for Ghanaian or Kenyan nurses, who can increase their wages by a factor of 10.

Then there's the less obvious: nurses who choose to stay in Kenya may essentially be choosing unemployment. In 2006, Clemens learned from Kenyan officials that 7000 nurses licensed to practise there were not working in their field due to a Ministry of Health hiring freeze. In his view, the opportunities that beckon African health care workers abroad are "a good thing" because such opportunities are in short supply back home. Moreover, health professionals who go abroad send huge amounts of money back to Africa.

Clemens contends there's a link between the number of doctors who leave a country and the number working within that nation. In support of that proposition, he cites the findings of an analysis undertaken on health professionals from the 53 African countries (*Hum Resour Health* 2008;6[1]:1 [epub ahead of print]). Using census data from the 9 countries to which African health professionals are most likely to emigrate, including Canada, Clemens and Gunilla Pettersson plotted the numbers of African-born individuals working in those countries as physicians (65 000 in the year 2000) and as nurses (70 000 in 2000) and found that the numbers leaving don't correlate with the numbers left behind — the nations losing larger numbers of health professionals are wealthier countries with larger numbers to lose.

Graphing the data, Clemens expected to see a downward slope: "I was sure that ... I would measure the effect [of doctors leaving] and say, for every doctor who's outside, there are 5 fewer doctors at home, but no."

Instead, he found a "very sharp, positive relationship."

That correlation between the high number of doctors departing and the higher number working within a country was true for all 53 countries. In light of that, Clemens found himself increasingly offended by talk of countries "exporting" nurses or "poaching" physicians (*CMAJ* 2008;178[3]:269-70; *CMAJ* 2008;178[3]:270-71; and *CMAJ* 2008;178[4]:379-80).

"You don't export a person, you export ivory," he says, "You poach elephants."

Taking issue with that analysis, though, is the Canadian physician who's arguably done more than anyone else to spotlight physician recruitment patterns. World Health Organization (WHO) Assistant Director General Tim Evans is incredulous at Clemens' findings and says dryly that the anecdotes he hears in Africa are "not captured in the econometric analysis."

Evans recalls a 2004 instance in which, over the course of a weekend between a World Health Assembly meeting and a WHO gathering, a doctor emigrated from Ghana, forcing the country's Minister of Health to close the surgical wing of a hospital. "The foundation of human resources in Africa is so fragile that you lose the only anesthesiologist in a hospital and all of a sudden there is no capacity to run basic, emergency obstetric care," Evans says. He doesn't accept that the outflow of physicians to the North has no adverse consequences.

Evans began working on the problem when he was at the Rockefeller Foundation in the late 1990s. "I remember being in Uganda in 1998 and asking, 'Why are you only producing 30 physicians per year?'," Evans says. Uganda was training the same number of doctors that year as it had in 1969, though the country's population had nearly tripled.

With donors increasing their investments to the billion dollar range from the million dollar range, Evans feared there wouldn't be sufficient doctors or nurses to staff new programs. After he joined the WHO, the organization began promoting ethical recruitment and produced a 2006 report that concluded Africa was "at the epicenter of the global health workforce crisis."

For Clemens, though, the paradoxical answer is to allow more health professionals to emigrate. He won't be in Uganda, though, to make that case when the WHO and a host of nongovernmental agencies focus their attention on the issue. In fact, the organizers didn't contact him. "If I had to guess, they probably just wish I would go away," Clemens says. — Miriam Shuchman MD, Toronto, Ont.

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News @ a glance

Candidates seven: A record 7 candidates, including 4 ex-presidents and 1 former provincial legislator are in the hunt to become the Saskatchewan Medical Association's next president and automatic nominee as president-elect of the Canadian Medical Association (CMA). Under the rotation used by the CMA to determine its president, the

Kutay Tanir / iStockphoto.com

Seven Saskatchewan doctors are bidding to become president-elect of the Canadian Medical Association.

"Land of Living Skies" will be taking its turn at the national helm commencing in 2009/10. The candidates are anesthetist Dr. Mark Arsiradam; family physician Dr. Anne Doig; family physician and former member of the legislative assembly Dr. Lewis Draper (New Democrat–Assiniboia–Gravelbourg); otolaryngologist Dr. James Fritz; family physician Dr. Allen Miller; family physician Dr. Stan Oleksinski; and general practitioner–anesthetist Dr. Vino Padayachee. The latter 4 are former presidents of the provincial association. Voting closes Feb. 26.

Green light: One-year research licenses have issued to King's College London and Newcastle University by Britain's Human Fertilization and Embryology Authority to create cytoplasmic embryos by merging animal eggs with human cells (*CMAJ* 2007;177[8]:847). The move followed an unsuccessful bid in the House of Lords to amend the Human Fertilization and Embryology Bill to prohibit the creation of interspecies embryos. The amendment was defeated 268–96.

Bluenose overhaul: In the wake of a commissioned study that indicated Nova

Scotia's health care system was unsustainable as configured, Premier Rodney MacDonald says his government will implement all 103 recommendations of the report, crafted by Corpus Sanchez International. At the core of the recommended overhaul lies the proposition that the province is over reliant on acute care in hospitals at the expense of community and personal health programs.

Charges dropped: Six nuisance charges against the former national medical director of the Canadian Red Cross Society's blood transfusion services stemming from the mid-1980s tainted blood scandal have been withdrawn. The withdrawal follows the October 2007 acquittal of Roger Perreault by the Ontario Superior Court on 4 charges of criminal negligence causing bodily harm and 1 charge of common nuisance. Perreault's lawyer, Edward Greenspan told the court that charges should never have been laid. "Not every tragedy requires a scapegoat or necessitates a finding of blameworthiness."

Suicide assessments: The US Food and Drug Administration has quietly changed its clinical trial policies to require that drug companies monitor patients in clinical trails for indications of suicidal thoughts or behaviours, the *New York Times* reported Jan. 24. The *Times* said the FDA has been issuing letters requiring a comprehensive suicide assessment for trials of drugs used to treat obesity, urinary incontinence, epilepsy, smoking cessation, depression and other conditions. The FDA declined comment.

Wired world: North American and European spending on electronic health records will reach nearly US$13 billion by 2012 from a current level of about $4.4 billion, according to the independent market analysis firm Datamonitor. — Wayne Kondro, *CMAJ*

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Dispatch from the medical front

Always accessorize

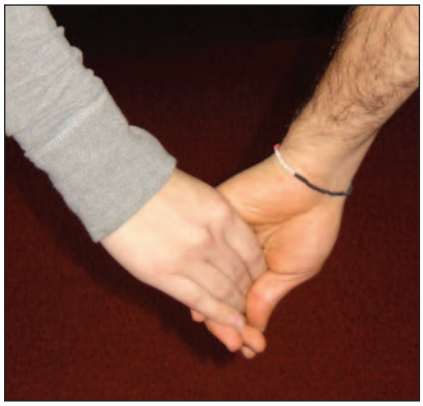
It is a perpetual struggle, to be sure, to persuade young people to use condoms while engaging in practices that, of course, predecessor generations never contemplated. Safe sex does not always trump the proverbial heat of the moment and considerations of sensitivity.

So we thought we'd suggest a new approach to the old safe sex message: accessorizing. In an elegant — if we do say so ourselves — bit of psychological research, a powerful video was used to instill the importance of condom use in those who self-reported as being among the inconsistently clad. One group then received a bracelet as a visual reminder of their new "no glove, no love" outlook on life. Think of it as a "more-than-friendship" bracelet.

The group was asked to recall stories from the video whenever they looked at the bracelet, to remind them of the dangers of unsafe sex.

The question was, would these simple bracelets serve as adequate reminders when it mattered most?

Because, in a world where less than 1 in 5 young people consistently use a condom, just getting the safe sex message out there isn't enough. The real challenge is getting people to remember its relevance when distracted by red wine, silk sheets and Barry White.



Omid Fotuhi

A "more than friendship" bracelet proved an excellent visual reminder of the "no glove, no love" message.

We were delighted to discover, and subsequently report (*Health Psychol* 2006;25[3]:438-43), that bracelets were up to the challenge.

Bracelet-wearing participants were twice as likely as their non-bracelet-wearing peers to report condom use in follow-up sessions 5 to 7 weeks later.

The bracelets worked even better when wearers had been drinking. While this may seem surprising, it fits with the idea of "alcohol myopia," the notion that a kind of short-sighted thinking lies behind drunken behaviour. When intoxicated, people pay attention to the information right in front of them, which is right where the bracelets put the safe sex message.

And there you have it. A low-cost, effective addition to the current panoply of safe sex interventions. And slightly more sophisticated than smacking a WEAR A CONDOM Post-it to the forehead of the nearest amorous teenager.

The spin-off potential is limitless. Safe sex bracelets could easily be added to university frosh kits or distributed in high school sex ed classes. While pinning a corsage or boutonniere on young prom-goers, parents could offer a matching bracelet. Condom manufacturers could hide bracelets in specially marked boxes, an adult version of the toy in the cereal box. — Tara Elton-Marshall and Julie Hachey, Waterloo, Ont.

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CMAJ invites contributions to Dispatches from the medical front, in which physicians and other health care providers offer eyewitness glimpses of medical frontiers, whether defined by location or intervention. The frequency of the section will be conditional on submissions, which must run a maximum 350 words or be subject to our ruthless editorial pencils. Forward submissions to: wayne.kondro@cma.ca