

UK seeks to integrate refugee MDs

Attempts are being made to help refugee physicians practise in Britain. The move comes as the National Health Service (NHS) seeks to bolster the MD supply by 2000 GPs and 7500 specialists by 2004. "Given that the NHS is critically short of doctors and it costs [Can\$600 000] to train one, it seems such a waste not to help qualified professionals," said Dr. Edwin Borman, chair of the British Medical Association's (BMA) International Committee.

The BMA is working to help more than 600 refugee physicians, but Borman thinks there are many more who would like to resume their careers. (In Canada, provincial governments and the colleges of physicians and surgeons are responsible for integrating such physicians into the medical system.)

The BMA and the Jewish Council for Racial Equality (JCORE) have published a guide for refugee doctors, which covers topics such as the NHS and requirements for practising in the UK. JCORE Director Edie Friedman says many refugees lack information in these areas and seemed resigned to being unable to practise. She said funding for doctors seeking requalification is "very patchy"; if more was made available it could actually cost far less than training new MDs from scratch.

The BMA, which waives membership fee for refugee doctors in financial need, also offers a free package of benefits for asylum-seeking MDs and provides an informal mentoring program. There are no similar programs at the national level in Canada.

The BMA's working paper on ways to help refugee physicians (www.bma.org.uk) notes that many of them were well advanced in their careers when they fled and they are now having a hard time adjusting to the training needed to meet requirements. Others may have had their training interrupted or their documentation destroyed and have difficulty securing references. As well, they often lack fluency in English. — *Mary Helen Spooner, West Sussex, UK*

Fallout from JAMA's HRT study continuing to land in MDs' offices

Physicians' offices were deluged with calls in July after results from a study involving the use of estrogen plus progestin hormone replacement therapy (HRT) were released early (*JAMA* 2002;288(3):321-33). Weeks later, doctors were still trying to figure out what findings from the Women's Health Initiative (WHI) trial actually mean.

Dr. Morrie Gelfand, president of the North American Menopause Society (NAMS), says media coverage alarmed many women. "There was lots of sensationalism," says Gelfand, who practises at Montreal's Jewish General Hospital. "Numbers can be used to make anything sound good or bad. We're talking 10 000 women-years here. What about the decrease in fractures and colorectal cancer rates? What does it really mean?"

NAMS (www.menopause.org/) has selected 10 experts to assess the study; findings will be released in October.

The trial, which involved 16 608 women aged 50 to 79, was stopped because preliminary results showed statistically significant increases in coronary disease, invasive breast cancer, stroke and pulmonary embolism in women being treated with estrogen plus progestin. The WHI trial, which was supposed to end in 2005, was designed to examine HRT's effect on the prevention of heart disease and hip fractures, and any associated change in risk for breast and colon cancer. The researchers concluded that "overall health risks exceeded benefits."

The 8506 women treated with estrogen plus progestin had about 40 more coronary events, 40 more strokes, 80 more episodes of venous thromboembolism and 40 more instances of invasive breast cancer than the 8102 women as-



Health Canada

Healthy aging post-HRT?

signed to the trial's placebo arm. However, Dr. Jennifer Blake, spokesperson for the Society of Obstetricians and Gynaecologists of Canada (SOGC), says data provided in the *JAMA* study are "small numbers among 16 000 women. The relative risk [of breast cancer because of this treatment] is the same as when a woman has her first baby after 35."

The SOGC initially cautioned women not to overreact and said that the study assessed only one product (Prempro, which isn't available in Canada) and didn't necessarily apply to other products. Blake says the society is now "seriously" assessing the study's implications and may modify its guidelines.

Blake agrees that the study is "going to affect how we use HRT. It's thrown a spotlight on the use of progestin."

Dr. Wulf Utian, executive director at NAMS, used more dramatic language: "This is the biggest bombshell to hit in my 30-some years in the menopause area." — *Barbara Sibbald, CMAJ*

Other HRT-related articles in this issue of *CMAJ*

- Yusuf S, Anand S. Hormone replacement therapy: a time for pause. p. 357.
- Day A. Lessons from the Women's Health Initiative: primary prevention and gender health. p. 361.
- Sackett DL. The arrogance of preventive medicine. p. 363.
- Farquhar D. Postmenopausal hormone replacement therapy for chronic disease prevention: results from the Women's Health Initiative trial. p. 377.