

## Is medical school only for the rich?

Times are getting tough in Canada for those who aspire to a post-secondary education but are not from wealthy families. Surveys done at the University of Western Ontario reveal that medical students are a privileged crew, coming from homes with family incomes in the top few percentiles. This phenomenon has intensified dramatically in the last few years, coinciding with huge increases in tuition fees. It struck me as unfair when I read in *CMAJ* that some of those unable to gain admission to a Canadian medical school can buy their way into an Irish one.<sup>1</sup> It's sad to see us regressing as a society and abandoning the legacy of the 19th century social activists who fought for equal educational opportunities for rich and poor.

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### 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.

## Brain refill from Down Under

Your article highlighting Canadians studying medicine in Ireland put a new spin on how Canada might fill an emerging need for physicians.<sup>1</sup>

As one of more than a dozen Canadian students at the University of Sydney, I also face an uncertain future. I am in a 4-year, graduate-entry medical program, so I am paying 2 years' less tuition than the students in Ireland. In Australia we also have a more favourable exchange rate. However, it is the daunting task of returning to Canada, with its associated expenditures, waiting and frustrating bureaucracy, that puts me in the same predicament as the "Irish-Canadians."

Currently, the Medical Council of Canada (MCC) does not consider Canadian citizens trained overseas as distinct from non-Canadians attempting to immigrate to Canada to practise medicine. In its attempt to enforce its own immigration policy, the MCC has effectively shut the door to a group of Canadian citizens who want to return to their country. We are, in effect, the brain refill — and we have cost our governments nothing in terms of training costs. What we need is a chance to be treated fairly and to be recognized as doctors-to-be who simply want to practise where they grew up.

If the MCC and the provincial governments are looking to relieve the pressure to train more physicians but are balking at the thought of bigger bills, they should look off both the east and west coasts to find an ideal solution.

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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.

## What's in a name?

We echo Peter Wing's sentiments regarding the use of the word "patient" rather than "client" for people

seeking health care.<sup>1</sup> The choice of words has perhaps more relevance in psychiatry than in other medical disciplines. Failure to call an ill person a patient may lead to suboptimal management of psychiatric disorders and may deprive the person of some state and insurance benefits. Indeed, the Mental Health Act continues to use the term patient.

Via a self-administered questionnaire, we surveyed the preferences of 402 consecutive people (median age 42 years) who sought outpatient mental health care between October 1997 and January 1998 from 5 psychiatrists in Langley, British Columbia. A similar questionnaire was also administered to 60 physicians (6 psychiatrists, 54 family physicians), 30 nurses, 16 social workers and 13 occupational therapists at Langley Memorial Hospital and Langley Mental Health Centre.

Seventy-two percent of the care seekers (289/402) preferred to be addressed as patients, with 27% preferring the term clients and 1% the term consumers. Older people preferred to be called patients. Ninety-five percent of the physicians preferred to address those for whom they care as patients. In contrast, 57% of the nurses and 15% of the occupational therapists preferred the term patient. None of the social workers wanted to use the term patient; they preferred the term client (75%) or consumer (25%).

There is a clear dichotomy between the preferences of physicians and non-

physicians. However, the majority of people seeking mental health care prefer to be addressed as patients, which leads us to believe that there is no reason to deviate from the current medical vocabulary.

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## HIV infection and risk behaviours in young gay and bisexual men

We have several concerns about the interpretation of the findings of a recent cohort study of sexual behaviour and HIV infection among young men who have sex with men in Vancouver.<sup>1</sup> Of the 11 subjects who became seropositive, 3 reported having injected drugs and 1 having shared needles. The other 2 may also have shared needles; this practice is often underreported because of its social undesirability and poor recall related to the effect of the drugs. Thus, the 3 subjects may have been infected through injection rather than through sex with other men. In fact, injection was significantly associated with HIV infection ( $p <$

0.001) whereas sharing needles was not ( $p = 0.06$ ), and HIV incidence among injection drug users during this period was extremely high (18.6 per 100 person-years<sup>2</sup>).

We also question the inclusion of the man who had an indeterminate result at baseline in the seroconverter group; subjects in a cohort study should be susceptible at study entry. Excluding the 3 subjects who injected drugs and the seroconverter yields an HIV incidence of 1.1–1.3 per 100 person-years (depending on whether the seroconverter also injected drugs). This is similar to the HIV incidence of 1.05 per 100 person-years we observed in men under 30 years old who have sex with men in Montreal from 1996 to 1999 (unpublished data). We believe HIV incidence among men who have sex with men should be calculated excluding those with other risk factors or, alternatively, calculations should be made separately for subjects with and without other risk factors.

Finally, the authors concluded that levels of unsafe sex increased over time on the basis of the proportion of subjects reporting safe sex at baseline who reported unsafe sex at follow-up. In Montreal we found that sexual behaviour is dynamic; a large proportion (51%) of those who practised unsafe sex at baseline practised only safe sex at follow-up,<sup>3</sup> which resulted in similar proportions of subjects reporting unsafe sex at baseline and follow-up despite the fact that about 10% of those reporting safe sex at baseline reported unsafe sex at follow-up. Therefore, risky sexual behaviour among both those with safe and those with unsafe

sexual practices at baseline must be examined at follow-up.

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1. Strathdee SA, Martindale SL, Cornelisse PGA, Miller ML, Craib KJP, Schechter MT, et al. HIV infection and risk behaviours among young gay and bisexual men in Vancouver. *CMAJ* 2000;162(1):21-5.
2. Strathdee SA, Patrick DM, Currie SL, Cornelisse PG, Rekart ML, Montaner JS, et al. Needle exchange is not enough: lessons from the Vancouver injecting drug study. *AIDS* 1997;11:F59-F65.
3. Alary M, Dufour A, Otis J, Remis RS, Masse B, Turmel B, et al. Determinants of transition from safe to unsafe sex among men having affective and sexual relations with men (MASM) in Montreal [abstract]. Eighth annual conference of the Canadian Association for HIV/AIDS Research; 1999 May 1-4; Victoria. *Can J Infect Dis* 1999; 10(Suppl B):75B-76B.

#### [The authors respond:]

We recalculated the HIV infection rate based on all years and on whether a subject had reported that they had ever injected drugs. These new person-time estimates of HIV incidence are based on 18 subjects who became HIV positive after their baseline seronegative test, 8 more than in our published study<sup>1</sup> and excluding the person with the baseline indeterminate result. The incidence rate has been revised to 1.2 per 100 person-years (95% CI 0.6–1.7) (Table 1) since the paper

**Table 1: Incidence of HIV infection among study participants, by study year and category**

Study year	All participants ( $n = 617$ )		Noninjection drug users ( $n = 555$ )		Injection drug users ( $n = 61$ )	
	New infections	Rate (95% CI)	New infections	Rate (95% CI)	New infections	Rate (95% CI)
1	1	1.0 (0.0–2.8)	1	1.0 (0.0–3.1)	0	–
2	6	1.7 (0.3–3.1)	3	0.9 (0.0–2.0)	3	11.4 (0.0–24.3)
3	2	0.5 (0.0–1.1)	1	0.2 (0.0–0.7)	1	3.2 (0.0–9.4)
4	5	1.2 (0.1–2.2)	4	1.0 (0.0–2.0)	0	–
5	4	1.8 (0.0–3.6)	4	2.0 (0.0–4.1)	0	–
All years	18*	1.2 (0.6–1.7)	13	0.9 (0.4–1.4)	4	3.1 (0.6–6.1)

\*Data regarding injection drug use were unavailable for 1 seroconverter, who was identified through anonymous database linkage.

was written. Gay and bisexual men who injected drugs have a higher incidence rate (3.1 per 100 person-years [95% CI 0.6–6.1]) than those who did not (0.9 per 100 person-years [95% CI 0.4–1.4]). Robert Remis and colleagues are correct in assuming that our rate of HIV incidence among noninjecting participants is similar to that reported for men under 30 years in the Omega cohort (1.0 per 100 person-years from 1996 to 1999). However, the annualized incidence rates presented in Table 1 for noninjecting gay and bisexual men indicate that HIV infection appears to be increasing in this population.

Remis and colleagues felt that we should have reported follow-up risky sexual behaviour among participants who had safe as well as unsafe sexual practices at baseline. Of the 285 men with regular partners, 89 (31.2%) reported having unprotected insertive anal sex and 100 (35.0%) reported having unprotected receptive anal sex in the year before the baseline visit. At 1-year follow-up, 66 (74.1%) of the 89 subjects and 71 (71.0%) of the 100 subjects reported having unprotective insertive and receptive anal sex respectively. Of the 279 men with casual partners, 46 (16.5%) reported having unprotected insertive and 36 (12.4%) unprotected receptive anal sex in the year before the baseline visit. Of these men, 21 (46.6%) and 16 (44.4%) reported having had unprotected insertive and receptive anal intercourse respectively by the time of their first follow-up visit. In combining these

data with other information presented in our paper,<sup>1</sup> the odds of relapse among men with regular partners increased 2-fold for both unprotected insertive intercourse (odds ratio 2.2, 95% CI 1.4–3.7) and receptive anal intercourse (odds ratio 1.9, 95% CI 1.4–3.0). Among men with casual partners, similar odds were observed for unprotected insertive intercourse (odds ratio 1.7, 95% CI 1.0–2.8), but the odds for receptive anal intercourse were not significantly increased (odds ratio 1.3, 95% CI 0.7–2.3). These new data along with the findings originally presented in our article confirm the high HIV rates and sexual risk behaviour in our cohort.

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1. Strathdee SA, Martindale SL, Cornelisse PGA, Miller ML, Craib KJP, Schechter MT, et al. HIV infection and risk behaviours among young gay and bisexual men in Vancouver. *CMAJ* 2000;162(1):21-5.

## Different centuries, same old story

The recent *Escherichia coli* outbreak in Walkerton, Ont., is remarkably similar to a cholera outbreak in Hamburg, Germany, in 1892. However, it is not the outbreak of waterborne disease that makes these stories similar but the delays in warning citizens of the emerging epidemics threatening them.

In Hamburg, the first person to die from cholera was a building worker who inspected a sewage outlet on Aug. 15. Although his vomiting and diarrhea were consistent with cholera, an official diagnosis could not be made without a cultured bacillus. Another building worker became ill with the same symptoms and died Aug. 17. However, gastrointestinal upset was not uncommon during the summer months in Hamburg and local doctors were not persuaded to take the time to investigate the cause of each illness. Physicians did not attempt to culture the bacillus until Aug. 20. In the meantime, others began to show signs of infection: 2 people on the 16th, 4 more on the 17th and 12 on the 18th. By Aug. 19, 31 patients had received treatment.

Although "official" confirmation of the cholera outbreak had been received by Aug. 22, the chief medical officer and the Senate chose not to warn people to boil water, and the contamination was not publicized until Aug. 24. By then, every part of the city had been infected and thousands of citizens had unsuspectingly consumed the infected water; they soon became ill with cholera and began to infect others. By the time the cholera outbreak was fully contained almost 17 000 people had been infected and 8600 had died. The outbreak of 1892 killed 13.4% of the population of Hamburg; it killed as many people as all other cholera outbreaks in Germany during the 19th century.<sup>1</sup>

Although several public inquiries and investigations are taking place to ascertain just what went wrong in Walkerton, the Hamburg outbreak does illus-

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trate the fact that history, even medical history, does tend to repeat itself.

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#### Reference

1. Evans RJ. *Death in Hamburg: society and politics in the cholera years 1830-1910*. London: Penguin; 1987. p. 285-314.

## Plastic bread-bag clips: the saga continues

We read with interest the recent report of plastic bread-bag clips in the gastrointestinal tract.<sup>1</sup> We were recently consulted regarding a patient whose small bowel was ultimately found to have been perforated owing to an impacted plastic bread-bag clip.

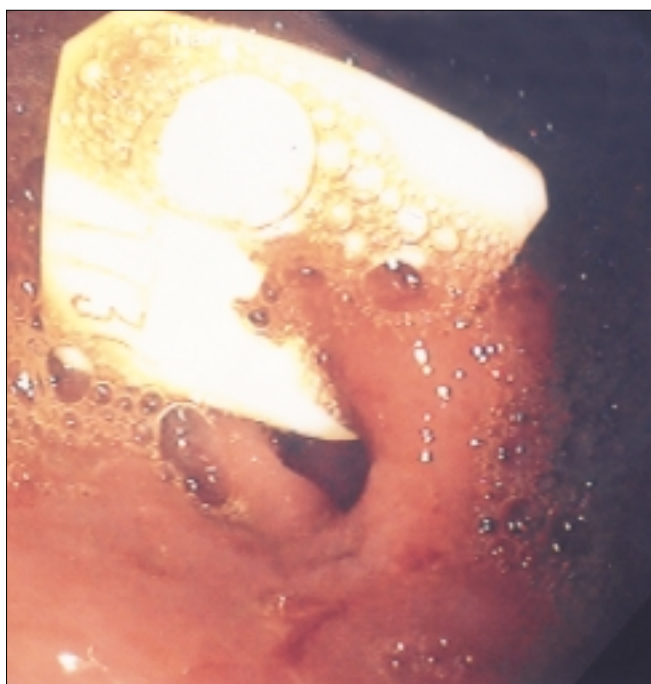
The patient, a 39-year-old man, had been experiencing intermittent episodes of colicky abdominal pain for about 5 years. He had previously been admitted to hospital with signs and symptoms consistent with a small bowel obstruction. He had undergone several investi-

gations, including CT scans and a small bowel follow-through, but no cause was identified.

He presented at our hospital with severe pain and a recent onset of nausea and vomiting. This followed several weeks of increasing crampy pain, associated with at least 1 episode of rectal bleeding. He was admitted to the GI service and over the next 36 hours developed signs of peritonitis, for which the surgical service was consulted. In the meantime, he had undergone both an ultrasound and a CT scan, which showed a small amount of free fluid but nothing else.

He underwent a laparotomy, and the clip was found in the distal small bowel, where it appeared to have attached itself and slowly eroded through the wall, as described by Ken Newell and colleagues.<sup>1</sup> He underwent a resection and primary anastomosis, from which he has recovered well. Unfortunately, the "best before" date was no longer visible on the clip.

In contrast to most of the patients in the study by Newell and colleagues,<sup>1</sup> this patient was young and had his own teeth. However, he is a single parent of young, active children and said that he often eats in a rush and does not chew his food well.



**Fig. 1: Endoscopic view of the pylorus with the plastic bread-bag clip embedded in the pyloric lip.**

The findings in this case support the authors' recommendation that the clips be made of a radiopaque material to allow early identification of the foreign body.

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#### Reference

1. Newell KJ, Taylor B, Walton JC, Tweedie EJ. Plastic bread-bag clips in the gastrointestinal tract: report of 5 cases and review of the literature. *CMAJ* 2000;162(4):527-9.

I was surprised to see how many cases of plastic bread-bag clip ingestion with complications have been previously reported.<sup>1</sup> We also had 1 case recently in a 73-year-old woman who had unknowingly ingested a plastic bread-bag clip and subsequently complained of epigastric pain. An upper gastrointestinal barium study suggested gastric ulceration. When we performed a gastroscopy we were surprised to see a plastic bread-bag clip lodged in the pylorus (Fig. 1). The angled teeth of the plastic clip had trapped the pyloric lip and had become deeply embedded. We used a snare to grab the clip and gently pull it out of the gastric mucosa. The clip was removed without sequela and the patient was placed on acid suppression with complete resolution of her symptoms. With regards to the risk factors mentioned by the authors, our patient wore dentures but did not have dementia.

I support Ken Newell and colleagues' suggestion that other forms of bag ties be used or that these clips be physically altered to minimize these occurrences.<sup>1</sup>

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