Establishing goals and setting priorities at different stages of life should be the objective. The rise in the number of female physicians has forced the importance of parenting responsibilities to surface. These issues are of equal importance to men. Flexibility in practice settings and training programs is helpful to all physicians — parents or not.

Bibiana Cujec
Department of Medicine
University of Alberta
Edmonton, Alta.
David Johnson
Departments of Medicine, Anesthesia, and Community Health and Epidemiology
University of Saskatchewan
Saskatoon, Sask.

References
1. Carr P, Ash AS, Friedman RH, Scaramucci A, Barnett RC, Szalacha L, et al. Relation of family responsibities and gender to the productivity and career satisfaction of medical faculty. *Ann Intern Med* 1998;129:532-8.
2. Cujec B, Oancia T, Bohm C, Johnson D. Career and parenting satisfaction among medical students, residents and physician teachers at a Canadian medical school. *CMAJ* 2000;162(5): 637-40.

Battling opiate overdoses

I thoroughly enjoyed your recent articles on substance abuse in the June 13 issue of *CMAJ*, especially Kyle Stevens' essay.[1] I cannot help but think that if the narcotic antagonist naloxone was made readily available to heroin addicts and others as a harm reduction measure (perhaps as an expansion of a needle exchange program) there would be fewer deaths from opiate overdose. After all, most addicts would have little trouble subcutaneously or intravenously injecting naloxone into an unresponsive friend while awaiting a 911 response,[2] and the drug would certainly not be used for recreational purposes. Indeed, this idea is being seriously explored in the addiction literature.[3,4]

D. John Doyle
Department of Anesthesia
Toronto General Hospital
Toronto, Ont.

References
1. Stevens KD. Stemming needless deaths: "medicalizing" the problem of injection drug use [commentary]. *CMAJ* 2000;162(12):1688-9.
2. Wanger K, Brough L, Macmillan I, Goulding J, MacPhail I, Christenson JM. Intravenous vs subcutaneous naloxone for out-of-hospital management of presumed opioid overdose. *Acad Emerg Med* 1998;5:293-9.
3. Darke S, Hall W. The distribution of naloxone to heroin users. *Addiction* 1997;92:1195-9.
4. Strang J, Powis B, Best D, Vingoe L, Griffiths P, Taylor C, et al. Preventing opiate overdose fatalities with take-home naloxone: pre-launch study of possible impact and acceptability. *Addiction* 1999;94:199-204.

You can't have one without the other

Did anyone else note the rather bizarre, if not macabre, juxtaposition of 2 articles in the July 11 issue?[1,2] One dealt with the prevention of motor vehicle injuries, whereas the other concerned improvements in organ donation rates. Seems to me you can't have it both ways!

Hugh M. Scott
Director General
McGill University Health Centre
Montreal, Que.

References
1. Kent H. Combating car accidents by examining the causes. *CMAJ* 2000;163(1):75.
2. Moulton D. NB launches ambitious Organ Donation Network. *CMAJ* 2000;163(1):75.

Attitudinal problems facing international medical graduates

T.B. MacLachlan's recent letter illustrates the attitudinal problems Canadian citizens who graduate from schools outside Canada face when they attempt to obtain licensure in Canada.[1]

The article on British Columbia's experience with the licensing program for international medical graduates (IMGs) showed that the program had a 100% licensure and in-country retention rate at a much lower cost than that of training a physician from scratch.[2] The program also eliminates the possibility of having newly minted, Canadian physicians ending up paying taxes to Uncle Sam after having had several hundred thousand taxpayer dollars spent training them in Canada.[3]

Instead of seeing such programs as cost-effective, short-term solutions to the oft-reported Canadian physician shortage,[4] people quibble about the "significant cost" or about whether such programs really meet the needs of *all* IMGs in Canada.

When faced with the possibility that IMGs might have to be considered for practice in Canada, Canadian doctors — at least the ones who have written to CMA publications — react by enacting rules to exclude them[5] or faulting them for having to study abroad.[6] This is done despite reports about the need for more physicians[7] and about how hard it is to get into medical school in Canada.[8]

Being a Canadian citizen and an IMG who has at least US$400 000 worth of postgraduate medical training in the United States, I find myself having to head back to the United States to join other Canadian citizens who are also IMGs, after being unsuccessful in my attempts to obtain licensure here. I knew I would have a hard time trying to get medical training here but I didn't know how hard it would still be after I received accredited training in the United States.

Canadians deserve the best medical care in the world, but are they getting it when doctors feel so overworked they take job action to get funding for additional manpower, as physicians have done in British Columbia?

David Roy M. Evangelista
Physician
Lethbridge, Alta.

References
1. MacLachlan TB. Licensing international medical graduates [letter]. *CMAJ* 2000;163(3):260-1.
2. Andrew R, Bates J. Program for licensure for international medical graduates in British Columbia: 7 years' experience. *CMAJ* 2000;162(6):801-3.
3. Andrew R, Bates J. Licensing international medical graduates [letter]. *CMAJ* 2000;163(3):261.
4. Sullivan P. Concerns about size of MD workforce, medicine's future dominate CMA annual meeting. *CMAJ* 1999;161(5):561-2.
5. Mador ML. History lesson. *CMA News* 2000; 10(7):2.
6. Milburn C. Is medical school only for the rich? [letter]. *CMAJ* 2000;163(1):13.
7. Sibbald B. Southern Ontario towns hang out