

## Is medical school only for the rich?

Times are getting tough in Canada for those who aspire to a post-secondary education but are not from wealthy families. Surveys done at the University of Western Ontario reveal that medical students are a privileged crew, coming from homes with family incomes in the top few percentiles. This phenomenon has intensified dramatically in the last few years, coinciding with huge increases in tuition fees. It struck me as unfair when I read in *CMAJ* that some of those unable to gain admission to a Canadian medical school can buy their way into an Irish one.<sup>1</sup> It's sad to see us regressing as a society and abandoning the legacy of the 19th century social activists who fought for equal educational opportunities for rich and poor.

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### Reference

1. Sullivan P. Shut out at home, Canadians flocking to Ireland's medical schools — and to an uncertain future. *CMAJ* 2000;162(6):868-71.

## Brain refill from Down Under

Your article highlighting Canadians studying medicine in Ireland put a new spin on how Canada might fill an emerging need for physicians.<sup>1</sup>

As one of more than a dozen Canadian students at the University of Sydney, I also face an uncertain future. I am in a 4-year, graduate-entry medical program, so I am paying 2 years' less tuition than the students in Ireland. In Australia we also have a more favourable exchange rate. However, it is the daunting task of returning to Canada, with its associated expenditures, waiting and frustrating bureaucracy, that puts me in the same predicament as the "Irish-Canadians."

Currently, the Medical Council of Canada (MCC) does not consider Canadian citizens trained overseas as distinct from non-Canadians attempting to immigrate to Canada to practise medicine. In its attempt to enforce its own immigration policy, the MCC has effectively shut the door to a group of Canadian citizens who want to return to their country. We are, in effect, the brain refill — and we have cost our governments nothing in terms of training costs. What we need is a chance to be treated fairly and to be recognized as doctors-to-be who simply want to practise where they grew up.

If the MCC and the provincial governments are looking to relieve the pressure to train more physicians but are balking at the thought of bigger bills, they should look off both the east and west coasts to find an ideal solution.

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### Reference

1. Sullivan P. Shut out at home, Canadians flocking to Ireland's medical schools — and to an uncertain future. *CMAJ* 2000;162(6):868-71.

## What's in a name?

We echo Peter Wing's sentiments regarding the use of the word "patient" rather than "client" for people

seeking health care.<sup>1</sup> The choice of words has perhaps more relevance in psychiatry than in other medical disciplines. Failure to call an ill person a patient may lead to suboptimal management of psychiatric disorders and may deprive the person of some state and insurance benefits. Indeed, the Mental Health Act continues to use the term patient.

Via a self-administered questionnaire, we surveyed the preferences of 402 consecutive people (median age 42 years) who sought outpatient mental health care between October 1997 and January 1998 from 5 psychiatrists in Langley, British Columbia. A similar questionnaire was also administered to 60 physicians (6 psychiatrists, 54 family physicians), 30 nurses, 16 social workers and 13 occupational therapists at Langley Memorial Hospital and Langley Mental Health Centre.

Seventy-two percent of the care seekers (289/402) preferred to be addressed as patients, with 27% preferring the term clients and 1% the term consumers. Older people preferred to be called patients. Ninety-five percent of the physicians preferred to address those for whom they care as patients. In contrast, 57% of the nurses and 15% of the occupational therapists preferred the term patient. None of the social workers wanted to use the term patient; they preferred the term client (75%) or consumer (25%).

There is a clear dichotomy between the preferences of physicians and non-

physicians. However, the majority of people seeking mental health care prefer to be addressed as patients, which leads us to believe that there is no reason to deviate from the current medical vocabulary.

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#### Reference

1. Wing PC. Patient or client? If in doubt, ask. *CMAJ* 1997;157(3):287-9.

## HIV infection and risk behaviours in young gay and bisexual men

We have several concerns about the interpretation of the findings of a recent cohort study of sexual behaviour and HIV infection among young men who have sex with men in Vancouver.<sup>1</sup> Of the 11 subjects who became seropositive, 3 reported having injected drugs and 1 having shared needles. The other 2 may also have shared needles; this practice is often under-reported because of its social undesirability and poor recall related to the effect of the drugs. Thus, the 3 subjects may have been infected through injection rather than through sex with other men. In fact, injection was significantly associated with HIV infection ( $p <$

0.001) whereas sharing needles was not ( $p = 0.06$ ), and HIV incidence among injection drug users during this period was extremely high (18.6 per 100 person-years<sup>2</sup>).

We also question the inclusion of the man who had an indeterminate result at baseline in the seroconverter group; subjects in a cohort study should be susceptible at study entry. Excluding the 3 subjects who injected drugs and the seroconverter yields an HIV incidence of 1.1–1.3 per 100 person-years (depending on whether the seroconverter also injected drugs). This is similar to the HIV incidence of 1.05 per 100 person-years we observed in men under 30 years old who have sex with men in Montreal from 1996 to 1999 (unpublished data). We believe HIV incidence among men who have sex with men should be calculated excluding those with other risk factors or, alternatively, calculations should be made separately for subjects with and without other risk factors.

Finally, the authors concluded that levels of unsafe sex increased over time on the basis of the proportion of subjects reporting safe sex at baseline who reported unsafe sex at follow-up. In Montreal we found that sexual behaviour is dynamic; a large proportion (51%) of those who practised unsafe sex at baseline practised only safe sex at follow-up,<sup>3</sup> which resulted in similar proportions of subjects reporting unsafe sex at baseline and follow-up despite the fact that about 10% of those reporting safe sex at baseline reported unsafe sex at follow-up. Therefore, risky sexual behaviour among both those with safe and those with unsafe

sexual practices at baseline must be examined at follow-up.

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#### References

1. Strathdee SA, Martindale SL, Cornelisse PGA, Miller ML, Craib KJP, Schechter MT, et al. HIV infection and risk behaviours among young gay and bisexual men in Vancouver. *CMAJ* 2000;162(1):21-5.
2. Strathdee SA, Patrick DM, Currie SL, Cornelisse PG, Rekart ML, Montaner JS, et al. Needle exchange is not enough: lessons from the Vancouver injecting drug study. *AIDS* 1997;11:F59-F65.
3. Alary M, Dufour A, Otis J, Remis RS, Masse B, Turmel B, et al. Determinants of transition from safe to unsafe sex among men having affective and sexual relations with men (MASM) in Montreal [abstract]. Eighth annual conference of the Canadian Association for HIV/AIDS Research; 1999 May 1-4; Victoria. *Can J Infect Dis* 1999; 10(Suppl B):75B-76B.

#### [The authors respond:]

We recalculated the HIV infection rate based on all years and on whether a subject had reported that they had ever injected drugs. These new person-time estimates of HIV incidence are based on 18 subjects who became HIV positive after their baseline seronegative test, 8 more than in our published study<sup>1</sup> and excluding the person with the baseline indeterminate result. The incidence rate has been revised to 1.2 per 100 person-years (95% CI 0.6–1.7) (Table 1) since the paper

**Table 1: Incidence of HIV infection among study participants, by study year and category**

Study year	All participants ( $n = 617$ )		Noninjection drug users ( $n = 555$ )		Injection drug users ( $n = 61$ )	
	New infections	Rate (95% CI)	New infections	Rate (95% CI)	New infections	Rate (95% CI)
1	1	1.0 (0.0–2.8)	1	1.0 (0.0–3.1)	0	–
2	6	1.7 (0.3–3.1)	3	0.9 (0.0–2.0)	3	11.4 (0.0–24.3)
3	2	0.5 (0.0–1.1)	1	0.2 (0.0–0.7)	1	3.2 (0.0–9.4)
4	5	1.2 (0.1–2.2)	4	1.0 (0.0–2.0)	0	–
5	4	1.8 (0.0–3.6)	4	2.0 (0.0–4.1)	0	–
All years	18*	1.2 (0.6–1.7)	13	0.9 (0.4–1.4)	4	3.1 (0.6–6.1)

\*Data regarding injection drug use were unavailable for 1 seroconverter, who was identified through anonymous database linkage.