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

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REFERENCE

1. Canadian Medical Association. *Determining medical fitness to operate motor vehicles. CMA driver's guide.* 7th ed. Ottawa (ON): The Association; 2006.

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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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5. Hamajima N, Hirose K, Tajima K, et al; for the Collaborative Group on Hormonal Factors in Breast Cancer. Alcohol, tobacco and breast cancer — collaborative reanalysis of individual data from 53 epidemiological studies, including 58,515 women with breast cancer and 95,067 women without the disease. *Br J Cancer* 2002;87:1234-45.
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DOI:10.1503/cmaj.1070048

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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REFERENCE

1. Busing N. Managing physician shortages: We are not doing enough. *CMAJ* 2007;176(8):1057.

DOI:10.1503/cmaj.1070057

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

a first-year radiology resident would not make this mistake!

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REFERENCE

1. Weir E, Cohen M. A 48-year-old woman with lymphangioleiomyomatosis. *CMAJ* 2007;176:1271-2.

DOI:10.1503/cmaj.1070060

[The authors respond:]

We thank John Clark and other readers for drawing our attention to the error.[1] The correct image is provided here with the original caption.

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REFERENCE

1. Weir E, Cohen M. A 48-year-old woman with lymphangioleiomyomatosis. *CMAJ* 2007;176:1271-2.

DOI:10.1503/cmaj.1070072

Apology

A recent news story on the HPV vaccine[1] was illustrated with a photograph of 2 young girls. In fact, that photo was taken by the Canadian Press for an article on juvenile arthritis, and, in accordance with the terms of *CMAJ*'s contract with Canadian Press, we were not authorized to use it for other purposes. We apologize to the children and their parents for this error and regret any inconvenience it may have caused.

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1. Comeau P. Debate begins over public funding for HPV vaccine. *CMAJ* 2007;176(7):913-4.

DOI:10.1503/cmaj.070747

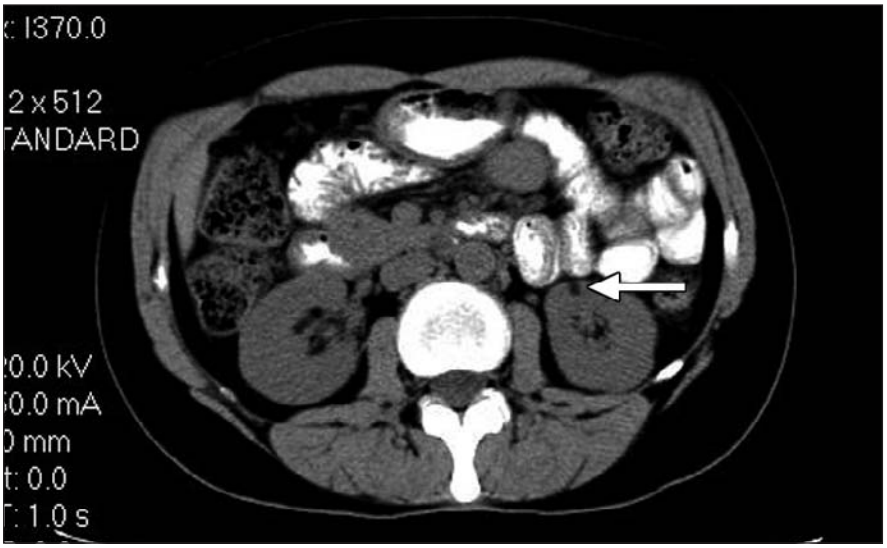

Fig. 2: CT scan of the abdomen showing renal angiolipoma (arrow).