Come north, Dr. Patterson

I certainly empathize with Dr. Robert Patterson ("I don't own a house, but at least the lien is off my truck," *Can Med Assoc J* 1997;156 [11]:1583-5) and his difficulty in finding a satisfying permanent position. It is ironic that while he has been looking for a position, the University of Manitoba has been unable to recruit an academic general surgeon. The suitable candidate would have a varied, interesting clinical practice in Thompson, Man., a small city with a university-based specialty program. There are teaching and research expectations, with particular opportunities in the areas of telemedicine and computer technology. The salaried compensation is very competitive and includes 8 weeks' annual vacation and professional leave.

As chief of staff at Thompson's hospital, I find it frustrating that despite extensive advertising for a number of positions, potential candidates still do not seem to be aware of our exciting new program. Any suggestions for reaching suitable candidates would be most appreciated.

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[The author responds:]

As noted by Dr. Wincott, some communities experience difficulty recruiting physicians as some doctors search haphazardly for a position, unaware of openings across the country. How do we avoid this "ships-in-the-night" scenario? In the case of general surgeons, there has been a proposal to establish a page on the Web site of the Royal College of Physicians and Surgeons of Canada that would list permanent and locum opportunities.[1] To date, this has not happened. When I contacted the college's webmaster, no definite start date was offered. When this service does appear, it should go a long way toward matching the needs of recruiters with those of physicians.

Wincott also claims that the salary for the position in Thompson is "very competitive." I assume this statement is based on Canadian standards. A quick search of the Internet using the key words "physician recruiting" turns up hundreds of positions in the US, where salaried general surgeons will earn US$160 000 to US$200 000 per year, plus benefits and bonuses. Fee-for-service surgeons can make considerably more. When one considers the exchange rate plus the significantly lower personal income tax rate south of the border, the money may be double what a Canadian general surgeon earns.

As my fellowship in Utah draws to a close, my wife and I must decide on which side of the border to make our future. Our decision involves much more than money: factors such as quality of life, proximity to our extended families, the atmosphere in which clinical medicine is practised, research funding and the fear that Canada may self-destruct in a few years all enter the equation. These decisions are always accompanied by introspection and trepidation. Time alone tells if the right decision was made.

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Reference

1. Taylor BR. Presidential address 1996: "Dear ministers of health . . . ." *Can J Surg* 1997;40[2]:101-7.

Time for legalized distribution of illegal drugs?

Dr. Catherine Hankins' thought-provoking editorial "Needle exchange: Panacea or problem?" (*Can Med Assoc J* 1997;157[3]:275-7) summarizes many of the issues concerning HIV infection among injection drug users (IDUs) and the possible benefits of needle exchange programs (NEPs).

It appears that NEPs decrease HIV transmission rates by reducing the amount of time needles are in circulation.[1] However, a California evaluation[2] concluded that NEPs are associated with decreased HIV risk behaviour and an absence of negative outcomes but found no clear evidence that the exchange programs actually reduce HIV infection rates. A recent Australian review[3] found that cities with NEPs tended to experience a decrease in HIV seroprevalence among IDUs, compared with cities without such programs. However, the sale of injection equipment by pharmacies can have a similar impact. Therefore, the difference in rate of change of HIV seroprevalence between cities with and without NEPs may not be due solely to the exchange programs.[3]

Hankins discusses increases in the use of cocaine relative to heroin by Canadian IDUs. In Vancouver some 2.38 million needles were distributed through NEPs in 1996.[4] Assuming that an average of 3000 IDUs received sterile needles daily, this figure translates into 800 needles a year for each IDU or about 2 per day. This supply would fall far short of meeting the needs of the average cocaine user.

Counselling, treatment and rehabilitation services for IDUs are inadequate across Canada. It makes no sense to have long waiting lists for those interested in rehabilitation and