Common PGY-1: pro and con

I was surprised by Pat Rich's recent article about support for changes to postgraduate medical education in Canada,[1] as discussed at the CMA's annual general meeting in August 2003. The common first postgraduate year of training that is being proposed sounds very similar to the now defunct rotating internship, which provided young doctors with a broad-based, common first year of training. The rotating internship was abolished in the early 1990s, mainly at the prompting of the College of Family Physicians of Canada (CFPC). As I recall, the college insisted that once it moved to the 2-year residency system, the internships could not continue; the college wanted residency to begin immediately after the fourth year of medical school. This change removed the opportunity for young doctors to experience some "real medicine" and reassess their first choice of specialty before entering residency.

In 1993/94, I was one of those lucky enough to experience 12 months of rotations throughout the Maritimes, courtesy of Dalhousie University's valuable rotating internship. After my internship I wrote letters supporting internships[2] and the position of my colleagues D.B. Craig and D. McKnight,[3] who reported how difficult it was to fill anesthesia residencies without the rotating internships.

Now that the CFPC is lacking interested applicants, it wants to reintroduce the internship. On the surface I support this change — an internship is a phenomenal learning experience, ensuring that all physicians have some common knowledge and experience, regardless of the residency and area of practice that they eventually choose. But I'm doubtful about the CFPC's motives. If the college sincerely cared about giving residents the best overall training, would it have played such a crucial role in ending rotating internships?

Brent Kennedy
Department of Anaesthesia
Sudbury Regional Hospital
Sudbury, Ont.

References
1. Rich P. Restore flexibility in postgraduate education, MDs beg. *CMAJ* 2003;169(6):594.
2. Kennedy B. Proposals for improving career selection [letter]. *CMAJ* 1995;152(8):1045.
3. Craig DB, McKnight D. Career selection regulations hurting anesthesia [editorial]. *CMAJ* 1994;151(11):1560.

I was dismayed to learn that a common PGY-1 year for medical graduates is being proposed for reinstatement.[1] A common year merely defers the decision that students must eventually make, without providing them with any helpful information, and denies students who already know what they want to do a year of specialty-specific training.

A common PGY-1 year would also undermine the efforts of family medicine programs across the country to make the most of the 2-year residency. Many core rotations are already generalist-oriented. For example, orthopedics rotations are often expanded into musculoskeletal rotations incorporating rheumatology and sports medicine. By making the first of 2 short years of family medicine a common year, residents interested in family practice may be forced to face a specialist-oriented year.

I agree that medical students are forced to choose their specialty too early — in the fall of fourth-year medical school — often before they have done elective rotations in areas of potential interest. The key is to offer opportunities for such career-determining experiences before the Canadian Residency Matching Service (CaRMS) match. Options include pushing back the match (i.e., having residencies begin in the fall rather than on July 1), restructuring medical school years, having electives for "career sampling" in first and second year, starting clerkships earlier or using the end of fourth year for review instead of clinical rotations.

At some point, every student needs to make a decision about his or her career, and not everyone will be happy with their initial choice. This is why we need re-entry options and flexibility in the system. Maximizing the potential of the current system is a much better strategy than revamping the system entirely every 10 years. After all, isn't the idea to provide residents with the best training possible and then get them out into the workforce?

Laura Loijens
Family Medicine Resident PGY-2
Queen's University
Kingston, Ont.

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1. Rich P. Restore flexibility in postgraduate education, MDs beg. *CMAJ* 2003;169(6):594.

It's no accident

In a recent article in the News section, Barbara Sibbald described a collision between a school bus and a

pickup truck in which one girl died.[1] Paragraph 4 of the article,[1] as well as the table of contents of the *CMAJ* issue in which it appears (page 891), use the word "accident" to refer to the collision. This terminology is misleading.

An accident is unpredictable and unpreventable. However, almost all motor vehicle collisions are due to driver error, often compounded by fatigue, alcohol or excess speed. Motor vehicle collisions are a major source of injury, disability and death. If this carnage were due to an infectious agent, the outcry would be deafening — witness the continuing furor concerning SARS.

Vehicular incidents are predictable and preventable. The *CMAJ* could help to improve public attitudes toward the causes of these events by using the proper words to describe them.

Robert Shepherd
Gatineau, Que.

Reference
1. Sibbald B. MDs call for new safety features after death in school bus crash. *CMAJ* 2003;169(9):951.

[The associate news editor responds:]

Robert Shepherd's point is well taken, and the CMAJ editors agree that the word "accident" should not have been used in my article[1] or in the table of contents for the issue.

We intend to follow the example of *BMJ*[2] and will in future avoid use of this term with reference to motor vehicle collisions and other predictable and preventable incidents causing injury and death.

Barbara Sibbald
CMAJ

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1. Sibbald B. MDs call for new safety features after death in school bus crash. *CMAJ* 2003;169(9):951.
2. Davis RM, Pless B. *BMJ* bans "accidents". Accidents are not unpredictable [editorial]. *BMJ* 2001;322:1320-1.

Mercenary hypocrisy at *CMAJ*

The CMA[1] and the Royal College of Physicians and Surgeons of Canada[2] both have guidelines restricting relationships between physicians and industry. These include specific admonitions against receiving gifts.

In its Sept. 30, 2003, issue, *CMAJ* published a news article containing criticisms of oxycodone (OxyContin) because of its highly addictive nature and describing legal actions being taken against the manufacturer. In the same issue, and in a much more prominent space, *CMAJ* sold a full-page colour ad promoting OxyContin for the treatment of chronic pain.

The usual tired caveats in the journal's defence will be invoked: that the prescribing physician is ultimately responsible for obtaining, synthesizing and interpreting the medical literature related to a treatment decision. It seems to me, though, that *CMAJ* has gone beyond mere hypocrisy to a new level of mercenary greed. While the CMA admonishes physicians against having truck with nefarious pharmaceutical types, *CMAJ* is lining its pockets with money from a company selling a drug that has introduced a new level of misery — addiction — into the lives of patients with chronic pain.

Michael Jacka
Department of Anesthesia
Division of Critical Care
University of Alberta
Edmonton, Alta.

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2. *Physicians and industry — conflicts of interest*. Ottawa: Royal College of Physicians and Surgeons of Canada; updated 2003 Aug 25. Available: rcpsc.medical.org/english/publications/ (accessed 2003 Oct 29).
3. OxyContin class-action suit to proceed. *CMAJ* 2003;169(7):699.

Competing interests: None declared.

[The editor responds:]

Michael Jacka criticizes *CMAJ* for accepting an OxyContin advertisement directed at physicians while publishing a news story[1] describing a US class action lawsuit against Purdue Pharma for aggessively marketing OxyContin.

Drug advertisements in Canada, unlike those in the United States, are regulated by the Pharmaceutical Advertising Advisory Board, an autonomous organization endorsed by Health Canada.[2] This process provides assurance that Canadian advertisements are appropriate for the intended audience. Undoubtedly narcotics can lead to addiction, but they are also useful in certain clinical situations.[3]

John Hoey
CMAJ

References
1. OxyContin class-action suit to proceed. *CMAJ* 2003;169(7):699.
2. Chepesiuk R. Supported by an unrestricted educational grant [editorial]. *CMAJ* 2003;169(5):421-2.
3. Gardner-Nix J. Principles of opioid use in chronic noncancer pain. *CMAJ* 2003;169(1):38-43.

Eliminate trade barriers

The collapse of the WTO meeting in Cancun[1] in September has exposed the gross disadvantage that African, Caribbean and Asian countries have endured for decades. The promise of the benefits of so-called free trade, and the absolute certainty of the trickle-down theory, so enthusiastically proclaimed by economics gurus, have been frustrated by new protectionist barriers erected to replace the more blatant ones of the colonial period.

Under these conditions, the socioeconomic determinants of health, so obvious to even the most casual observer, remain intractable impediments to good health for millions of people. The suicide of South Korean farmer Lee Kyung-Hae should convince us that unfair trade practices kill and maim people just as effectively as bombs, land mines and other conventional methods of warfare.

Nonreciprocal free access to the markets of the advanced countries of