Abortion referral and MD emigration: areas of concern and study for CMA

D.A. GEEKIE

An ethical physician:
When his personal ethic prevents him from recommending some form of therapy will so acquaint his patient and will advise the patient of other sources of assistance.*

This section of the Code of Ethics does not mention abortion, but that was the principle area of concern when this revised section was approved by General Council, the governing body of the Association, in June 1977.

The Code of Ethics does not require a physician whose personal morality prohibits him from counselling, recommending or arranging an abortion to refer a patient seeking that service to a physician who will definitely, without question, provide the service desired. Indeed, such action would be contrary to the intent of the Ethics Committee that proposed the change.

Incorrect mass media news stories spread confusion on this matter. Thus it is important that members of the profession not only be conversant with this section of the code and its intent, but that they take an active role in clearing up the apparent confusion.

Prior to the June 1977 meeting of General Council, a physician with a conflict of interest (professional vs personal interest position) because of his personal morality, was required to inform the patient, and nothing more. The Ethics Committee recognized that, on occasion, this could result in a patient being (*de facto*) abandoned — a result that was not in keeping with the tenets of the profession. The intent of the change was to place responsibility on the physician, not only to inform the patient of the conflict of interest created by his moral position, but also to help the patient find other sources of assistance.

The physician might refer the patient to a colleague without such a conflict of interest, to a social agency, to a clergyman for religious counselling, to all three or to other sources of assistance. The revised section of the Code of Ethics does not suggest or state that he must refer the patient to a colleague who is in favour of abortion on demand. Indeed, CMA policy clearly opposes such an approach. The Association has encouraged physicians to bring unbiased professional judgement to bear on each individual case. He should avoid the simplistic role of dispenser of a service desired or thought to be desired, by the patient.

MD emigration

Canadian physician emigration to the United States is another subject suffering from a lack of objective comment based on hard, reliable data. Recent mass media reports would lead you to believe that Canada is suffering from a mass exodus of physicians. Recently, officers of the CMA and the OMA met with the federal Minister of Agriculture, the Honourable Eugene Whelan; Parliamentary Secretary to the Minister of Health, W.K. Robinson; MP Mark McGuigan and staff representatives of the Ministries of Health, Employment and Immigration and Finance to discuss the matter. The meeting was stimulated by the migration of 27 Windsor area (Whelan's riding) physicians in recent months. At the request of Mr. Whelan, the meeting was arranged by Dr. Stanley Oleksiuk, president of the Windsor District Medical Society. Briefing notes prepared for that meeting indicated there has been a marked increase in Canadian physician interest in migrating to the US. Canadian medical students and practitioners are sitting US state medical board examinations and otherwise qualifying for licence to practice, in one or more states, in increasing numbers. But there is little hard evidence to suggest that a mass exodus of physicians is currently underway.

US immigration service statistics indicate that 222 physicians migrated to the US from Canada in 1974; that figure increased to 298 in 1975 and 425 in 1976. Present estimates indicate this figure will exceed 500 in 1977. While the number of Canadian physicians migrating to the US was markedly reduced during the Vietnam war, possibly because of the likelihood of military conscription, the annual figure has been around 300 for several years.

However, the recent trend toward increase is significant and the greater numbers of Canadian physicians applying for licensed status in several states (particularly Texas, Arizona, Massachusetts and California) is even more significant. A CMA survey of state medical licensing boards indicates a 500% increase in such applications in the 1974-77 period. The number of licenses issued in Massachusetts has increased from 10 in 1974 to 48 during the first 11 months of 1977. During a comparable period, the number of licenses issued to Canadian physicians in Texas increased from 10 to 93. The state now is processing an additional 139 applications and anticipates a final figure of about 180 for 1977. Arizona has increased from 16 to 64. It should be noted that these figures relate to the number of licenses issued; they do not indicate that this number of Canadian trained physicians have migrated to and taken up practice in that state — or that they will. Indeed, it is a com-

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*CMA Code of Ethics, Chapter 16, June 1977

Slow-K®

(slow-release potassium chloride tablets.)

Indications — All circumstances in which potassium supplementation is necessary and particularly during prolonged or intensive diuretic therapy.
Patients at special risk are those with advanced hepatic cirrhosis or chronic renal disease, patients with considerable edema (particularly if urinary output is large) and patients receiving digitalis (a lack of potassium sensitizes the myocardium to the toxic effects of digitalis).
The range of indications for SLOW-K may be summarized as follows:

As a supplement to diuretics	Ulcerative colitis
Hypochloremic alkalosis	Steatorrhea
Cushing's Syndrome	Chronic diarrhea
Corticosteroid therapy	Regional ileitis
Liver cirrhosis	Ileostomy
Digitalis therapy	

SLOW-K is also indicated during convalescence of patients following "diseases characterized by persistent vomiting" and of surgical patients in whom prolonged withdrawal of fluids had taken place.

Contraindications — Renal impairment with oliguria or azotemia, untreated Addison's Disease, myotonia congenita, hyperadrenalism associated with adrenogenital syndrome, acute dehydration, heat cramps and hyperkalemia of any etiology: conditions associated with stasis of the G.I. tract; esophageal compression due to an enlarged left atrium; patients undergoing heart surgery.

Warnings — A probable association exists between the use of coated tablets containing potassium salts, with or without thiazide diuretics and the incidence of serious small bowel ulceration. Such preparations should be used only when adequate dietary supplementation is not practical and should be discontinued if abdominal pain, distension, nausea, vomiting or gastrointestinal bleeding occurs.

Precautions — Administer cautiously to patients in advanced renal failure to avoid possible hyperkalemia. SLOW-K should be used with caution in diseases associated with heart block since increased serum potassium may increase the degree of block.

Adverse reactions — Small bowel ulceration has been very rarely reported.

Dosage — The dosage is determined according to the needs of the individual patient. When administered as a potassium supplement during diuretic therapy, a dose ration of one SLOW-K tablet with each diuretic tablet will usually suffice but may be increased as necessary. In general, a dosage range between 2-6 SLOW-K tablets (approximately 16-48 mEq K) daily or on alternate days, will provide adequate supplementary potassium in most cases. Preferably, administer after meals.

Overdosage — Symptoms found in hyperpotassemia closely resemble those of hypopotassemia; these include asthenia, hypotension, mental confusion, paresthesias, pallor, bradycardia and cardiac arrhythmias. Hyperpotassemia may be treated by i.v. administration of sodium chloride, calcium chloride or calcium gluconate (10-20 ml of a 10 percent solution), dextrose (100 ml. of a 50 percent solution or 1,000 ml of a 10 percent solution with 30 units of unmodified insulin injection), or by administration of a cation-exchange resin which removes potassium, given orally or as a retention enema.

Supplied — Tablets (pale orange, coated), each containing 600 mg (8 mEq) of potassium chloride in a slow-release, inert wax core.

References

1. O'Driscoll, B.J.: Potassium chloride with diuretics, Brit. Med. J. 11:348, 1966.

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mon practice for Canadian physicians to apply for and obtain a licence in more than one state. Many no doubt are obtaining a US state licence just in case they *might* wish to emigrate in the future.

US legislation important

The early 1977 changes in the US Immigration and Nationality Act have had an important impact on MD emigration. It is now extremely difficult for foreign trained physicians to obtain visas and work permits. On the other hand, *Canadian medical school graduates* are considered equivalent to US graduates and are accepted as such. They have comparatively little trouble obtaining visas, work permits and licences to practise medicine in most states. Indeed, the waiting period between application for visa and work permit and acceptance has been steadily declining.

As a result, Canadian trained physicians have become the prime targets for US areas recruiting foreign trained physicians. This is particularly true in rapidly growing US communities that have difficulty recruiting sufficient US trained physicians (for example, Texas, Arizona, Louisiana, Alabama). While recent reports suggest the US will have a surplus of medical manpower by the early 1980's, it has a physician distribution problem in many ways comparable to that of Canada. For about 18 months, there has been a marked increase in US advertising for physicians in Canada. The *CMAJ* has published 35 to 40 such advertisements in several issues.

We have also witnessed the development of a new phenomenon: physician recruiting teams attending Canadian medical conventions. In recent weeks, four of these US professional recruiting companies have established Canadian subsidiaries. These companies are recruiting physicians mainly in the 35-50 range who have reached or are approaching the peak of their professional life productivity. They are recruiting in all disciplines, but particularly in general practice and the medical subspecialties.

It is common knowledge that medical fee schedules are considerably higher in most parts of the US, income tax levels are lower and allowable deductions are greater. The result: a physician may anticipate a disposable income increase of $15-20 000 more for a comparable work load.

It should be noted that MD emigrants to the United States now are almost exclusively Canadian medical school graduates and represent a figure comparable to the total 1977 physician production of the four Quebec medical schools, or the five medical schools in the western provinces.

The increased emigration of physicians to the US is significant — but in our opinion, the marked increase in interest in migration, as represented by inquiries and applications for licence in the United States, is more significant. These increases exemplify the frustration and malaise that grow more obvious within the profession in many parts of the country, particularly metropolitan Montreal, Ontario and the western provinces. The frustration is created by real and perceived increasing governmental and bureaucratic interference and control of the practice of medicine, declining public prestige and professional satisfaction, mass media criticism, and declining real disposable income.

The profession is acutely aware of the fact that it has lost its traditional leading net income position among self-employed professions with which it is traditionally compared. Current data indicate that both lawyers and dentists have passed physicians during 1976. The profession sees no way out of these deteriorating situations in the future, indeed believes the situation will continue to worsen. This belief is supported by actions and statements made by leading political figures in recent months ("All Quebec doctors will be on salary by 1980 . . . I am not concerned with increased physician emigration; we have a surplus . . .").

The emigration of Canadian trained physicians is not yet a problem of major proportion — but it has all the earmarks of becoming just that. One of the most vivid indicators is the increased interest in migration among Canadian medical students. In 1976, 411 students took Part I exams of the (US) National Board of Medical Examiners. In 1977, that figure increased over 75% to 733 — an all time high.

Canada and the United States have long enjoyed, and benefited from, a relatively free exchange of medical talent for educational, teaching and practice purposes. As long as the medical manpower flow across the 49th parallel remains relatively balanced, it is a healthy situation. If the flow becomes distorted for any period of time, it could become a negative influence on medical care in one or both countries. That eventuality would no doubt lead to governmental action in the United States, Canada or both countries restricting the beneficial free flow of medical manpower between the two countries. ■