

Why are Quebec's doctors leaving?

The Canadian Institute for Health Information (CIHI) recently reported that Quebec shows a net loss in the interprovincial migration of physicians,¹ and this poor performance is compounded by the departure of physicians to other countries. In all, 653 doctors have left Quebec in the past 5 years. Their average age was 40.8 years, so they were at the peak of their productivity. Why are they leaving?

The migration of significant numbers of skilled professionals is one of the signs of a society's total or partial inability to allow those professionals to grow and thrive. While the causes of such an exodus may vary, the message that must be drawn is harsh: such movement almost invariably implies that this society is relatively less capable of supporting — in logistical, technological, scientific or financial terms — the activities of this special workforce.

We believe that physicians belong to this special workforce and that their exodus is highly significant. The debate surrounding physicians' migratory trends is highly charged, but beyond sensationalism and scoring political points we need to take a serious look at the issue because even though the statistics appear to suggest a slight improvement, the exodus from Quebec is real.

Beyond mere figures, there is a "qualitative" exodus because highly skilled physicians with special expertise depart, leaving behind hospitals incapable of providing extra-specialized care, surplus work for colleagues who remain and a weakened teaching base.

That 653 skilled medical professionals should leave Quebec in 5 years is scandalous. So what can we do to end the scandal? Medical practice in Quebec has to be made more attractive. Coercive measures concerning physician employment must be eliminated. We have to take a fresh look at how our system is managed and find new ways to fund it, while still maintaining the principles embedded in the Canada Health Act. Health care and the biomedical

sciences have to aim for excellence. If we do that, then perhaps we will be able to offer our physicians a more attractive environment.

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Canker sore remedies: baking soda

It is with great pleasure that I look forward to reading your Holiday Review each year! I was especially interested in the home remedy on canker sores submitted by Jane Mettham.¹ For as long as I can remember, I have used baking soda on canker sores. It is used in a similar fashion as described for alum powder and is a common household product. Similarly, it hurts like heck but it seems to work. A quick search of PubMed revealed a reference for using baking soda mouthwashes in the treatment of oral ulcerations.²

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Adverse drug reaction reporting controversy

Volumes have been written on the limitations of spontaneous reporting systems as means of identifying and evaluating drug-induced disease. However, when *CMAJ*'s editors commented that "when serious drug interactions are discovered, physicians, pharmacists and patients appear to remain unaware of

them"¹ and that in spite of 4 *Dear Health Professional* advisories and articles in 3 issues of the *Canadian Adverse Drug Reaction Newsletter* (published in *CMAJ*), a young woman died from taking cisapride² — they shot the messenger. Some of the remedies proposed in the editorial for postmarketing surveillance in Canada have merit, but other comments are simply regurgitations of past sentiments that fail to appreciate how our current system works.

No evidence exists that mandatory adverse drug reaction reporting for physicians provides any better data than what is available presently. In fact, those who have worked in this field for some time suggest that a reporting system be based on direct communication between clinicians and professionals at the monitoring centres.³ Countries with mandatory reporting for physicians provide no better "signals" from adverse drug reaction data than those without mandatory reporting. The intention of the Canadian Adverse Drug Reaction Monitoring Programme (CADRMP) Regional Centres is to provide the close link with practitioners necessary for encouraging reporting as well as providing feedback regarding the reports that are received.

More is not necessarily better. Although Canada has a respectable reporting rate compared to other countries with well-recognized regulatory programs (176 per 1 000 000 population, in the range of 56-429),⁴ the quality of reports is of more concern. A recent study by Liu and colleagues⁵ shows that among 97 cases of fatal adverse drug reactions, 70% did not include information on medical history, and 42% did not have adequate information to assess time of onset of the adverse drug reaction. These are perennial problems with adverse drug reaction reporting that are not solved by simply increasing the number of reports provided by practitioners.

In the first reorganization of the CADRMP between 1990 and 1995, effective aspects of pharmacovigilance programs in various countries were incorporated: regional reporting centres, an expert advisory committee and the

Canadian Adverse Drug Reaction Newsletter. These programs cost money and require a continued commitment. The regional centres struggle on paltry budgets to provide minimal service, the expert advisory committee has been all but abandoned and the use of high-quality provincial health databases is beyond the program's financial reach. Evidently, Health Canada does not understand that drug-induced illness is a major public health concern.

Setting up proactive surveillance programs would be a worthwhile endeavour in any country.⁶ The New Zealand Intensive Medicines Monitoring Program⁷ is a good example of what can be done at a reasonable cost. Health Canada would do well to explore this option once it decides to support pharmacovigilance in our country.

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Clinicians' role in responding to bullying

I read with great interest Erica Weir's Public Health article on the potentially harmful impact of bullying on victims' psychosocial adjustment.¹ As a high percentage of children and adolescents are exposed to bullying with-

out adequate intervention from school personnel, parents or mental health professionals,² I was particularly pleased to read Weir's discussion about the role of clinicians in responding to peer victimization.

In addition to enhancing the self-esteem of the victim, psychotherapy can address the contribution of psychiatric symptomatology, namely difficulties with social anxiety, to problematic peer relationships. Socially anxious people typically experience cognitive, behavioural and physiological symptoms in anticipation of or during social interactions. Such symptoms are often associated with difficulty in peer relations, as overt anxiousness may interfere with the development of social skills and friendships.³ In addition, the overt anxiety displayed by some victims may make them vulnerable to peer maltreatment because they present easy targets to bullies.⁴

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Air travel and venous thromboembolism — the jury is still out

Recent correspondence by Michael Mant states that the association between air travel and venous thromboembolism is weak.¹ However, more evidence has appeared in the literature in the last few months on this association. A recent study found that distance

travelled is a significant contributing risk factor for pulmonary embolism associated with air travel.² In this study, the rate of pulmonary embolism was 4.8 cases per 1 000 000 passengers for those travelling more than 10 000 km, and 1.5 cases per 1 000 000 for 5000 km of travel, as compared to 0.01 cases per 1 000 000 among those travelling less than 5000 km.

Symptomless deep vein thrombosis (DVT) might occur in up to 10% of long-haul airline travellers, and the wearing of elastic compression stockings during long-haul air travel is associated with a reduction in symptomless deep vein thrombosis.³

A report from the House of Lords in the United Kingdom entitled *Fifth Report: Air Travel and Health* has reviewed the evidence available and put forward certain recommendations to prevent deep vein thrombosis based on the baseline risk of the passengers.⁴

Finally, information for air travellers on ways to prevent venous thromboembolism is abundant on the Internet. The Web site www.airhealth.org has produced an excellent information sheet.⁵ Travellers can print it off and carry it with them. Some interesting tips on in-flight exercises can also be found from the Web site of Qantas.⁶

The jury is still out on this association, and we can expect a verdict as more high-quality evidence emerges in the literature.

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