

A homegrown solution, via Ireland?

We were interested to read about the CMA's recent call for a made-in-Canada solution to Canada's physician shortage.¹ We have a suggestion.

There are currently many Canadian citizens studying medicine in Ireland. The main reasons are that we were unable to find positions at Canadian medical schools and that our desire to be physicians was so great that we were willing to leave Canada to study. However, when we graduate it will be next to impossible for us to obtain a residency position in Canada, where we only have access to positions left unfilled by Canadian graduates. Not only are there relatively few positions, but there are also few openings in the popular specialties.

Most of us would love to come back to Canada to practise. Because the CMA is looking for a "homegrown" solution to the physician shortage, we would like to suggest that it try to find a way to bring us back home. Why not allow us to transfer into the clinical years at Canadian schools? We would be more than willing to start a couple of months early and do any review courses or exams to ensure that our skills and knowledge are on par with those of Canadian medical students entering third year. (In Ireland we take a 6-year program, with clinical rotations beginning in the middle of our fourth year.)

Your article stated that 24% of Canada's current physicians are foreign graduates who have passed Canadian licensing examinations. The register for the College of Physicians and Surgeons of British Columbia clearly indicates that most of these physicians are from the UK, Ireland and South Africa. If they were able to pass the Canadian licensing exams, it would appear that foreign medical schools are producing doctors just as knowledgeable as the ones graduating in Canada. In other words, Canadian schools are not the

only ones that produce competent physicians. Furthermore, considering the small number of students accepted for training at Canadian schools compared with the huge number of well-qualified applicants, Canadian students in the UK and Ireland are by no means "rejects" unworthy of consideration.

Now that the physician shortage has reached a critical stage in Canada, perhaps our case could be taken up and supported by the CMA and other physician groups.

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Reference

1. Sullivan P. Concerns about size of MD workforce, medicine's future dominate CMA annual meeting. *CMAJ* 1999;161(5):561-2.

Ritalin use in BC

The letter from 3 employees of the BC Ministry of Health calling into question a series of newspaper articles I wrote on rates of methylphenidate use in BC is misleading and conveys a false impression of the series by making a direct comparison between 2 entirely different sets of data.¹ I wish to make the following corrections.

The ministry staff challenged as "untrue" the claim made in my articles that "children in some parts of British Columbia were being prescribed methylphenidate (Ritalin) at the highest known rate in North America." This is inaccurate and misleading. The government researchers reached this conclusion by mixing statistical apples and oranges.

First, in their Freedom of Information request to PharmaNet the ministry employees requested prescribing data

for a different time frame than that used by *The Vancouver Province*. This explains why their 12-month total varied from mine by about 200 children.

Second, I clearly stated that my conclusions were based on a survey of prescribing rates in 39 of BC's biggest communities. It is well known that city kids are more likely than rural kids to be diagnosed and treated for attention deficit disorder. They have more access to doctors. But the ministry employees took a much broader survey approach in their Freedom of Information request. Instead of looking at the same data for the specific communities used by *The Province*, the researchers reviewed prescribing data by "region," which would include many largely rural districts. It is not surprising that direct comparisons found lower rates in these "regions" than in urban communities. I reject as meaningless the claim that "variation in use of the drug across regions was also much smaller than reported by the newspaper." I didn't report by region.

Third, a key point in my series on methylphenidate use is that boys in certain age groups are prescribed stimulants at a much higher rate than any other group in society, including girls of the same or any other age. Even when compared with girls in the same age group, up to 6 times as many boys were on stimulant medications. I published detailed graphs demonstrating the differences between boys and girls in each of the 39 communities. But the ministry researchers blended data for boys and girls and made a direct comparison with my findings for boys alone, which is meaningless.

Fourth, I found marked differences in prescribing rates among boys in different age groups. After carefully analyzing the data for the 39 communities I found that the highest prescribing rates were for boys aged 8 to 13 years. The ministry employees studied a different age group; they looked at combined statistics for boys and girls aged 10 to 14 years, a group who in the com-