

## Incidental findings and patient autonomy

In their article on handling incidental findings, Ells and Thombs<sup>1</sup> compare the extensive official guidance available in the United States with the rather more concise comments for Canadian researchers in the Tri-Council Policy Statement.<sup>2</sup> Although the report, “Anticipate and communicate: ethical management of incidental and secondary findings in clinical, research, and direct-to-consumer contexts,”<sup>3</sup> provides helpful details for US-based research, the Tri-Council Policy Statement is essential in the Canadian context.

A core principle of the statement is respect for persons, which incorporates the dual moral obligations to “respect autonomy and protect those with developing, impaired or diminished autonomy.”<sup>2</sup> In the case of the competent patient, the moral obligation, according to article 1.1, is to respect autonomy. The statement further clarifies that “[r]especting autonomy means giving due deference to a person’s judgment and ensuring that the person is free to choose without interference.” Dictating what incidental information is withheld, in the absence of patient input, interferes with a patient’s freedom to choose without interference.

Ells and Thombs<sup>1</sup> recommendation that the plans for incidental findings simply be described to patients could be revised to ensure patient awareness of their own autonomy. Article 1.1 could be preserved by seeking the patient’s decision after describing the potential benefits and harms of disclosure of the incidental findings. This approach could elicit an informed decision while respecting patient autonomy and values and could be applied even when patient preferences differ from current research on the benefits and harms of disclosure.<sup>4</sup>

**Sean M. Nurmsoo MSc**  
Researcher, Dalhousie University,  
Halifax, NS

## References

1. Ells C, Thombs BD. The ethics of how to manage incidental findings. *CMAJ* 2014;186:655-6.
2. *Tri-Council Policy Statement: ethical conduct for research involving humans*. Ottawa (ON): Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, Social Sciences and Humanities Research Council of Canada; 2010. Available: [www.pre.ethics.gc.ca/eng/policy-politique/initiatives/tcps2-eptc2/Default/](http://www.pre.ethics.gc.ca/eng/policy-politique/initiatives/tcps2-eptc2/Default/) (accessed 2014 June 23).
3. *Anticipate and communicate: ethical management of incidental and secondary findings in clinical, research, and direct-to-consumer contexts*. Washington (DC): Presidential Commission for the Study of Bioethical Issues; 2013. Available: <http://bioethics.gov/node/3183> (accessed 2014 Jun. 23).
4. Montori VM, Brito JP, Murad MH. The optimal practice of evidence-based medicine: incorporating patient preferences in practice guidelines. *JAMA* 2013;310:2503-4.

*CMAJ* 2014. DOI:10.1503/cmaj.114-0063

## Suicidal ideation and poverty in First Nations

Eggertson’s article on gas sniffing shines a light on the conditions on the Pikangikum First Nation in Ontario.<sup>1</sup>

From 2007 to 2008, 25 of Pikangikum’s 2500 residents (1% of the population) took their own lives; 16 were children under the age of 19.<sup>2</sup> This would be comparable to about 28 000 Torontonians taking their own lives. The number of suicides in Ontario each year is about 1100.<sup>2</sup>

As the Ontario Coroner’s Report outlines, Pikangikum has inadequate, overcrowded housing, no indoor plumbing, little gainful employment, continuous food and water insecurity and no connectivity to the hydro grid. In 2007, 542 heads of household received social assistance.<sup>3</sup> This poverty results in substance abuse: children sniff gasoline, adults abuse alcohol. Death due to suicide is pervasive.

Canada continues to accept poverty as a societal inevitability. Yet the poverty rates of other wealthy nations (i.e., Sweden) are less than half of Canada’s.<sup>4</sup> Canada ranks 21st in the world in child poverty, and 22nd in infant mortality.<sup>5</sup> Can we justify excess infant mortality and youth suicides in First Nations based on policy choices?

We need to establish a guaranteed annual income for all impoverished

Canadians, including First Nations citizens. Our per capita spending on health care would likely decrease and population health would likely increase. Nordic nations, such as Sweden are “social democratic political economies” that “promote economic and social security for their citizens.”<sup>6</sup>

Poverty is associated with poorer health for every income quintile.<sup>7</sup> Canada should redistribute its wealth to improve health, living standards and well-being for our vulnerable populations. We have been late to accept the concept of the social determinants of health. If we address poverty among First Nations people, we will likely begin to see mental illness, substance abuse and suicide rates abate in communities like Pikangikum.

## Bert Lauwers MD

Vice President — Medical and Chief of Staff, Ross Memorial Hospital, Lindsay, Ont.

## References

1. Eggertson L. Children as young as six sniffing gas in Pikangikum. *CMAJ* 2014;186:171-2.
2. *The Office of the Chief Coroner’s death review of the youth suicides at the Pikangikum First Nation 2006–2008*. Toronto: Office of the Chief Coroner; 2011: 50.
3. *The North South Partnership for Children and the Pikangikum Community Members participatory assessment of Pikangikum*. Toronto: North South Partnership for Children; 2008:12.
4. Rachlis M, Goel R, Mackie C, et al. Policy and population approaches to poverty. *Ont Med Rev* 2013; 80:30.
5. Adamson P. *Child well-being in rich countries: a comparative overview: Innocenti Report Card 11*. UNICEF; 2013:7.
6. Raphael D, editor. *Health promotion and quality of life in Canada: essential readings*. Toronto: Canadian Scholar’s Press; 2010:282.
7. Dorman K, Pellizzari R, Rachlis M, et al. Why poverty is medical problem. *Ont Med Rev* 2013;80:17.

*CMAJ* 2014. DOI:10.1503/cmaj.114-0065

## Perspectives on studying abroad

Barer and colleagues<sup>1</sup> present a sobering picture for Canadians studying abroad. Although the number of Canadians studying abroad continues to grow, the demographics of this population are changing. Personally, I have seen a decrease in the age of those applying to international medical schools and an

increase in the number of students who are applying directly from secondary school. This shift could indicate a change in the reasons for student migration. I would argue that there are some Canadians studying abroad who have never applied to a Canadian medical school. These students may have chosen to apply abroad because of the attractive streamlined direct entrance from secondary school that some international medical schools offer. Although well established in Europe, direct-entry programs are relatively new in Canada: Queen's University in Kingston, Ontario, accepts only 10 students each year into its direct-entry program.<sup>2</sup>

Barer and colleagues<sup>1</sup> fail to see the benefits of studying abroad. In 2009, at the age of 18, I decided to study in Ireland, and it was the best decision of my life. I am entering my final year of study and am glad to say I have no regrets. In addition to receiving a great education, I have had the opportunity to travel throughout Europe both for leisure and to enhance my medical education. These experiences will stay with me regardless of where I work and will provide me with a unique set of skills that will change the way I look at and deal with difficult situations.

I wholeheartedly agree with Barer and colleagues<sup>1</sup> that the majority of students studying abroad are disillusioned about working in Canada and need to be aware of the prospects for foreign-trained Canadian physicians. However, there will always be hope for those who take advantage of all that an education abroad has to offer.

#### Pishoy Gouda

Fifth-year medical student, National University of Ireland, Galway, Ireland

#### References

1. Barer ML, Evans RG, Hedden L. False hope for Canadians who study medicine abroad. *CMAJ* 2014;186:552.
2. Queen's University Accelerated Route to Medical School (QuARMS). Kingston (ON): Queen's University. Available: [www.queensu.ca/admission/programs/quarms.html](http://www.queensu.ca/admission/programs/quarms.html) (accessed 2014 Apr. 9)

*CMAJ* 2014. DOI:10.1503/cmaj.114-0064

To my considerable surprise, I found myself agreeing with everything that Barer and colleagues<sup>1</sup> wrote in their *CMAJ* salon article. The authors are

right in describing Canadian health care as an “essentially unmanaged system where physicians can practise what they want, where they want, when they want.”

It was not always thus. I came to British Columbia with my wife and three children 50 years ago and was told by the College of Physicians and Surgeons of British Columbia that I would have to work in an underserved town or city in northern BC. This seemed perfectly reasonable, and so, I went to work in Prince Rupert, BC.

All this has been changed by the Canadian Charter of Rights and Freedoms, which guarantees all Canadians and permanent residents freedom of mobility within Canada to pursue their occupation. Ironically, the same charter offers no “right to health care,” although most Canadians assume it does. Until these two conflicting aspects of the charter are dealt with, we shall continue to see a very disturbing maldistribution of doctors throughout Canada, with rural Canadians, who produce much of the nation's wealth, being shortchanged.

To open the gates to all Canadian medical graduates from overseas would offer no guarantee of better health care to those Canadians living in rural and isolated areas.

We have a politicized health care system, and it seems that no federal government has the courage to address its problems.

#### Robert G. Holmes MD

Retired rural surgeon and general practitioner, Nicola Valley, BC

#### Reference

1. Barer ML, Evans RG, Hedden L. False hope for Canadians who study medicine abroad. *CMAJ* 2014;186:552.

*CMAJ* 2014. DOI:10.1503/cmaj.114-0067

The bleak picture and much of the statistical information Barer and colleagues<sup>1</sup> present for Canadians studying abroad who want to enter Canadian residency programs are accurate. The authors conclude that the road is very dark and difficult for these brave and enterprising students who return home to practise medicine.

I would also advise Canadians who study medicine abroad that if they were

to continue their postgraduate medical education and training in specified foreign jurisdictions, they could obtain Canadian medical training equivalency and then re-enter Canada on equal footing with their Canadian-trained colleagues. Specifically, Canadians who study abroad, complete their family medicine/general practice training and obtain certification in the United States, United Kingdom, Ireland, Australia or New Zealand are eligible for certification by the College of Family Physicians of Canada, possibly without writing the examinations. Further, depending in which Canadian province they choose to practise, they may also be exempt from the Medical Council of Canada examinations.

Canadians who choose to complete their specialty training and obtain certification in one of several recognized jurisdictions across the globe, can become eligible to write the corresponding Royal College of Physicians and Surgeons of Canada examinations and obtain certification before or after their return to Canada.

Alternate pathways exist via specific provincially managed medical assessment programs. These programs are typically targeted toward specific medical disciplines in high-need communities and can change over time. Therefore, a careful evaluation of the program and medical credentials must be completed before making such a commitment.

Unfortunately, the authors<sup>1</sup> chose to present only the bleak side of this issue, rather than research more deeply to uncover alternative global medical education options. We can guide Canadians who study abroad back to Canada, with their heads held high with pride.

Canadians studying medicine abroad should consult with a Canadian physician recruitment specialist to help plan their return home, on their own terms.

#### Phil A. Jost MBA

Vice President and Regional Manager, CanAm Physician Recruiting Inc. (PEI, New Brunswick, Alberta and Saskatchewan), Summerside, PEI

#### Reference

1. Barer ML, Evans RG, Hedden L. False hope for Canadians who study medicine abroad. *CMAJ* 2014;186:552.

*CMAJ* 2014. DOI:10.1503/cmaj.114-0066