Reflections from young physicians

I had a feeling of great comfort and pride when I read the commentaries by Ben Hoyt[1] and by Sacha Bahtia and Adam Natsheh:[2] if the opinions expressed by these authors reflect the attitudes of young physicians to health care in Canada for the future, we are in safe hands. The medical establishment should heed their message. I have practised under systems of no health insurance and of multiple insurers in addition to our current national system. I would never want to see us return to some version of the former 2 systems or to adopt a costly, confused, limited scheme like that in the United States. I hope our current medical leaders and those they represent can see past their desire for immediate financial gratification with a long-term view of what is best for the average Canadian.

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2. Bhatia S, Natsheh A. Should Canadian physicians support parallel private health care? [editorial]. *CMAJ* 2005;173(8):901-2.

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It was heartening to read the articles by Ben Hoyt[1] and by Sacha Bhatia and Adam Natsheh[2] in response to the potential implications of the decision by the Supreme Court in the Chaoulli case. If these authors reflect the ideas of young physicians and medical students more generally, the Canadian approach to universal health care will not be compromised by short-sighted policy changes that could irrevocably undermine an ethically and professionally commendable approach to the provision of health care services to Canadians.

The evidence-based approach is an intrinsic part of the way young physicians assess potential clinical and policy changes. As these authors have indicated, the evidence from other jurisdictions is not there to support the contention that a so-called private, parallel system would enhance access and decrease wait times.

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Training more doctors

Every time I tell someone that I am doing my residency training in the United States, I get the same reaction: "Why are you in the United States? Are you going to come back to Canada? We need more doctors." Moving to the United States was a last resort for me.

When I graduated from McGill University's medical school in 2004, I failed to match to my chosen subspecialty. I obtained a training position in another field. Several months into my PGY-1 year I knew I would not be happy working in that field. Because I was no longer eligible to participate in the first round of the CaRMS match, I contacted most of the Canadian training programs in my preferred field to ask about the possibility of applying. Answers such as "We don't take out-of-province applicants outside the match" or "We don't have funding for another position" filled my email in-box. I entered the US match and obtained a training spot in my preferred field. Although I love what I am now doing, I still want to train in Canada. However, this year I am getting the same responses to my inquiries about PGY-2 positions in Canada.

Simply increasing the number of spots for medical students will not solve the problem of the lack of doctors in Canada. More residency training spots are also needed. In a recent *CMAJ* news article,[1] Health Minister Ujjal Dosanjh was quoted as saying that the barriers that prevent international medical graduates from working in Canada need to be lowered. Why don't we start with the barriers preventing Canadian graduates from coming home?

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REFERENCE

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Unnecessary exposure?

In the informative article by Mithu Sen and colleagues[1] concerning neonatal exposure to active pulmonary tuberculosis, some very revealing, and I think irrelevant, details were provided about the index case. The reader learns not only this man's age and occupation, but also his ethnicity, immigration history and specific place of employment. Some of those pieces of information, by themselves, could have led to the identification of the subject. When taken together, they leave no doubt.

Would the scientific value of the article have been compromised by simply

stating that this man had emigrated from an area where tuberculosis is prevalent? Would the public health implications have been any less significant had the subject been referred to as a "health care professional working in the neonatal intensive care unit?"

I presume that the physician described in this report gave written consent (as is *CMAJ*'s policy for such matters). Even so, I see no reason why his identity had to be made so transparent.

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REFERENCE

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DOI:10.1503/cmaj.1050144

[The authors respond:]

We thank Steven Shumak for his insightful comments concerning our recent case report in *CMAJ*.[1] Many of the details in the article concerning the index case were requested during the editorial review process. Indeed, the editors asked for additional details that were not included in the published version of the article because of confidentiality concerns. We take full responsibility for our work; perhaps we erred in supplying any of the details that the editors requested.

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REFERENCE

1. Sen M, Gregson D, Lewis J. Neonatal exposure to active pulmonary tuberculosis in a health care professional. *CMAJ* 2005;172:1453-6.

DOI:10.1503/cmaj.1050211

[Editor's note:]

It is difficult to completely conceal the identity of an individual in a case report unless he or she has a common disease with a common presentation. In this report of exposure of neonates, staff and visitors in an intensive care unit it was important to describe the index case, the resident and his background, previous exposure to tuberculosis and dates of his chest x-rays during the immigration process. Because of the authors' affiliations, the identity of the intensive care unit could not be concealed. Also, because of the large number of people involved in the investigation of possible tuberculosis, it is likely that the identity of the index case was known.

John Hoey
Editor
CMAJ

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Reporting communicable diseases

Although the article on dermatologic emergencies[1] was directed primarily at the clinical management of the presenting patient, I noted that there was no mention of the fact that cases of staphylococcal toxic shock syndrome, necrotizing fasciitis, and invasive *Neisseria* meningitis infections should be reported to the medical officer of health.

I would encourage *CMAJ* to attempt to include reporting to public health as one aspect of the management of any of the generally recognized "reportable communicable diseases" throughout Canada, as this one step in treatment may sometimes be overlooked by our acute care colleagues.

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REFERENCE

1. Freiman A, Borsuk D, Sasseville D. Dermatologic emergencies. *CMAJ* 2005;173(11):1317-9.

DOI:10.1503/cmaj.1050270

A painful elbow?

May I suggest the patient consult a real doctor, since the condition appears to be bilateral (text v. picture).[1]

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REFERENCE

1. Shu DH, Shu AC, Yuen M, et al. A case of painful elbow: What's your diagnosis? *CMAJ* 2005;173(12):1445-6.

DOI:10.1503/cmaj.1060003

Measuring the presence of chronic diseases

It is interesting that the time when patients were evaluated using the Charlson Comorbidity Index was not mentioned in the study by Pepin and colleagues.[1] It is possible that *Clostridium difficile* infections occurred in patients who were in a more serious condition; evaluation of the baseline characteristics of the 2 patient groups would have been best done 48 to 72 hours before the diagnosis of *C. difficile*-associated disease (CDAD) was made.

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REFERENCE

1. Pépin J, Valiquette L, Cossette B. Mortality attributable to nosocomial *Clostridium difficile*-associated disease during an epidemic caused by a hypervirulent strain in Quebec. *CMAJ* 2005;173(9):1037-42.

DOI:10.1503/cmaj.1050236

[One of the authors responds:]

The Charlson Comorbidity Index measures the presence of chronic diseases, and we used diagnoses listed in the discharge summaries of current and prior hospital admissions. For conditions such as ischemic heart disease, peripheral vascular disease, diabetes, chronic obstructive lung disease, dementia and the like, we feel that the exact timing of