Letters

Correspondance

And God said . . .

You may be interested in a page I pulled from my extensive file of nonsensical jottings after reading a recent News and Analysis item, "Grant applicants take note" (*CMAJ* 1998;158[5]:580), which concerned some information taken from the Internet. The item gave reasons why God does not get research grants. About 10 years ago I came across a similar piece that speculated on why God had never received tenure. Many of the items were the same or similar to those in your list, but a couple were different: "He rarely came to class, and simply told students to read His book," and "Some say He actually had His Son teach the class."

I guess this all goes to prove that what goes around comes around, particularly where cyberspace is concerned.

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Job wanted, anywhere!

In response to the editorial "A warm place to practise: meeting the challenges of medicine in the north" (*CMAJ* 1998;158[3]:337-8), by Dr. Allon Reddoch, I would agree that there are not enough Canadian doctors willing to practise in rural areas. If doctors are needed in these areas, then Canada must open its doors to international medical graduates (IMGs).

When I was at McMaster University completing my undergraduate degree, the competition for getting into a Canadian medical school was intense, so I decided to leave Canada to study. Now that I am back, my first choice is to practise here. Everyone keeps telling me that this will be tough to do because Canada does not need doctors. Perhaps not in the big cities, but I am willing to go wherever I can get a residency and a job. Unfortunately, no one wants IMGs!

If doctors are needed in rural areas, why does Canada not give IMGs like me a chance? It is ironic that one part of the Canadian government does not object to students obtaining their medical training abroad, for I did receive Canada Student Loans. But how does the government expect us to pay the loans back if we are unable to work? It is sad that IMGs cannot even be included in the first iteration of the residency match. Perhaps contracts could be made with IMGs: they would be accepted for a residency program but would have to agree to serve in a rural area for a certain period after completing the residency.

Farida Atcha, MD
Mississauga, Ont.

A really bad locum

Having done several locums lasting 1 to 3 weeks during the past year, I share some of the concerns expressed in Dr. Kirsten B. Emmott's article "A really bad locum" (*CMAJ* 1998;158[2]:235-6).

Although generally satisfied with the quality of the practices I took over for short periods, I would like to see the following arrangements made:

- All patients scheduled to be seen by the locum physician should be informed before their arrival that they will be seeing a new doctor.
- All patients scheduled to be seen by the locum physician should be asked to bring along all their medications (with the containers), and whenever possible the regular physician should attempt to refill narcotic prescriptions (when indicated) just before or on completion of his or her leave.

Do others have additional suggestions?

Aaron D. Bernstein, MD
Ottawa, Ont.

As an emergency physician who has done the odd locum, I enjoyed Dr. Emmott's article. It is unfortunate that she had to encounter this type of practice, but I am glad that she took the time to describe her experiences. I have been in similar situations many times, both in the office and in the emergency department: a chart is opened or arrives by fax and contains nothing but a date for a visit and the word "well." I have discovered that this word can mean many things.

- Well, healthy as always.
- Well! I can't believe she said that.
- Well? Maybe I should consider the symptom that the patient spoke about.
- Well, I've got my billing quota in for the week.

In my experience, bad charts are a sign that "bad medical care is provided here." Medicine as a profession must learn better ways to assess physicians' ability to provide good medical care and either improve the skills of doctors who provide shoddy care or remove them from practice.

Terence Bergmann, MD
Winnipeg, Man.

As a physician who has both worked in a variety of locum settings and experienced the trials of finding a suitable locum physician for my own practice, I read with interest

the article by Dr. Emmott and the editorial "A warm place to practise: meeting the challenges of medicine in the North," by Dr. Allon Reddoch (*CMAJ* 1998;158[2]:337-8). The horrors of the former are finely balanced by the call of the latter to take a creative breather in a northern setting.

Nothing is known about the effects of a locum tenens on patient care, despite the enormous number of patient–locum encounters that take place annually. One can only guess at the measurable rewards and hazards encountered by the replacement locum and the surprises awaiting the returning incumbent. Simple evaluative literature is yet to be written, and serendipity alone determines what might loosely be termed success or failure. The arrival of a locum can provide a valuable opportunity for professional enrichment and CME, gentle peer evaluation (in both directions), exposure to new populations and challenges, and reflection on the most effective ways of delivering health care. When things go badly, poor communication, unrealized expectations, financial catastrophe and irreparable harm to patient care may be involved. Many of us know of an enthusiastic locum who, in a matter of weeks, has reduced a flourishing practice to a small band of loyal followers genuinely sorry to see him (or her) depart for new pastures.

It would be instructive to take the experience beyond the level of anecdote. As I limber up for a new season of locum negotiations, I wonder whether any colleagues feel that this common player in the Canadian medical scene deserves more careful evaluation.

Barry W. Munn MD
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Hamilton, Ont.

I hope that Dr. Emmott does not have the further misfortune of replacing me during my infrequent absences, for she will see on my shelves elderly texts such as the last edition of Jeffcoate's *Gynaecology*. I also have the 1982 edition of a book first published in 1908, which quotes Smellie's *Midwifery* of 1764. I can recommend to Emmott Smellie's accurate and succinct account of soft-tissue dystocia. I also have an elderly copy (1958) of *Gray's Anatomy* that is in constant use.

Emmott notes with regret the absence of framed medical degrees on the office walls of the physician she replaced. I have 4 such degrees, and not one adorns my walls, for I cling to the notion that patients recognize skill or the lack thereof, and a wall full of diplomas will mean little to them.

More serious, however, is her throw-away line that doctors who care for patients with drug habits have given up. I would argue that they are the doctors who listen and try to define who is addicted and who needs these medications. The use of these drugs is regional, cultural and patient-driven, not physician-promoted. Overall, her comments suggest a preoccupation with appearance rather than substance.

H.G. Harding MB, ChB
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Chetwynd, BC

[Dr. Emmott responds:]

I appreciate my colleagues' thoughtful comments. As someone who has hired locums for my own practice, I rarely write in a chart without thinking of the possible replacement who is, figuratively speaking, looking over my shoulder. Readers may be interested to know that I received personal letters from physicians in 2 different communities, both claiming to have recognized the anonymous doctor I described!

Dr. Harding misinterprets my comments about the age of "Dr. Smith's" reference books. I have Getchell's 1885 *Illustrated Encyclopedia of the Science and Practice of Obstetrics*, Harry Pye de Chavasse's 19th century book of advice for young mothers, the 1948 edition of *Childbirth Without Fear* and the 10th edition of *Williams Obstetrics* (although I also have the 17th edition). I've got a fine old (1962) gynecology text and a shiny new one. The point is that Harding and I benefit from the wisdom of our elders and our betters, yet we also keep up with the literature, whereas some other doctors seldom open a book after graduating.

If there had been any evidence that "Dr. Smith" had attempted to define which of his patients were addicted and had then done something appropriate, I would have noted it. I applaud Harding's sympathetic approach to the problem of addiction. Simply handing out hundreds of tablets without questioning the rather thin stories offered is not true caring — I couldn't agree more.

Kirsten B. Emmott, MD
Comox, BC

Herbal medicine: Show me the proof!

The New Medicine is upon us! The article "Herbal medicine takes root in Germany" (*CMAJ* 1998;158[5]:637-9), by Pam Harrison, points out that the prescription of these "natural substances" is quite common in Germany. It appears to be a very lucrative pursuit there.

However, I am curious to learn that these substances are "natural." Is this true? Is no manufacturing process used in their production? She also states that "there is a conviction" that there is little to choose between these potions and synthetic pharmaceuticals, but conviction is not proof — unfortunately, though, the road to clinical hell is paved with strong convictions that are subsequently found wanting. Ten years ago we were convinced that peptic ulcer disease was