Appetite suppressants withdrawn

Health Canada has warned consumers not to use appetite suppressants containing fenfluramine or dexfenfluramine, prescription drugs used in the short-term treatment of obesity. They are also prescribed in a combination therapy known as fen-phen (fenfluramine and phentermine). The warning was issued Sept. 15, the same day an editorial on the subject appeared in *CMAJ* (1997;157:705-6). Companies agreed to suspend sales that day because of the high incidence of serious heart valve disease observed in the US in patients who have taken the drugs.

MDs the key to better pain management

The American Pain Society says adequate treatment of symptoms should take precedence over the legalization of physician-assisted death at the end of a patient's life. One of the keys is better education for physicians, nurses, patients and families about pain treatment. This means materials to guide treatment must be readily available to help clinicians write orders. As well, pain must be made "visible" and routinely charted as a "fifth vital sign" so that unrelieved pain triggers a prompt response. In its recently approved statement on pain treatment, the society said a physician trained in pain control can provide adequate pain relief for more than 90% of dying patients.

Task force to study impact of hospital closures on MDs

The Health Services Restructuring Commission that is revamping Ontario's hospital system recently named 3 physicians to deal with potential "physician labour adjustment issues" arising from restructuring in London, Metropolitan Toronto and Ottawa. Ottawa anesthetist John Atkinson will chair the group, which will include Kingston-based family physician Ruth

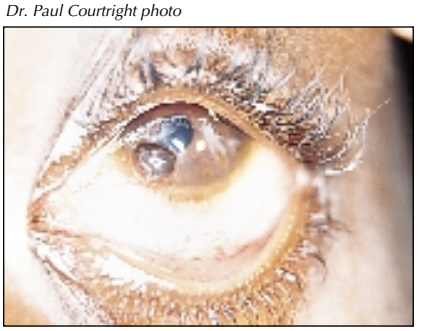
Traditional meets modern in Malawi eye program

Paul Courtright, PhD, director of the BC Centre for Epidemiology and International Ophthalmology, is as much an anthropologist as epidemiologist. In 1991, during a 4-year stay in Malawi, he pioneered a collaborative program to prevent blindness in rural villages by bringing modern science and traditional healers together.

Courtright, who works with his wife, ophthalmologist Susan Llewallen, recognized that the healers are a force to be reckoned with in Malawi's villages and that their support would be key in motivating people to have eye surgery. In Malawi, up to 4500 visits are made to traditional healers for each patient who seeks care from an ophthalmic medical assistant. Courtright estimates that about 10% of cases of blindness in the country are caused by toxic substances that have been deliberately placed directly in the eye because healers believed they would cure eye problems. Cataract surgery reverses blindness in an overwhelming number of these cases.

Courtright began his program with a series of workshops in about 15% of Malawi's villages, which attracted 300 healers. He achieved a coup by persuading some them to undergo cataract surgery themselves. Most participants returned to their villages as enthusiastic advocates, and surgery rates increased by 80%. The program, now well established in Southern Malawi, is run by ophthalmic medical assistants. It will eventually spread to all southern villages, which have a combined population of 5 million people, as well as to a district in northern Malawi.

Dr. Paul Courtright photo



Damage caused by toxic substances placed in the eye is responsible for 10% of cases of blindness in Malawi

Courtright plans to expand the program to Mozambique and West Africa, beginning in Niger. He organized a World Health Organization symposium in Malawi in September, which was attended by representatives from nongovernmental eye-care organizations, ophthalmologists, field workers and healers. The goal was to produce a manual to use as a template for establishing similar programs elsewhere. Courtright hopes new programs will look at traditional healers as positive forces for eye care. "If they reach the stage of 'let's collaborate,' " he says, "I'll be thrilled." — © *Heather Kent*

Wilson and Dr. John Jarrell, chief medical officer with the Calgary Regional Health Authority. The task force is to identify ways to maintain sufficient medical resources when clinical programs are transferred and to advise hospital boards how to determine requirements for physicians and other personnel following restructuring. The group, which will consult with the Ontario Medical Association and Ontario Hospital Association, is to issue its report by Nov. 30.

Hypertensive crisis on tap?

The *Canadian Journal of Psychiatry* reports that patients taking traditional monamine oxidase inhibitors (MAOIs) may experience a hypertensive crisis after consuming just 14 ounces of draft beer. Dr. Kenneth Shulman and colleagues suggest that all beers on tap be restricted from MAOI diets because several of them have dangerously high levels of tyramine (1997;42:310-2). The recommendation is based on cases

BC appeals court decision on billing numbers

The British Columbia government has appealed the July 30 court ruling that rejected its 1994 agreement with the British Columbia Medical Association concerning billing-number allocation. The original court challenge was launched by 3 doctors and the Professional Association of Residents of BC (PARBC).

The agreement was designed to manage the entry of new doctors to fee-for-service practice and to improve physician distribution. BC currently has the second-highest ratio of physicians to patients in the country (1:520), after Quebec (1:486), but many rural areas remain underserviced. The 1994 limits on billing numbers reduced the fees paid to new physicians practising in overserviced areas, with the amount of the cut depending on the geographic area. After 5 years, doctors with these numbers were eligible for payment at the 100% rate and free to practise anywhere in the province.

Martin Sereniak, PhD, chair of the Medical Services Commission, says that "only a couple" of doctors eventually worked at a reduced rate because many found locum positions and therefore were paid at the 100% rate; 462 doctors were upgraded to 100% billing status without limits following the court ruling.

Dr. Don Young, past president of PARBC, acknowledges that there are distribution problems but says the issue is fair application of the agreement. "Our motivation in this was to ensure that our members, when they go out to practise, have the same rights as those already in practice."

Sereniak says that the court decision "significantly hampers" the government's mandate to provide equitable distribution of doctors throughout BC. However, he does not expect a large number of new physicians to apply for billing numbers. "If physicians are rational, they would reassess that process of going through the initial phase of establishing a practice in a saturated market," he says. Fifty-five new billing numbers were issued in the month following the court decision.

Dr Granger Avery, president of the BCMA, which supports the government's court appeal, says the previous agreement "allowed the profession to maintain control of itself." He is concerned that if the BCMA is not involved, the government will control billing numbers autonomously through new initiatives designed to regionalize health care. He is also worried about the financial impact of having more doctors sharing decreasing dollars. A 4.4% clawback on earnings is already in place in BC. Avery says the previous arrangement was "starting to work" by attracting new doctors to "intermediate" areas, although it had not yet affected centres with the greatest need.

Both Avery and Young agree on some of the incentives that they say need to be built into any agreement to attract physicians to underserviced areas. They include support from locums and continuing education opportunities, as well as improved training in rural medicine. Avery would also like to see financial incentives such as signing bonuses, and an extension of the northern isolation allowance. He thinks locum coverage could be improved if the BCMA ran a 2-year-old government program that attempts to provide this, but only has about 7 participating doctors.

He also thinks medical schools must deal with students' urbanization. "Most medical students [are used] to the city," he says, and this ensures that a preponderance of city-oriented physicians will graduate from medical school. He would like to see the current rural-training program extended to include 6 months of rural training in fourth year, as well as a doubling in rural exposure for residents.

The BC appeal will represent a test case for the country. Young says that "British Columbia is the only province in which Charter arguments have been advanced through the courts regarding physician supply, and we know the rest of the country is watching closely." —