Physician distribution: everybody's responsibility

There have been many suggestions about how to encourage physicians to practise and remain in underserviced parts of Ontario, including proposals that communities and government offer incentives. What I have not heard are the responsibilities of physicians practising in overserviced areas.

I suggest that all physicians in overserviced areas could serve as a locum in an underserviced area, perhaps for 1 week every 5 years. This would provide our family practice and specialist colleagues in underserviced areas with time off when they want or need it. An alternative for specialists in overserviced areas would be to provide consultation services for underserviced areas 1 weekend every 2 to 3 years.

Reasonable exemptions would have to be permitted, and central coordination would be required to match needs with services and to organize accommodations and travel stipends. The frequency of required services per physician would depend on the assessed need.

This is just one suggestion, and it would require a commitment from physicians in overserviced areas and the government. However, it would make an important point: finding a solution to physician-distribution problems is everyone's responsibility, and government and new physicians should not have to bear the brunt alone.

Tracey Asano, MD
Toronto, Ont.

Repressed memories: Middle ground or no man's land?

In response to the article, "The repressed memory controversy: Is there middle ground?" by Dr. P. Susan Penfold (*Can Med Assoc J* 1996;155:647-53), total repression is a presumed ability of the human mind to push memories of repeated, traumatic events into the unconscious, completely and involuntarily, and to recover them years or decades later. The human mind either possesses this ability or it does not. There is nothing in between. What is erroneously perceived as "middle ground" is a moderate position in which total repression is still accepted as a valid psychologic mechanism.

Despite the many people with allegedly repressed and recovered memories of sexual abuse in the past decade, the promoters of the repression concept have failed to prove in a systematic, acceptable way that it exists. Unwisely defending a middle-ground position for the sake of a "balanced" view, in the absence of solid evidence, contributes to the proliferation of potentially harmful beliefs. For example, Dr. Penfold's conclusion that "both genuine recovered memories and fabricated memories appear to exist" is unfounded. Unfortunately, her well-intentioned article only adds to the existing confusion.

To overcome the mental health care crisis brought about by the recovered-memory movement, all parties should strive not for middle ground but for common ground. Common ground does not call for compromise between 2 irreconcilable views. It involves finding points of agreement and working from these toward a common goal. A great step in curbing harmful therapeutic practices would be achieved if clinicians, licensing bodies and memory researchers agreed that (1) false memories are not rare and can appear spontaneously or under the influence of an authority figure, and that (2) there is no way to distinguish between true memories and pseudomemories without independent external corroboration. Universal acceptance of the need for corroboration in cases involving "recovered memories" would put an end to the harmful practices that have damaged so many lives.

Paula Tyroler, PhD, PEng
Associate Professor
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As one of the 14 contact people in Canada for people falsely accused on the basis of ideas of abuse generated in repressed- or recovered-memory therapy, I am offended by suggestions that there is a possible middle ground.

On one side are a large number of middle-aged "survivors," 100 000 people in Canada alone by a conservative estimate. This group did not exist 10 years ago, before the advent of trauma-search therapies, but survivors now believe that they were sexually abused for years on end.

On the other side is an equally large group of people, 60 years of age and older, who tell the world that these accusations are false. Where can the middle ground possibly be for them? Dr. Penfold, as a "neutral" observer, confused by the array of books and literature by advocates on both sides, may think or wish that there is a middle ground, meaning that half of the memories are recovered and true and half are fabricated and false. However, this is pathetic nonsense.

If half of the memories are false, this would still give us a "therapy epidemic." In that case, half of the memories have to be true. Hence, the police, the courts and the jails had better be prepared for a crowd of male senior citizens to be arrested, convicted and incarcerated. This could be one of the best job-creation programs in Canada. Large numbers of therapists would have to deal with the convicts and the guilty consciences of the "enablers": the wives of the convicted men.

Penfold believes that more research about memory is needed. That may be so. In the absence of such

research and the lack of empirical evidence for Freudian concepts of repression, let us first condemn memory-retrieval techniques such as guided imagery, bibliotherapy (the reading of highly suggestive books), trance writing, dream work, body work, hypnotherapy, visualization, interviews conducted under the influence of amobarbital and other quackery. These have no basis in science.

Adriaan J.W. Mak
London, Ont.

[Dr. Penfold responds:]

In summarizing the arguments and evidence for both sides of the repressed-memory debate I hoped to raise awareness and promote understanding of the dilemmas that a practising physician may face. Although I am very concerned about parents who are falsely accused and victims who are erroneously disbelieved, the present state of knowledge about memory does not permit a black-and-white approach.

Although I agree with Dr. Tyroler that repression is an outmoded and unclear concept, we cannot throw out the baby with the bath water. As I emphasized in my article, there is evidence supporting the existence of both genuine recovered memories and fabricated memories. For instance, memory researcher Elizabeth Loftus, a member of the advisory board of the False Memory Syndrome Foundation, is the principal author of an article describing a study of women involved in outpatient treatment of substance abuse.[1] Of the women reporting childhood sexual abuse, 19% reported that they had forgotten the abuse for a period of time. The memory returned later.

Is this failure to remember childhood trauma due to "repression," "amnesia," "dissociation" or "forgetting"? The terms are not clearly delineated and are sometimes used interchangeably. The fact remains that some kind of traumatic forgetting happens, under some circumstances, to some victims. I do not believe that we are looking at 2 "irreconcilable views," but that shades of grey will exist in this area for some time, until much more research has clarified the many unknown aspects of memory.

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Reference

1. Loftus EF, Polonsky S, Fullilove MT. Memories of childhood sexual abuse: remembering and repressing. *Psychol Women Q* 1994;18:67-84.

In praise of commonplace conferences

I hope I speak for many physicians in this country when I say that I would like a list of meetings that could be practical at the bedside. In *CMAJ* I am offered a conference list that includes Pathways to Community Performance — Bringing Leaders from All Sectors Together to Build Community-wide Collaboration and Partnerships. As young people today would say, Hello? An alternative meeting that I could go to during the same week is Supporting Women, Supporting Ourselves — A Conference on Reproductive Psychiatry. Excuse me? How about Feminist Approaches to Bioethics? I do not think so.

Many of us are tired of being upbraided, put down, trivialized and treated arrogantly. In contrast, we are anxious to bring to our patients, whom we like and respect, medical wisdom that is up to date, affordable (unlike Transgenic Technologies — Producing Next Generation Therapeutics Conference) and what you would call pedestrian or commonplace (unlike 3rd Annual Novel Amplification Technologies Conference).

Could you please provide us with a few such meetings each month?

Donald P. Warren, MD
North Vancouver, BC

[The editor-in-chief responds:]

We have received several letters and calls about conferences, none as lively as Dr. Warren's, but all with a similar message. Our policy has been to publish at least once, and more often as space permits, all notices of conferences in the medical field that we receive. However, in light of the feedback from readers, we plan to re-examine this policy. We encourage readers to let us know what you think of our listings of conferences and continuing medical education courses to help us in this process.

John Hoey, MD
Editor-in-chief
Rédacteur en chef

The tobacco tragedy in Northern Canada

Thank you for calling attention to Dr. Richard Bargen's frustrated efforts to reduce smoking and smoking-related disease in the eastern Northwest Territories (*Can Med Assoc J* 1996;155:1383). When the Baffin, Kitikmeot and Keewatin regions become the Nunavut Territory in 1999, the issue of cigarette smoking, which Bargen brought very much to the fore, will remain a fundamental issue. Unfortunately, the smoking issue will not and cannot be resolved by the lone voices and hard work of medical officers struggling in isolation.

I recall well my first year as a federal medical officer working in a northern region. Chest diseases made