Iraq: Time to PAUSE?

Physicians have been leaders in making the world aware of potential health hazards such as cigarette smoking, nuclear-arms proliferation and land-mine production. We now have an opportunity to remind elected officials in Canada, the US and elsewhere of the devastating effects of punitive air raids on innocent people. The sanctions against Iraq have already caused a breakdown in the country's health care system. How much additional suffering will another one-sided war inflict?

Perhaps PAUSE — Physicians Against Unnecessary Suffering Everywhere — would be an appropriate acronym for doctors who believe that bombing civilians is a major health concern. Politicians might also heed this advice and take time to reflect and seek other means of extirpating the underlying malignancy characterized by the dictatorship in Iraq.

Ron Benzie, MB, ChB
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Received by email

A GOFM and damn proud of it!

In his letter explaining the Royal College of Physicians and Surgeons of Canada policy on acceptance of non-Canadian specialist training ("Where does our duty lie?" *CMAJ* 1997;157[12]:1740), Dr. Hugh Scott loyally attempts to defend an apparently indefensible position. His last sentence — "surely, our first duty is to Canadians" — contradicts the rest of his thesis. Certainly our duty does lie there, and the first duty of the Royal College is to do all that it can to ensure skilled specialist services are available for Canadian patients *today*, not at some indefinable point in the future.

When I came to Canada in 1956, I received credit for 2 years' training in Europe. I did 2 more years of residency training in Saskatoon and passed the certification exams in 1958. We were desperately short of specialists then, and 40 years later things haven't changed in the provinces perceived as unattractive.

We still rely heavily on physicians born and trained, in whole or in part, outside Canada. I have listened to 40 years of talk about self-sufficiency, maldistribution and the export of physicians, during which the Royal College has not addressed the issue in any concrete fashion. Consider the facts in Saskatchewan: there are 5 radiologists where there should be 12 and 2 endocrinologists where there should be 12. Certainly the fault is not the Royal College's alone, but equally certainly the college should not be exacerbating the situation.

Are we really to believe that candidates for specialty examinations who receive part of their training in "the UK, Ireland, South Africa, Australia and New Zealand" have "little chance of success" and a "failure rate . . . exceed[ing] 90%" in Canadian examinations? I would like some hard figures. Does only the US train to Canadian standards? Does the Council of the Royal College expect its policy to produce a magic flood of Canadian-trained specialists from sea to sea, including the unattractive bits? The policy seems much more likely to make things worse.

During the last 40 years I have become accustomed, if not inured, to derogatory and pejorative epithets on my origins — FMG [foreign medical graduate], GOFM [graduate of a foreign medical school] and the like. However, Canada still depends on people like me for much of its medical care. The Royal College should remember that, and we at the grass-

NEW SERIES

Unconventional breast cancer therapies

Starting next issue, *CMAJ* will be publishing a series on unconventional therapies for breast cancer. A task force of the Canadian Breast Cancer Research Initiative has reviewed available information on Essiac, green tea, Iscador, hydrazine sulfate, vitamins A, C and E, and 714-X. The findings summarized in each article will provide physicians and patients with reliable information in this area. Also accompanying the series will be a general patient-information piece designed to assist people who are considering taking unconventional therapies and to promote open communication between patients and providers.

roots and in the stubble should remember that the Council is an elected body.

Harry E. Emson, BM, BCh
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[The author responds:]

The Royal College has recently changed and refined its mission statement to dedicate itself to "ensuring the highest standards and quality of health care." Thus, the college and I share Dr. Emson's objective that everywhere in Canada specialized services of the highest quality should be available.

Where we differ is in our interpretation of certain facts and in our opinion as to what can and should be done. Emson appears to argue that Canada is incapable of meeting its own requirements — that 40 years of talk should cause us to throw up our hands and remain forever in a colonial, dependent position. I disagree. I, like him, am proud and feel that we as Canadians have enough to offer that we should be net exporters of our expertise to the rest of the world.

It is ironic that he says the Royal College has not "addressed the issue in any concrete fashion." I believe the "facts" he cites are based on a 1988 Royal College survey and report, which was followed by another in 1995. The college persists in sounding the alarm that Canada will be desperately short of physicians generally, but specialists in particular, by 2011. What is perplexing is that we will have inflicted this wound upon ourselves by slavish adherence to bad advice from a succession of government advisers. Implicitly, they too appear to believe that it is better to have too few rather than too many doctors. After all, we can always import more if we need them.

Consider Saskatchewan. In 1977, its medical school produced 64 physicians. Since then, as in many other provinces, there has been a concerted effort to decrease enrolment. By ministry edict, only 55 students were allowed to enter medical school in Saskatchewan in 1997; throughout this decade, an annual average of fewer than 60 Saskatchewan residents have been able to secure a place in any Canadian medical school. The "relative opportunity" of a Saskatchewan resident to find a place in medical school ranks sixth in Canada — right at the national average, an average that is about 30% below that in the UK. Had the Saskatchewan College of Medicine been allowed (and given adequate resources) to increase enrolment by 10 students per year instead of being forced to decrease enrolment by the same number, the situation would be vastly better and different today in terms of the very real problems Emson describes.

Emson does not like "pejorative epithets" but he uses them freely to describe the Royal College and its Council, which has 2 elected members from Saskatchewan. I suggest we put away the hatchet and instead work together to solve an important and urgent problem that exists "from sea to sea."

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Can CJD be transmitted through the blood supply?

In the editorial "Human rights, ethics and the Krever inquiry" (*CMAJ* 1997;157[9]:1231), Dr. John Hoey states that "there is evidence that variant Creutzfeldt–Jakob disease (vCJD) can be spread through the blood supply." This statement contrasts sharply with information given to the Canadian Red Cross Society by experts in the North London Blood Transfusion Service, who have stated that "there is absolutely no evidence that vCJD can be spread through the blood supply."

There *has* been conjecture based on tentative evidence that a staining procedure for tonsillar tissues may demonstrate vCJD, as well as a report from Switzerland that the receptor for vCJD may occur on B cells. In addition, studies from the National Institutes of Health have shown that only under certain controlled conditions can the vCJD prion occur in the blood of mice and furthermore that the prion can be transmitted and cause CJD only if the blood is injected into the brain of the mouse; transmission does not occur through the blood–brain barrier. The inaccurate statement in the editorial is disturbing to physicians charged with counselling patients who may have received blood components from donors in whom CJD was subsequently diagnosed. It also stands in stark contrast to the article "Is Creutzfeldt–Jakob disease transmitted in blood? Is the absence of evidence of risk evidence of the absence of risk?" (*CMAJ* 1997;157[10]:1367-70), by Dr. Maura N. Ricketts, who concludes, "Evidence indicates that the risk of transmission of CJD through blood and blood products is not simply rare or even exceedingly rare. It is theoretical."

My experience with *CMAJ* is that it often includes unqualified statements in reports of new medical developments in Canada and the rest of the world. Such statements have the potential to set up a chain reaction among physicians, who will worry and arrive at the wrong conclusions.

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The editorial by Dr. Hoey was thoughtful and timely, but I was surprised by the statement that vCJD