Pressure mounting to curb MD poaching by rich nations

The rising international demand for physicians is continuing to fuel fears that developed countries like Canada will siphon too many doctors from poor nations (see *CMAJ* 2001;164[3]:387-8).

Canada has long relied on a steady supply of physicians from countries such as South Africa to supplement its own supply — in Saskatchewan, more than half the practising MDs trained outside the country. However, a recent international conference on the medical workforce made clear that a move away from "plundering" physicians from the developing world is gathering momentum.

"As chair of our committee on ethics, I have a particular issue with the developed world taking physicians from the developing world, which can ill afford to lose them," said Dr. Trevor Mudge of the Australian Medical Association.

The 4-day conference in Ottawa featured participants from Britain, Canada, Australia and the world's largest importer of MDs, the US. Codes concerning the ethical recruitment of physicians from underdeveloped countries have already been devised, but their effectiveness remains unclear. "The fact is, the core issues [that encourage emigration] are in the developing countries themselves," said Dr. Thomas Getzen, director of the graduate program in health care finance at Temple University in Philadelphia and executive director of the International Health Economics Association.

The recruitment issue was discussed during the World Health Organization's recent World Health Assembly in Geneva, where delegates from developed countries pointed out that the "push" for physicians to leave their native countries is often as strong or stronger than the "pull" from countries like Canada.

"It makes it very difficult to thoroughly examine the issue of medical migration if there is no recognition that adverse living conditions, poorly funded health systems and other factors are pushing them out too," said CMA President Henry Haddad, who was a member of the Canadian delegation at the assembly.

The CMA Masterfile of Physicians indicates that 23% of Canada's practising physicians trained outside the country (see *CMAJ* 2002;166[10]:1320). Their presence ranges from a low of 12% in Quebec to a high of 53% in Saskatchewan.

The World Medical Association (WMA) recently created a committee to examine physician recruitment and to develop a policy concerning the exploitation of doctors recruited to work in other countries. "These recruits are often treated as less than equal than physicians in those countries," said Dr. Hugh Scully, a CMA past president who is chairing the WMA group examining the issue. "For instance, [some have] their passports kept until their contracts are fulfilled or receive less sick pay and fewer benefits. We want to ensure that once a physician moves from one country to another, [he or she] will be treated no differently from physicians in that country."

The notion of "social responsibility" within the international medical community is also gaining momentum.

"If we don't put health care and social resources back into developing countries as fast as we take them out, we will have another Sept. 11 as sure as eggs is eggs," warned Dr. Peter Bundred of the University of Liverpool. — *Steve Wharry*, CMAJ

"Completely ridiculous" demands ruining medicare

A spirited attack on a society that places many unnecessary demands on Canada's health care system was the focus of the showcase lecture during the May annual meeting of the Canadian Health Economics Research Association.

In delivering the Justice Emmett Hall Lecture, Dr. Charles Wright contended that the demand side of the health care equation has been ignored in recent reviews and critiques of medicare because all attention has been focused on the supply of medical and health services. Wright, a professor of health care and epidemiology at UBC, said Hall could not have foreseen how the scope of and demand for services would grow as he helped create Canada's medicare system in the 1960s.

He said current popular thinking that medicare can publicly fund all medical services that all people might want and demand is "completely ridiculous." He pointed to the growth of elective medical services and the waiting lists for them. "We're not talking about gunshot wounds to the belly," he said, but about surgical procedures, the need and timing of which are largely a judgement call on the part of the physician.

Wright listed a growing number of medical procedures that have not been proved clinically necessary, ranging from the use of antibiotics for minor childhood infections to mammography and prostate specific antigen screening. And he was applauded when he attacked direct-to-consumer advertising for prescription drugs. "Good morning! used to be a greeting between friends," he said, referring to an ad for sildenafil.

He then turned to the "medicalization" of life, with a special focus on conditions such as complicated grief disorder and generalized anxiety disorder. "Unhappiness is now a serious condition," he noted, adding that "we have narrowed the bandwidth of normal behaviour" so that many more behaviours now are targets for medical intervention. He called for education blitzes to challenge ad campaigns and the inappropriate prescribing pressures they create.

He said there is a need to change medical culture and foster more consideration of the appropriateness of medical interventions, and that physicians must reconsider the notion that just because something can be done, it should be done.

Wright admitted that all attempts to correct the problem face an uphill battle because of politicians and health care providers who are unwilling or unable to act. "Politicians are terrified about this stuff," he said, noting the unwillingness of any politician to tell the public that access to all the medical services they want may be impossible.

Wright, a frequent contributor to *CMAJ*, is a member of the Clinical Epidemiology and Evaluation Centre at the Vancouver Hospital and Health Sciences Centre. — *Pat Rich*, CMAJ