university level, graduates of health programs accounted for 20% of those who moved to the US but for only 8% of total graduates remaining in Canada. Within the college-level group, 54% of those who moved to the US were graduates of health-related programs; only 15% of college-level students remaining in Canada were from those programs. The majority of college graduates who moved to the United States were nurses. Texas and Florida were favoured destinations, claiming 47% of emigrating health graduates.

The study found that graduates in health fields were highly likely to have relocated to the US for work-related reasons (87%, compared with 57% of all graduates who relocated). Greater job opportunities, both in general and in a particular field, were the factors most likely to attract health graduates to the US. Graduates in health fields were less likely than graduates of other programs to mention higher salaries as a major factor in their decision to relocate. The vast majority of health graduates who moved to the US (87%) began work immediately, compared with only 57% of all graduates who moved. — *Shelley Martin*, CMA, **martis@cma.ca**



NS radiation oncologists opt for salary

It's bye-bye fee for service and hello salary for Nova Scotia's 9 radiation oncologists. The move to "fixed payments" is part of the health department's efforts to increase the number of cancer specialists practising in the province. "Cancer specialists are in high demand across Canada and throughout North America," says Health Minister Jamie Muir. "Moving from fee for service will help us attract and retain radiation oncologists, enabling us to provide high quality cancer care to patients. The agreement enhances the working environment for these doctors by allowing them to spend more time with patients and involved in research and academic interests."

The proposal to put radiation oncologists on salary was originally brought forward last spring by Dr. Paul Joseph, the provincial head of radiation oncology. He says the new method of payment means that the province can now offer the specialists a competitive compensation package — an important factor in recruiting. On average, Nova Scotia's radiation oncologists were making 20% less than their Canadian counterparts. The new payment method "frees us from the yoke of fee for service," says Dr. Andrew Padmos, Nova Scotia's Cancer Care Commissioner. "We're in a position to match or better salaries paid for medical oncologists in other parts of Canada."

The strategy has worked. Last year there were only 6 oncologists on staff at the Queen Elizabeth II Health Sciences Centre, and several vacancies. This fall the last 2 vacancies will be filled, despite stiff competition across the country, where there are more than 20 vacancies for these specialists. The health department has also approved the addition of 3 new radiation oncologists to the province's cancer care team. These positions will be phased in by October.

But staffing is only the beginning, notes Padmos. "We've plugged the holes in the roof. Now we're going to start on serious renovations. We have an organizational structure and mandate to make cancer care better. We're poised to do a lot of change in the system in a short period." — *Donalee Moulton*, Halifax

On the Net

New and improved: CMA's guidelines infobase now at MDs' fingertips

The CMA's online database of clinical practice guidelines (CPGs), the *CMA Infobase* (**www.cma.ca/cpgs**), made its much-anticipated debut in early March during the CMA Leadership Conference in Ottawa.

Formerly known as the *CPG Infobase*, the product was renamed *CMA Infobase* after recent focus group testing revealed that physicians did not have a clear understanding of the CPG acronym.

The new product represents a giant leap forward from the original collection of browsable lists launched in 1996. A search engine now allows direct searching of the CMA's rich internal CPG database, expanding coverage to guidelines from more than 100 developers and thereby establishing the Infobase as a one-stop, comprehensive national resource. The new version offers descriptive details on all current Canadian CPGs and supplementary information on their development, implementation and evaluation, as well as other resources such as quick reference guides and patient versions of guidelines. Most important, links to the electronic full text of both the guidelines and associated resources are included when available, as is any available structured abstract. Important contact information, including email links, is also incorporated.

A simple keyword search capability is offered from the *CMA Infobase* Home Page. However, for greater precision, use the Basic Search interface. Basic Search offers users the ability to combine keywords, medical subjects headings (MeSH), medical specialties and publication/review dates. Searches can be limited by language or by the date when records were added to the database. Users can create a personalized list from their search results and change record-display formats to view additional information.

A group of more than 30 volunteer physicians, health researchers and policy-makers, medical librarians, Webmasters and staff of various Canadian specialty societies participated in beta testing the Infobase. Their feedback allowed the CMA to fine-tune the Infobase before its release. One important recommendation included the opening of a second browser window whenever users leave the site, allowing them to explore off-site resources without losing their position in the Infobase. Links to other reputable guideline collections have also been added to the Home Page.

The new interface will be launched in stages. A bilingual Advanced Search interface offering additional power and flexibility for creating and combining search sets, as well as for saving search strategies for later use, is anticipated later this year. — *Becky Skidmore*, CMA Infobase Manager

And the winner is . . .

CMAJ's second OSLER Challenge has been won by Dr. Henry Phillips of Kingston, Ont. (see *CMAJ* 2000;162[2]: 251). OSLER (the CMA's free online search service) users were asked to submit the MEDLINE searching strategy that they used to answer this question: Is there any evidence that zinc lozenges shorten the duration and severity of the common cold in children? A copy of Jacalyn Duffin's *History of Medicine: a Scandalously Short Introduction*, goes to Phillips. Details of the strategy needed to conduct the search and various searching techniques will be reviewed in a future On the Net column. Physicians interested in using OSLER can contact Member Services, 800 457-4205.

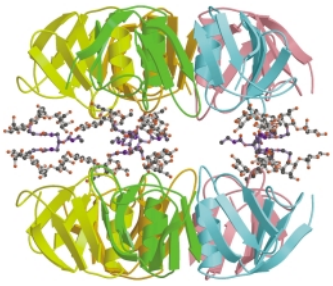
Research Update

A Starfish that stops deadly toxins

A simple injection to treat often-deadly cholera and hamburger disease may be developed in the future, thanks to a research team at the University of Alberta that has designed a molecule to treat enterotoxins (*Nature* 2000;403:669–72).

Shiga and cholera toxins, caused by gastrointestinal pathogens, are responsible for millions of deaths annually. Once the toxins enter the circulatory system, they cause cramps, bloody diarrhea, vomiting and fever. Many patients eventually suffer severe kidney damage because there is no effective cure.

But the newly developed "Starfish" molecule holds tremendous promise, standing out during in vitro tests as 1 million to 10 million times more effective than any other inhibitor of these toxins. That is no small feat. Shiga and shiga-like toxins are armed with 15 binding sites in 3 groups of 5 that lock onto cell surfaces. The Starfish molecule designed by Dr. David Bundle's team mimics receptors on healthy cells that the toxins seek out, acting as a decoy to lure the toxins away from the body. And, because of its shape, the Starfish molecule can lock onto 2 toxin molecules simultaneously.



"We have embraced the whole surface so, if you like, we have taken 2 donuts and stuck them together," says Bundle. "These 2 surfaces are now facing each other with the inhibitor [Starfish molecule] in the middle. The toxins are facing each other so they are totally prohibited from binding to another cell."

The molecule's ability to take on 2 toxin molecules at once was a pleasant surprise. "It was better than we envisaged. It was an accident, but it worked in our favour."

Currently, clinical trials are under way to test an insoluble absorbent called Synsorb Pk that could attack the toxins in the gut. But because the Starfish molecule is soluble, it could be used as an injectable treatment to clean up toxins in the bloodstream, where they cause the most damage.

"The real problem is for patients who have toxins that have exited the gut and entered the circulation. Our molecule could be used as an injectable that could neutralize the toxin in the circulation system," says Bundle. — *Richard Cairney*, Edmonton

Suicide linked to serotonin gene

Canadian researchers have discovered a genetic mutation that appears to double carriers' risk of suicide (*Am J Med Genet* 2000;96:56-60). The finding could be a significant first step toward developing a test to identify at-risk people and improving prevention and treatment.

In a study involving 251 patients, Dr. Pavel Hrdina and colleagues from the University of Ottawa's Institute of Mental Health Research (IMHR), found that a mutation in the gene encoding the serotonin 5-HT_{2A} receptor was much more common in patients with major depression and suicidal tendencies. Serotonin has long been recognized by scientists as playing a major role in mood regulation, depression and suicide.

"Ours is one of the first demonstrations that a variant of a gene encoding a neurotransmitter receptor is associated with clinical signs of suicidal behaviour," says Hrdina, director of the neuropharmacology lab at IMHR. "This is a small step toward understanding the genetic basis of suicidal behaviour and identifying the contribution that various genes may make to a complex behavioural syndrome such as suicide." The Canadian researchers believe the genetic variation also may help explain the higher incidence of suicide among people with schizophrenia.

Hrdina, along with Drs. Lisheng Du and David Bakish, analysed DNA in blood samples drawn from 131 people with no mental illness and 120 patients with major depression, 78 of whom were suicidal. They found the genetic mutation in 41% of suicidal patients and 24% of non-suicidal patients with depression, but in just 18% of the healthy control group.

The team has shown only that a variant of a gene encoding for a seratonin receptor is significantly associated with increased risk of suicidal behaviour in patients with depression, cautions Hrdina. "We did not show the existence of a 'suicide gene.' It is unlikely that any single gene will be a causative factor." Because the study focused on people with major depression, its findings cannot be generalized to otherwise healthy individuals who attempt to take their life as an isolated call for help or attention, say the researchers.

Replicating and confirming the team's results, and identifying other genes linked to increased risk of suicide, would pave the way for a genetic marker test. Treating those individuals who test positive for the genetic variation, says Hrdina, could prevent unnecessary loss of life. — *Greg Basky*, Saskatoon

Public Health

Female genital mutilation

Epidemiology

The removal of external female genitalia has been part of a celebrated ritual in the lives of girls and women in some cultures and countries for centuries. Despite a growing international campaign to abolish female genital mutilation (FGM) that has been endorsed by both the World Medical Association[1] and the World Health Organization,[2] many still see this tradition as an effective and acceptable method of controlling women's attitudes toward sex and sexuality and of ensuring their virginity and suitability for marriage. An estimated 120 million girls and women have undergone FGM, and approximately 2 million procedures are performed annually on girls under the age of 11.[3] Most commonly performed in Africa, FGM is also practised in parts of Southeast Asia, the Middle East and in Central and South America. In countries such as Somalia, an estimated 70% to 90% of women have undergone FGM.[4] Civil unrest has brought several waves of refugees who have undergone FGM to Canada, where they seek health care.

WHO adopted the term "female genital mutilation" in 1996 to describe any of 4 forms of the procedure.[3] The least invasive is the clitoridectomy, also known by the Arabic term *sunna*, which involves excision of the prepuce and part or all of the clitoris. The second form, "excision," involves removal of the clitoris and part or all of the labia minor. "Infibulation," which means "to fasten with a clip or buckle," is the most invasive form and is most common in Somalia, Ethiopia, parts of Kenya and the Sudan. It involves removal of the clitoris, all of the labia minor and part or all of the labia majora, and the pinning or stitching of the two sides of the vulva closed. A narrow opening is left for urinary and menstrual outflow.

A fourth, unclassified type includes procedures such as pricking, piercing, stretching, scraping or cauterization.

Table 1: Rates of female genital mutilation (FGM) and of literacy in selected countries

Country	Usual type of FGM	Prevalence of FGM, %	Female literacy rate, %
Egypt	Excision/infibulation	60	34
Kenya	Excision	60	59
Nigeria	Excision/infibulation	60	40
Somalia	Infibulation	99	9
Sudan	Infibulation	85	12

Source: Health Canada.[4]

Clinical management

Immediate complications include severe pain, urinary retention, hemorrhage and infection. Canadian physicians are more likely to encounter the chronic health effects, including urinary tract infections and painful menstruation. They must also manage prenatal care and vaginal deliveries involving infibulated women.[3] The American College of Obstetricians and Gynecologists has developed a kit, available through its Web site, to help doctors handle delicate issues like requests for deinfibulation (reversal of the procedure) or reinfibulation (reclosure following vaginal delivery).[5]

Prevention

In Canada, FGM is considered child assault and prohibited under sections 267 (assault causing bodily harm) or 268 (aggravated assault, including wounding, maiming, disfiguring) of the Criminal Code.[4] Some provincial colleges have issued statements advising physicians to refuse requests to perform FGM or reinfibulation.[6,7]

The National Organization of Immigrant and Visible Minority Women of Canada has prepared a workshop manual for health care workers and facilitators working with communities that have traditionally practised FGM.[3] The aim is to educate participants about the health and legal consequences of FGM, to correct misperceptions and fallacies about the tradition and to support efforts to eradicate the practice.[3] In 1994, the Federal Interdepartmental Working Group on Female Genital Mutilation was established. Its mandate is to identify and promote methods to prevent the continuation of FGM by families now living in Canada. This organization is establishing a national FGM network and preparing a Health Canada document for dissemination.[4]

Further information is available from the National Organization of Immigrant and Visible Minority Women of Canada (tel. 613 232-0689), the Federal Interdepartmental Working Group on Female Genital Mutilation, Health Canada (tel. 613 957-1944) and the Circumcision Information and Resource Pages (**www.cirp.org/pages/female.html**) — *Erica Weir*, CMAJ

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Enter the hospitalist: new type of patient creating a new type of specialist

Patrick Sullivan

Canada's shortage of family physicians is so severe that it is creating unprededented demand for a new type of medical specialist, the hospitalist.

These new specialists, usually internists but sometimes family physicians, take over responsibility for the care for "orphan patients" who arrive in hospital without an FP or someone else to assume the role of most responsible physician (MRP) during the patient's hospital stay. In many cases, patients become orphaned when family doctors resign their hospital privileges because of the increasing demands associated with hospital-based care.

Dr. Tom Dickson, chief of staff at the William Osler Health Centre in Brampton, Ont., said the FP shortage is so severe in the ring of suburbs surrounding Toronto — the "905 belt" — that dozens of orphan patients are arriving at local community hospitals every day.

He told 120 physician managers attending the recent annual meeting of the Canadian Society of Physician Executives (CSPE) that the hospitals are then forced to find a doctor willing to assume the MRP role.

Enter the hospitalist. Dickson, who noted that the word didn't exist before 1996, said there are now more than 10 000 hospitalists in the US, primarily because of the advent of managed care. Now the movement has come to Canada. Dickson's 350-bed community hospital has just hired its first 2 hospitalists, a geriatrician and a general internist. In Canada, the term defines doctors who spend almost all of their practice time managing the care of hospital inpatients. The hospitalist issue is primarily confined to community hospitals because training staff and medical specialists fill the MRP role at large teaching centres.

In community hospitals, surgeons still assume the role for surgical patients, but for internal medicine patients the role was presumed to belong to family doctors. No longer. "At many large community hospitals in my area, the FPs have threatened or actually withdrawn from the role of MRP for patients who are admitted and do not have a family physicians on staff," Dickson explained. "And now they are extending this withdrawal to their own patients."

Hugh Malcolm

Dr. Les Pattison, chief of medical staff at the Royal Victoria Hospital in Barrie, Ont., says staff managers throughout southern Ontario are becoming familiar with the problem. "It really started to be noticeable in the past 2 years," said Pattison. He said the orphan-patient problem first became serious in Windsor, Ont., which has a well-documented shortage of FPs.

Although family doctors working a hospital rotation have traditionally taken over MRP responsibilities for orphan patients, Pattison said the low fee paid for providing this service — $13 in Ontario — combined with the growing number of orphans and added responsibilities, meant that many FPs refused to accept them. "Physicians have a healthy dose of altruism, but after a while the goodwill starts wearing thin," he said.

Dickson, a past president of the Ontario Medical Association, said that both financial and social issues are driving family physicians from hospital work. "At our hospital," he said, "we charge more for parking than physicians can make caring for orphan patients."

He also thinks physicians are being driven away from hospitals because today's patients tend to be sicker and to be released earlier, "sicker and quicker" in today's doctors' lounge jargon. This means that the FP might become responsible for an orphan patient released from hospital following an acute illness.

"Family doctors have found this situation increasingly stretching their comfort zone, particularly when covering each other's practices after hours," said Dickson. "And they're dealing with a payment system that reflects fee relativity based on acuity levels from the 1970s."

As a result, "serious cracks" have started to appear in what, until 18 months ago, had been a "very stable system of care."

At Dickson's hospital, the newly hired geriatrician and general internist work 8 am to 5 pm shifts and deal with all orphan patients; each hospitalist handles 12 to 15 patients a day, with a 5-

physician call group providing after-hours coverage. "Our experience to date is that it is working," he said. "And the family physicians seem to be happy."

Dickson said hospitals are in a difficult position because family doctors no longer need them to remain busy. "The demand [for physician services] today is such that you can survive quite well from your office."

He has 4 suggestions for dealing with the current problems:

- fix the payment system, which is "a mess";
- provide target funding to allow hospitals to hire hospitalists;
- produce more hospitalists, either general internists or FPs with enhanced training; and
- develop a welcoming environment for FPs in community hospitals.

Dickson admits that the introduction of the hospitalist carries risks. "We pride ourselves in Canada on our system of family physicians who quarterback their patients through the complete process of care. With the advent of the hospitalist, we are at risk of marginalizing the valued role of the primary care physician in the community."

Pattison agrees that the hiring of hospitalists is a potential solution, although it does raise budgetary issues because the dollars involved are "not insignificant."

Meanwhile, he remains concerned about what the future holds for his hospital, whether or not it hires hospitalists. "Barrie is 20 FPs short right now, we're not producing enough new graduates and the number retiring is growing. Things are just getting tighter and tighter all the time."

During the meeting, one doctor may have summed up the situation best with a question: "Where do I get some hospitalists? We want 3 right now."

There was no ready answer available at the CSPE meeting, but it was clear that more doctors in more hospitals are going to be asking the same question shortly.

Patrick Sullivan is CMAJ*'s News and Features Editor.*

Growing interest in group for MD managers

Membership in the 2-year-old Canadian Society of Physician Executives has passed the 250 mark and attendance at the second annual meeting more than doubled, organizers report. The fledgling society, designed as a networking and information-sharing organization, has proved particularly popular with physicians such as chiefs of staff.

"We were quite pleased with the attendance, which amounted to half of our membership, and feedback from the meeting has been very positive," said Dr. Chris Carruthers, the president. Carruthers, chief of staff at the Civic Campus of the Ottawa Hospital, said the organization hopes to hold some regional workshops in conjunction with other medical organizations in the next year.

Membership costs $75 a year. Doctors can join online (**www.cma.ca/cspe**) or by sending a cheque payable to the CSPE to Dr. Chris Carruthers, 3540 Paul Anka Dr., Ottawa ON K1V 9K8; **ccmd@home.com**.

Canada's new doctors turning backs on family practice

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Barbara Sibbald

Initial results from the 2000 residency match indicate that fewer of Canada's new doctors are choosing family medicine, while interest in obstetrics and gynecology appears to have rebounded.

Data from the first iteration of this year's match, completed in mid-March, indicate that 58 of the 445 family medicine residency positions went unfilled. Only 29% of new graduates selected family medicine as their first choice, compared with 32% last year and nearly 35% in 1997.

"One thing is very clear, and it is that the future of Canada's health care system is dependent upon 50% of our physicians in practice being family doctors," said Dr. Calvin Gutkin, executive director of the College of Family Physicians of Canada. He said governments, medical schools and medical leaders must pull together to reverse the trend.

Most medical specialties appeared to fare better this year. Last year, one-third of obstetrical residencies remained unfilled, but only 1 of the 46 positions went vacant this year. Anesthesia also continued to do well; all 60 positions were filled in 2000; in 1998, 15 of 58 spaces were not filled. Only psychiatry appears to be in the doldrums, with 11 of its 76 residency positions left vacant after the first round of the match.

In all, there were 101 residency vacancies left after the 1154 graduates went through the matching process. Eighty percent of students were matched to their top 3 choices, a slight increase over 1999. Of the 65 graduates who weren't matched, 12 are trying to go to the US. (Eighty-six doctors, including 39 graduates of foreign schools, were matched during the second round Mar. 28. Six slots in rural family medicine remained unfilled, and there were 3 unfilled spaces in psychiatry and 1 each in general surgery, general internal medicine, community medicine and general pathology.)

Sandra Banner, executive director of the Canadian Resident Matching Service, said the "serious" number of family medicine vacancies after the first round is probably due to "the radical change in the way family medicine is practised." A family physician shortfall is a sign that these doctors are overworked, and Banner said this has a negative effect on lifestyle. In addition, nearly all the incentives and disincentives for practice location focus on family medicine. Another factor in the declining numbers may be re-entry restrictions that make it very difficult for residents to switch from family medicine to a specialty later in their careers. "These things could be scaring them off," said Banner. Conversely, nearly every specialty has job opportunities galore, and several, including anesthesia and obstetrics, have been actively recruiting residents.

Residents may be giving Dalhousie the cold shoulder because they can take home about $10 000 more in Ontario.

Whatever the cause, "nationally, planners have some thinking to do on policies to address this," said Banner. "This is particularly true now that national groups are calling for a 50-50 split between family medicine and specialties."

Dr. Richard MacLachlan, head of family medicine at Dalhousie, heartily concurs, because 20 of his 44 family medicine residency positions remained empty after the first round of the match. This is partly because Dalhousie is in one of only 2 provinces that have increased the proportion of family medicine positions in its training program. Dalhousie, which had 29 of the positions in 1997, has 44 today.

This year, Dalhousie accounted for about a third of the vacancies in family medicine residencies after the first round, a result that MacLachlan describes as a "disturbing revelation."

Contributing factors include increased workload for family physicians, a growing reluctance to work in rural areas, and lower resident salaries and higher tuition fees on the East Coast. "There's a difference of about $10 000 just for the privilege of coming to Dalhousie," he said.

Saskatchewan was also hit hard, with half of its 22 family medicine position remaining empty after the first iteration. The main deterrent, according to a 1999 survey, is a reluctance to train in Regina, which has no medical school; 9 of the vacant positions are located in that city. Dr. Gill White, head of family medicine at the University of Saskatchewan, says something has to be done quickly given his province's declining number of family physicians. The university is planning to step up recruitment efforts. "The problems we have in this area are tied to problems we have with physician recruitment generally," said White.

The chairs of family medicine across Canada were slated to discuss the issue at the Association of Canadian Medical Colleges meeting in April.

Barbara Sibbald is CMAJ's Associate Editor, News and Features.

"Why does such a big issue rest on the shoulders of two citizens?" FP asks after losing private medicine battle

Susan Pinker

Jacques Chaoulli, a family doctor who petitioned a Quebec court last September to permit privately billed and insured medical care, finally got his answer in late February. "No," wrote Honourable Madam Justice Ginette Piché, the judge who presided over the hearings on creating a two-tiered medical system in Quebec.

Last fall, Chaoulli and George Zeliotis, a hip-replacement patient, were co-plaintiffs in a controversial case that pitted the testimony of a series of frustrated doctors and critically ill patients against federal and provincial lawyers and experts defending medicare.[1] In hearings spanning 4 weeks, witnesses repeatedly testified about the problems of a health care system run exclusively with limited public funds. A number of impassioned witnesses argued that a private parallel system operating alongside a universal public program would shorten the waiting periods for surgery and chemotherapy.

Chaoulli's primary contention was that restricted access to timely medical care contravenes the right to life, liberty and security guaranteed by the Canadian Charter of Rights and Freedoms. He opposes a government monopoly on health care and marshalled sources from Karl Marx to Jean-Paul Sartre to argue his point: most Quebecers are now forbidden to spend their savings to save their skins, and this violates their fundamental rights.

But Piché refused to strike down the articles of the Quebec Health Care and Hospital Insurance acts that prohibit doctors from providing private services in public hospitals and prevent Quebec residents from buying their own insurance to pay for private care. Preventing discrimination based on one's ability to pay does not violate the values of the charter, Piché stated in her 156-page judgement. And creating a parallel system would threaten the viability of the publicly funded health program.

At one time, said the judge, many sick Canadians did not seek medical care because they had no money to pay for it. Eliminating the profit motive is the reason why Quebec's health insurance and hospital acts exist, she wrote.

And despite the current problems with accessibility, which she described as short term, Piché defended the laws as guaranteeing "equal and adequate access to health care" for all Quebec residents. She emphasized the need to balance an individual's rights with the needs and values of society as a whole, and questioned Chaoulli's motives in creating a "crusade" against medicare.

This latest "crusade" is just one of a series of cases Chaoulli has brought before the courts on the right to practise medicine privately. Although he opted out of medicare between 1996 and 1998, he has since rejoined the system.

Dr. Edwin Coffey, a past president of the Quebec Medical Association and one of the physicians who testified in favour of allowing private health insurance coverage, said the latest decision was "quite a disappointment. They [Chaoulli and Zeliotis] are going to appeal the decision if they can raise the money."

Chaoulli estimates that it will take $40 000 to $50 000 to mount an appeal, including the cost of transcribing and photocopying testimony from the month-long hearing and its exhibits. So far there are no legal costs because the lawyers advising Chaoulli and Zeliotis have donated their time.

Even though they lost this battle, Chaoulli and Zeliotis still feel they have a chance to win the war. In a press release, they stated that Piché recognized that prohibiting citizens from buying private health insurance constituted a threat to their right to life and security as guaranteed by section 7 of the Charter of Rights and Freedoms. Chaoulli understands this to mean that the right of a patient to contract with a physician is protected, and therefore it follows that this right is reciprocal.

"When the judge said the patient has the economic right to contract with the doctor, then it doesn't make sense that the doctor doesn't have the right to contract with the patient. When you want to dance the tango, you can't dance alone."

Chaoulli's zeal and tenacity in preparing and fighting this case almost single-handedly is the subtext of a drama that may eventually reach the Supreme Court of Canada. Even Piché found his intense commitment overwhelming at times, commenting that "everyone was so tired, except Dr. Chaoulli, who was tireless."

Chaoulli agrees that his focus is unwavering. "If you want to prove something, you have to go far. If I lose the case, it will not only be total bankruptcy for me, but a state monopoly on health care forever. How come such a big issue for the country rests on the shoulders of two citizens?"

Susan Pinker is a Montreal journalist.

Reference

1. Pinker S. The Chaoulli case: one-tier medicine goes on trial in Quebec. *CMAJ* 1999;161(10): 1305-6.