close communication has allowed the CMA to influence the licensing standards.

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The disease burden of alcohol consumption

Although we appreciate Tony George's Public Health piece on problem drinking,[1] there is an underlying assumption in the article that most of the disease burden of alcohol consumption is associated with alcohol use disorders, and this is not the case. In 2002, the most common cause of deaths attributed to alcohol consumption in Canada[2,3] and globally[4] was drinking while engaging in another activity, such as driving (38.1% of alcohol-attributable deaths in Canada).[2] Liver cirrhosis, a condition that is often associated with alcohol use disorders, ranked third (15.4%); alcohol-attributable cancer ranked second (22.6%).[2] In fact, many alcohol-attributable deaths from cancer occur in people who do not have an alcohol use disorder; for instance, the risk of developing breast cancer increases with alcohol consumption levels as low as 1 drink per day.[5]

It should be noted that these detrimental effects of alcohol consumption are far more significant than its cardioprotective or other beneficial effects.[3] Alcohol also has important effects on people other than the drinker, such as newborns whose mothers drank while pregnant or bystanders who are struck by drunk drivers.

To reduce the disease burden of alcohol consumption, the most effective and cost-effective measures are not individual interventions, but population-level policy measures such as increasing the taxes levied on alcohol purchases or lowering the blood-alcohol concentration legally permitted for driving to 0.05%[6]; a recent national working group on alcohol in Canada has called for both of these measures.[7] Brief individual interventions cost significantly more than taxation initiatives to generate the same reduction in alcohol-attributable harm.[6] Therefore, although targeting problem drinkers who show up in their physician's office or a hospital emergency department is critical, changes in legislation may be more useful in terms of lives (and dollars) saved.

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Physician migration: pitting one province against another

Nick Busing's recent guest editorial on physician shortages raised many important issues that need to be addressed.[1] I am concerned, however, that Busing did not discuss the interprovincial migration of physicians, a key issue that may become the downfall of health care in many parts of the country. As a practising physician in St. John's, I see the effects of the physician shortages that Newfoundland suffers in all specialties. We lose Newfoundland physicians not only to other nations but also to other provinces.

Under the current funding formula for health care, the provinces bear a large portion of the responsibility for physician salaries. Provincial economies are obviously not all equivalent. Without a federal program guaranteeing uniform salary levels for all specialists across the country, I worry that some of the smaller provinces, such as Newfoundland, will continue to lose physicians to other regions of the country. I agree with Busing that we need to keep our physicians at home in Canada, but we also need federal measures that will free us as professionals to decide where to practise on the basis of our personal desires and community needs, without having to contend with varying remuneration scales from region to region.

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Imaging error

As a radiologist, I routinely enjoy the case reports with imaging in the Practice section of *CMAJ*. Unfortunately, it seems that the imaging content of reports is not always reviewed by someone with imaging expertise.

This is demonstrated in a recent case report.[1] In Figure 2, the arrow points to a small nonspecific lesion in the spleen, which the caption claims is a renal angiolipoma. I would hope that