Letters

Correspondance

Training aboriginal health care workers

Perhaps I let my pride in our program and its achievements carry me away when I told your writer that the University of Alberta has graduated the largest number of aboriginal physicians in Canada.[1] It was not my intention to demean the Professional Health Program at the University of Manitoba, nor its success in training aboriginal health professionals.[2] I should have qualified my statement by noting that although we have graduated the largest number of aboriginal physicians in the shortest time — 20 since 1993 — the University of Manitoba program, with its longer history, has a larger number of aboriginal graduates overall.

At the same time, I'm sure that the University of Manitoba did not intend to reduce the achievements of our program to a single sentence. Far from selecting only qualified applicants nationally, we have offered positions to out-of-province students who did not qualify for admission to medical schools that have no admissions policies for aboriginal Canadians, as well as to applicants who qualified in the general pool. Nor have we found our national recruitment policy incompatible with developing a strong aboriginal applicant pool in Alberta. In the 1999/2000 academic year, 8 of the 12 aboriginal students enrolled in our medical program were Albertans.

However, rather than launching a debate about numbers, we need to talk more with our sister medical schools and other health professional training programs, particularly those that have not been as active in training aboriginal health professionals. In its 1996 report, the Royal Commission on Aboriginal Peoples identified a need for 10 000 aboriginal health professionals in Canada. This would include about 1000 physicians — roughly 10 times the current number — to bring the ratio close to that for the general population.

Despite the best efforts of both our programs, we are far from being on track to achieve this goal. We need a concerted effort from all 16 medical schools, coordinated through the Association of Canadian Medical Colleges and the Canadian Association for Medical Education, to develop plans to achieve these targets.

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References
1. Kent H. U of A proving popular with native students. *CMAJ* 2000;162(4):550.
2. Pinette G, Herrmann R, Hennen B. Training aboriginal health care professionals in Manitoba [letter]. *CMAJ* 2000;162(12):1661-2.

Hepatitis B and medical students

Because of hepatitis B virus (HBV) infection and other infectious diseases, several Canadian medical schools have created controversial admissions policies that have led to ethical debates about the rights of students and their future patients.

One prevention strategy requires students to provide evidence of vaccination before clerkship or face training and career restrictions, thus making successful immunization a condition of employment. To minimize high-risk encounters, most schools steer HBV-positive students into community medicine, administration, laboratory medicine, psychiatry and research. Only one school permits students to enter family medicine or certain subspecialties, with the understanding that they are not to perform any elective obstetric or invasive procedures. To allow students to make informed decisions regarding career goals and preferred training locations, all Canadian medical schools should be reading off the same song sheet.

Given the perception of exposure risk, public disclosure of (future) physicians' serologic status would have devastating effects on their livelihood and invade their right to privacy. A delicate balance must be struck between a patient's right to informed decision-making and the potential harm caused by disclosure. Physicians and ethicists must make a "best-interest judgement" and determine the risk that a reasonable person in the patient's position would be willing to take. Unlike medical students, who agreed to a certain level of risk upon entering medicine, it may not be right to assume that patients also agree.

The principles of biomedical ethics do not point to a clear course of action but provide conflicting guidance. In the meantime, schools must inform (prospective) students of the risk of training-related disability, offer appropriate counselling services and provide options for income security through meaningful work or retraining.

The debate over the suitability of potentially infectious students raises legal, ethical and individual issues. Voluntary testing, coupled with an intensive public health initiative to vaccinate the entire population, may be the most respectful of solutions. Nevertheless, patients must come first. Students performing "exposure-prone" procedures have a moral and ethical obligation to

know their HBV status. However, students should be free from unwarranted immunologic discrimination based on remote risks that are generally tolerated within society, such as those seen in noninvasive medical procedures. But how much risk is acceptable?

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Antismoking documents now available on Web site

I wish to clarify our position on claims made in a recent *CMAJ* article.[1] Your reporter stated that British Columbia is withholding internal tobacco industry documents (the Guildford documents) collected to support the government's lawsuit to recover health care costs associated with smoking-related disease.

That is not the case. To avoid any suggestion that government action might influence the outcome of a constitutional challenge to the legislation upon which the lawsuit was based, the province temporarily withheld publishing the Guildford documents until a decision in the constitutional challenge was rendered. After the decision was handed down, the documents were made public on Apr. 18 (www.health.gov.bc.ca/tobacco). These 15 000 pages of documents concerning British American Tobacco and its Canadian associate, Imperial Tobacco Ltd., were retrieved by BC from the Guildford document depository in Guildford, England. These documents were first made available at the depository as part of the settlement of Minnesota's lawsuit against tobacco companies. Another 5000 documents have recently been received from Guildford and will be added to our Web site shortly.

The documents provide inside information on the tobacco industry, including its marketing and promotional strategies. With them, health organizations and governments interested in tobacco reduction can find information about business practices within the industry.

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Reference
1. Sibbald B. Physicians fight for access to tobacco info, hope to show criminal negligence. *CMAJ* 2000;162(10):1468.

Licensing international medical graduates

Rodney Andrew and Joanna Bates recently reported on an attempt to manage the significant problems surrounding the licensing of international medical graduates (IMGs) in British Columbia.[1] The financial burden must be significant, yet this solution only accommodates 6% to 8% of eligible applicants. It will not satisfy the BC applicants who are not selected, nor the many more scattered across the country.

It should be no surprise that none of the successful candidates has left Canada for the United States, since this is becoming more difficult these days. The fact that only 4 candidates were recognized to have attitudinal difficulties is not surprising either. Most faculty give only lip service to this topic, and avoid it if possible.

I found parts of the report unclear. If, as they say, "No passing grades are set; IMGs compete against each other at each step …," how are the top 2 candidates selected? The assumption would be that a bell curve was created from the grading system and a cut-off determined. If the selection is based on subjective evaluation, BC may face appeals by those not chosen. How is this eventuality avoided?

Finally, the federal government has created this problem, since immigration is a federal authority. IMGs

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