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.

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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.

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[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.

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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

due to a complex psychosomatic process, a theory that has since been relegated to the ash can of etiologic speculation. If an herb happens to ameliorate symptoms, the effect may be due to a placebo effect, especially among patients disenchanted with modern medical pharmacology.

Curiously, herbal compounds appear to have no value in treating acute illness. Although these herbs — it is politically incorrect to call them drugs yet because profits may tumble — may have active ingredients, as Ken Keirstead was quoted as stating, there is little if any scientific evidence that they really do anything. Is St. John's wort significantly better than placebo in carefully conducted clinical trials? Does *Ginkgo biloba* really increase oxygen supply to the brain in patients with Alzheimer's disease, as CNN informed me the other night? Most puzzling is the fact that the prestigious US National Institutes of Health has bowed to the media darlings and received funding for research involving "alternative medicine."

And most surprising of all is that organized medicine raises not a whimper about all of this. Science, I would have thought, is the only means we have to separate the truth from whim, fraud and, of course, simple stupidity!

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Perspectives on overpopulation

Dr. W. Harding le Riche, in his letter "Overpopulation and Rwanda" (*CMAJ* 1998;158[7]:868-9) is joking, right? Rwanda has just lost 800 000 people to genocide and, if it is like its neighbours, the country's population will also be decimated by HIV. And yet le Riche proposes better population control. The logic escapes me.

The West, in its arrogance and hubris, has done enough to harm Africa. Leave population control to the Africans. If le Riche wants to reduce Africa's birth rates, let him agitate for development of a malaria vaccine or improve women's educational status in Rwanda or pursue some other helpful goal. If women in Africa did not see so many of their children die of malaria or diarrhea or measles, they might have fewer children. The same forces operated on population size in the West 100 years ago.

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Dr. le Riche is absolutely correct in suggesting that the carrying capacity of all countries must be considered as the world population continues to increase.

At the University of British Columbia, the School of Community and Regional Planning has been developing methods of planning for healthy and sustainable communities. On the basis of the average consumption demands of citizens as measured by carbon dioxide emission, purchasing power, vehicles per 100 persons, paper consumption, and use of fossil energy and fresh water, an ecological "footprint" was calculated for 1991.[1] The global average was 1.8 hectares per person, but those in the developed world have much larger "footprints." The people of the Lower Fraser Valley in BC depend on land 19 times the area in which they live to satisfy demands for food, forest products and fossil fuel. Holland, among the 3 most densely populated countries in the world, uses over 15 times more land than lies within its political boundaries.

Certainly population increase is out of control, as measured by the carrying capacity of many countries. Rwanda and the rest of Africa are just representative of a global problem.

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Reference

1. Wachernagel M, Rees WE. *Our ecological footprint: reducing human impact on the earth*. Gabriola Island (BC): New Society Publishers; 1996.