Letters

Correspondance

Update from the Canadian Dyspepsia Working Group

In our recently published *CMAJ* supplement on the management of uninvestigated dyspepsia in the era of *Helicobacter pylori*,[1] we (on behalf of the Canadian Dyspepsia Working Group) made a very cautious statement about the use of cisapride, given the increasing number of publications that have recently described rare but potentially serious cardiac consequences associated with use of this drug. Cisapride was listed as a third option in the mini-management schema for gastroesphageal reflux disease (Fig. 3)[1] and was also listed as a third option in the treatment schema for patients who have a negative result of noninvasive diagnostic testing for *H. pylori*. Given the cardiac side effects of cisapride use, both the Health Protection Branch and the US Food and Drug Administration have decided that cisapride should be withdrawn from the market and only released following special authorization for selected individuals. Given these recent changes in the availability of cisapride, the Canadian Dyspepsia Working Group feels that we can no longer recommend this medication for the treatment of gastroesophageal reflux disease or for the treatment of dyspepsia that is *H. pylori* negative.

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A parent and a doctor

The recent article by Bibiana Cujec and colleagues highlighted several important factors relating to lifestyle and general life satisfaction within medicine.[1] The accompanying commentary also raised a number of important issues.[2] I was disturbed, however, by the statement that "women sacrifice productivity to parenting (or vice versa)."[2] This suggests that parenting is a nonproductive activity.

It is true that for women the pursuit of any career is often filled with stress and guilt, and these feelings also occur when women choose to remain at home with their children. Statements suggesting that parenting work at home is nonproductive only serve to increase those feelings.

I was much more encouraged by the recent suggestion by Barbara Lent and colleagues that, in relation to parental leave, all employers "should be encouraged to facilitate the efforts of both women and men to balance work and family responsibilities."[3]

We should not be focusing on encouraging (and sometimes pushing) women to leave the home and go into the workplace. Instead, our challenge is to encourage both men and women to be all they can be and want to be. The aspirations of parents may include pursuing a career outside of the home, but we should also encourage men and women to share responsibilities for our children, who often don't see enough of us.

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[Two of the authors respond:]

We agree wholeheartedly with Cornelius Woelk that parenting is rewarding and productive work and should be recognized as such. Parenting does have costs, such as limits to career advancement[1] and personal pursuits. Although ideally both parents are interested and equally involved in parenting, this is often not the case. Women bear the brunt of child-rearing responsibilities, whether by choice or by default.[2] Unfortunately, one cannot be everything to all people (oneself and one's children, spouse, patients, department heads, etc.).

Establishing goals and setting priorities at different stages of life should be the objective. The rise in the number of female physicians has forced the importance of parenting responsibilities to surface. These issues are of equal importance to men. Flexibility in practice settings and training programs is helpful to all physicians — parents or not.

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Battling opiate overdoses

I thoroughly enjoyed your recent articles on substance abuse in the June 13 issue of *CMAJ*, especially Kyle Stevens' essay.[1] I cannot help but think that if the narcotic antagonist naloxone was made readily available to heroin addicts and others as a harm reduction measure (perhaps as an expansion of a needle exchange program) there would be fewer deaths from opiate overdose. After all, most addicts would have little trouble subcutaneously or intravenously injecting naloxone into an unresponsive friend while awaiting a 911 response,[2] and the drug would certainly not be used for recreational purposes. Indeed, this idea is being seriously explored in the addiction literature.[3,4]

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You can't have one without the other

Did anyone else note the rather bizarre, if not macabre, juxtaposition of 2 articles in the July 11 issue?[1,2] One dealt with the prevention of motor vehicle injuries, whereas the other concerned improvements in organ donation rates. Seems to me you can't have it both ways!

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Attitudinal problems facing international medical graduates

T.B. MacLachlan's recent letter illustrates the attitudinal problems Canadian citizens who graduate from schools outside Canada face when they attempt to obtain licensure in Canada.[1]

The article on British Columbia's experience with the licensing program for international medical graduates (IMGs) showed that the program had a 100% licensure and in-country retention rate at a much lower cost than that of training a physician from scratch.[2] The program also eliminates the possibility of having newly minted, Canadian physicians ending up paying taxes to Uncle Sam after having had several hundred thousand taxpayer dollars spent training them in Canada.[3]

Instead of seeing such programs as cost-effective, short-term solutions to the oft-reported Canadian physician shortage,[4] people quibble about the "significant cost" or about whether such programs really meet the needs of *all* IMGs in Canada.

When faced with the possibility that IMGs might have to be considered for practice in Canada, Canadian doctors — at least the ones who have written to CMA publications — react by enacting rules to exclude them[5] or faulting them for having to study abroad.[6] This is done despite reports about the need for more physicians[7] and about how hard it is to get into medical school in Canada.[8]

Being a Canadian citizen and an IMG who has at least US$400 000 worth of postgraduate medical training in the United States, I find myself having to head back to the United States to join other Canadian citizens who are also IMGs, after being unsuccessful in my attempts to obtain licensure here. I knew I would have a hard time trying to get medical training here but I didn't know how hard it would still be after I received accredited training in the United States.

Canadians deserve the best medical care in the world, but are they getting it when doctors feel so overworked they take job action to get funding for additional manpower, as physicians have done in British Columbia?

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