shopping by physicians who have lost their licences in one province and successfully seek licensure elsewhere. I do not know how often this occurs, but the solution is tougher and more consistent self-regulation. This includes cooperation among the colleges to keep sexually abusive, chronically impaired or incompetent physicians out of practice in every province unless there is unequivocal evidence that it is safe for them to resume clinical work — with or without ongoing conditions and supervision.

I understand that the Federation of Medical Licensing Authorities of Canada has initiated more systematic sharing of information on discipline and assessment proceedings, and it is also testing a system of unique national identifiers for all licensed physicians.[1]

As Robson argues, available research suggests that successful malpractice suits are neither specific nor sensitive measures of clinical competence. Disciplinary actions appear more specific but are hopelessly insensitive to most of the systematic quality problems in modern medical care. Although I accordingly question whether individual patients will truly benefit from better access to this information, informed consent is not the only rationale for Kluge's proposal. In an essential-service sector where the state has ceded substantial self-regulatory privileges to providers, the balance must inevitably be weighted in favour of transparency — the public's "right to know." With due attention to practicalities and potential pitfalls, Kluge's proposal merits serious consideration on the latter grounds alone.

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Reference

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Fruitful discussions about drug interactions

I was struck by the similarity of a recent *CMAJ* editor's preface on drug interactions[1] to a piece I wrote a couple of years ago.[2] To date the drug interactions with grapefruit appear to include inhibition of gut wall cytochrome P450 3A4 by naringin and dihydroxybergamottin,[3] as well as an interaction with P-glycoprotein.[4] In the case of drug–drug interactions, there are mechanisms for warning physicians, pharmacists and patients. However, in the case of grapefruit, special efforts are required: grocers seldom take a drug history when dispensing grapefruit.

In the Australian state of Victoria, it has been required for some time that pharmacists provide warnings when dispensing some drugs with known grapefruit interactions[5]; however, not all drugs have been tested for the interaction.

A simple rule of thumb for anticipating grapefruit interaction with drugs is that if erythromycin is a problem, then grapefruit is a problem.

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2. Spence JD. Drug interactions with grapefruit juice: Whose responsibility is it to warn the public? *Clin Pharmacol Ther* 1997;61:395-400.
3. Bailey DG, Arnold JMO, Bend JR, Tran LT, Spence JD. Grapefruit juice – felodipine interaction: reproducibility and characterization with the extended release drug formulation. *Br J Clin Pharmacol* 1995;40(2):135-40.
4. Soldner A, Christians U, Susanto M, Wacher VJ, Silverman JA, Benet LZ. Grapefruit juice activates P-glycoprotein-mediated drug transport. *Pharm Res* 1999;16:478-85.
5. Roller L. Drugs and grapefruit juice. *Clin Pharmacol Ther* 1998;63:87.

Correction

A recent article stated incorrectly that Raheem Kherani of Edmonton is president of the Canadian Federation of Medical Students.[1] When the article was written, that post was held by Marc Zerey of McGill University and Kherani was the federation's western regional representative. We apologize for this error.

Reference

1. Sullivan P. Concerns about size of MD workforce, medicine's future dominate CMA annual meeting. *CMAJ* 1999;161(5):561-2.

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