Where Shall John Go?

Canada

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Obvious mutual advantage is the surest basis for any successful partnership, including marriage. Conversely, the partnership is doomed to recrimination and painful failure if either partner feels that the other is being done a favour. These truisms are specially applicable to the relationship between host country and "guest worker" or immigrant. They are relevant to the Yugoslav machinist in Düsseldorf, the Pakistani foundry worker in West Bromwich and, equally, to the British doctor contemplating Canada. Once any ideas of escape to a northern Eldorado, a punitive resignation from the National Health Service, or even a charitable duty are dispelled, it is possible to define worthwhile and enjoyable opportunities for the young physician in Canada where mutual advantage exists. The chance may be there to take up a research fellowship, enjoy the disciplined learning of a good residency training programme (contrasting it with the informal apprenticeship of British postgraduate training), or experience the rigors and pleasures of practice in a remote community. Above all, there may be the opportunity to combine well-paid occupation and education with the chance to travel, to see another part of the world, and to gain insight into a different way of life. The pleasures and advantages of extended tourism should not be underestimated.

Overall, Canada has little need to import physicians. In December 1975 Canada had one physician for every 595 of the population (the figures for physicians include interns and residents in training). In spite of overall satiation, however, there are many examples of uneven distribution and local shortage of physicians, and particular types of physicians. Such maldistribution is familiar and inevitable in a society which rejects direction of labour and allows the physician free choice in selecting his or her type of work and place of work. Although the cost of medical care for Canadians is very largely paid for by Provincial Government insurance plans, the restrictions on where individual doctors may practise are less than those under the National Health Service, and the opportunities for local misalignment of supply and demand are considerable.

Advantages of uniformity

Postgraduate medical education is more formally organised and much more systematic than in Britain. Elitists may decry its rigidity and uniformity, finding it pedestrian and restricting. They will point to the successes achieved by the better students under the haphazard clinical apprenticeship/wandering scholar

system. Nevertheless, there are rival virtues in the thoroughness and regular assessments of the residency training programmes and fewer casualties. The wider clinical experience of the neophyte consultant in Britain, as compared with the newly certified Canadian specialist, is very often accompanied by lacunae in knowledge relevant to the professed specialty, particularly of its basic science. (Remarks about the cult of the gifted amateur versus dull professionalism are usual at this stage.) Both physicians may hope to make up their relative deficiencies during the first few years of consultant practice and the best do so. I suspect that for the average consultant in busy practice systematic acquisition of basic knowledge is more difficult and less likely than the accretion of clinical experience.

Opportunities for British graduates

The enterprising British graduate may exploit the opportunity offered by the informality of his native system and get the best of both worlds by spending one or two years in a Canadian residency training programme. Circumstances may result in one- or two-year vacancies in excellent specialty training programmes, including those in family practice. It may be impossible to fill an unexpected or temporary vacancy with a Canadian graduate. In those circumstances a well-qualified British graduate may be welcome since the residency training programmes function efficiently when all positions are filled and any programme may be enlivened by bringing in an outsider with something to offer. In such a case a Canadian graduate is not being displaced from a training opportunity and the temporary resident returning to his native country does not compete for a permanent senior position. This is a good example of a mutually advantageous arrangement. Postgraduate training programmes in all specialties are organised by the universities through their faculties of medicine. The Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada are responsible for inspecting and accrediting programmes, and for examining and certifying specialists. In the Province of Quebec the Corporation Professionnelle des Médecins du Québec has similar functions to the Royal College and collaborates closely with it.

On graduation, the Canadian doctor is a year or two older than his or her British counterpart and often has incurred debts (which must be repaid) of several thousand dollars in student loans or other borrowings to get through medical school. After completing an internship followed by up to five years in a specialty training programme and obtaining certification, there is an understandable tendency to go straight into practice. The absence of a fixed establishment of consultant positions such as in the National Health Service means that there is no bar to entering practice and no waiting for dead men's shoes, but it also means that the first few years in practice may be lean. In these circumstances it may be difficult to attract able young doctors into research fellowships. Herein lies an opportunity for

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British graduates, particularly those who have been skilful or fortunate enough to have obtained their membership or fellowship soon after graduation. For them a sojourn in a good transatlantic research establishment may advance their careers directly, whether or not they hope for a permanent appointment in academic medicine and quite apart from its other advantages. Equally, a Canadian research team may be pleased to have the services of an enthusiastic clinician to whom it has no long-term obligation. Funds to pay the salary of a research fellow may be available locally, or obtained in Britain as travelling research fellowships such as those of the Medical Research Council. The effective devaluation of the pound against the Canadian dollar in recent years has created severe problems with the latter.

Locums and exchanges

Short-term locums and other opportunities for employment lasting from a few weeks to one or two years may arise in a variety of circumstances in Canada and elsewhere. They may offer adventure and excitement in remote or unusual places, or something much more humdrum but well-paid. The very fact that they may be in Yellowknife or Thunder Bay rather than Tunbridge Wells or Glasgow makes them more interesting. To the young physician between jobs, gathering material for a novel, not yet ready to surrender to middle-age and mortgage, or just anxious to have one enterprising and different thing to offer to an appointment committee they may represent a great opportunity. The fact that a local applicant has not been obtained and the position is advertised to overseas physicians is not necessarily sinister, any more than it would be in Britain.

Various exchange schemes are in existence by which physicians in practice or in training in Britain can change places with an opposite number in Canada for a few months or up to a year. The Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada sponsor such exchanges in co-operation with the various royal colleges in Britain. Enterprising individuals have managed to arrange their own exchanges through classified advertisements in this and other journals.

A diverse country

Those who regard perception of the distinction between north and south of the Thames or east and west of the Pennines as no great test of their diagnostic acumen will appreciate the foolishness of making blanket generalisations about a country of 23 million people stretching for more than 3500 miles from Atlantic to Pacific. Canada is the second largest country in the world but most people live in a narrow strip running parallel to the United States border and have as little chance of going to the Arctic or meeting an Eskimo as the average Briton. Within the most populated area there is an enormous diversity of scenery, climate, and lifestyle. The aptly-named Nova Scotia coast, the flat vineyard, fruit and tobacco country of Southern Ontario, the wheat and cattle lands of the prairies, the Rocky Mountains, and the forests of British Columbia illustrate this. So do the different ways of life in a small mining town in the rocks and lakes of the Canadian Shield around Hudson Bay, the cosmopolitan world of Montreal (the second largest French-speaking city in the world), and the transplanted Englishness of Victoria, British Columbia.

Officially Canada is a bilingual country with all Government and official business conducted in English and in French. Most of the population in the Province of Quebec is Francophone, and there are substantial Francophone minorities in other provinces. In spite of the great emotional heat that bilingualism generates, it is hardly evident in many places except

on packages of breakfast cereal, and on signs and announcements at railway stations and airports. In a country which has been peopled by immigration there are large minority groups whose mother tongue is neither English nor French.

Politically Canada is a confederation of provinces established by the British North America Act of 1867 with Newfoundland, its most recent member, joining in 1949. The Provincial Governments have a great (by British standards) degree of autonomy including the right to levy income and numerous other taxes. The essence of confederation is a perpetual struggle between the Provincial Governments and the Federal Government (situated in Ottawa). The fragile nature of confederation has been highlighted by the recent election of a Government with the avowed aim of separatism in Quebec. Spending a little time in Canada might allow physicians and others to speak more knowledgeably on devolution of government in Britain and Celtic nationalist movements.

The Provincial Governments have responsibility for health care, and licensing of doctors is in their jurisdiction. Before taking up an appointment a physician coming to Canada must apply for a licence to the College of Physicians and Surgeons of the province in which he or she intends to work. A full licence is normally granted only to physicians who have satisfied certain educational criteria, and who have successfully passed the licensing examination of the Medical Council of Canada (LMCC). Various forms of restricted licence are available without examination to graduates of British and certain other overseas medical schools who wish to practise temporarily, under supervision, in teaching hospitals or in certain designated locations where there is a particular need for physicians. The provincial colleges are generally helpful in explaining their licensing rules and requirements. Physicians from the United Kingdom who have obtained temporary employment in Canada of one of the kinds illustrated above will usually have no difficulty in obtaining a restricted licence adequate for that employment.

Climate and leisure

Apart from the Atlantic and Pacific coasts and the Arctic and sub-Arctic regions, Canada has a continental type of climate with colder winters and warmer summers than in Britain. Houses and public buildings, clothes, cars, and public transport are all designed and equipped to cope with a climate whose excesses can be relied upon to appear and to stay. It is no use, therefore, adopting the British ploy of shivering or sweating while waiting for the temporary aberration to go away. The winter will be cold and it will snow. Therefore, make up your mind to enjoy it. I've been more miserably cold in English bedrooms than at any time in the Canadian winter. Winter daylight is longer than in Britain because of the latitude, and much more sunny. As a result there isn't the same feeling of being shut in and oppressed. Skiing through the woods behind my home on a brilliant day with the bluest of skies on dazzling fresh snow is one of the best forms of self-indulgence I know. With the opportunity for skiing, cross-country and downhill, skating, tobogganing, or simply hiking or snowshoeing, winter is something to look forward to.

Summer and Fall are also reliable and again give the opportunity for every kind of outdoor pursuit, athletic or otherwise. The colours of the leaves in fall are every bit as vivid as those difficult-to-believe photographs you will have seen in the *National Geographic Magazine*. Camping can be as primitive or as luxurious as you like, although it is generally less spartan than in Britain. It gives you an opportunity to get out and see the country which surely must be one of the main reasons for coming, at reasonable cost. If you would rather just sit in the sun on the seashore, or by the pool with a drink in your hand, you can do that too.

By emphasising the outdoors I may have reinforced your prejudices concerning a paucity of cultural activities such as

music and the theatre. A glance at the appropriate section of the weekend editions of the Montreal or Toronto newspapers should reassure you on that score, even if you are the complete urban sophisticate. Naturally you will not find a symphony orchestra in a small country town but the orchestra at my daughter's high school gives a fair rendering of Dvorak's "New World" Symphony.

Despite what may be true in certain large cities in the United States, fear of mugging or other violent attack in the streets is not a Canadian problem. Generally speaking you may safely walk at will anywhere in Canadian cities, downtown or across the park, day or night. Of course there is crime, including violent crime, but you need not walk in fear in the street or turn your home into a fortress.

Should you be interested in natural history, the pleasure and excitement of discovering a host of new birds, butterflies, and flowering plants, is enormous. I recall (with some embarrassment now) chasing after my first Camberwell Beauty, Swallowtail, and Monarch. I insisted on telling everyone of my extraordinary discoveries, not knowing that these rarest of all British butterflies are among the commonest in this part of Ontario. To see thousands upon thousands of Monarch butterflies massing on the trees at Point Pelee for their migration to Mexico rates amongst my all-time highs. There may be no bluebell woods in Ontario, but a cloud of Trillium lilies in a beech wood is an acceptable substitute, and a carpet of trout lilies makes up for the absence of primroses. Although welcome as a sign of spring, the American robin is large, vulgar, and, in any case, a thrush! It doesn't compare with *Erithacus rubecula*. But when it comes to Christmas card scenes, a cardinal, brilliant red against the snow, takes some beating.

The people

Canada and Canadians are often thought of as occupying, in everything except a literal sense, a mid-Atlantic position. Inevitably the friendly giant neighbour to the south has a major influence economically and socially. That influence, which in some areas, amounts to domination, brings benefits and disadvantages and results in both admiration and resentment. In spite of the many similarities, and the openness of the border, there are important differences between Canada and the United States which are to be cherished. If you are contemplating visiting Canada then you should be courteous enough to observe and appreciate the distinctions rather than lumping all North Americans together in a high-handed imperialist fashion.

The caricature Canadian is allegedly a quiet, conservative, bland American except when incited to extreme savagery by playing or observing ice hockey. Like all such generalisations, this is calumnious. Canadians, however, are generally more courteous than the British in spite of overt informality. Their conversation is less liberally sprinkled with harmless profanities and obscenities than that of polite society in Britain, and therefore use of these may give gratuitous offence. Irony and sarcasm, litotes, and hyperbole do not dominate conversation to the same extent as in Britain. As a result, your remarks are likely to be taken literally and your most amusing jokes may be received with blank stares. This latter phenomenon is particularly upsetting to a lecturer accustomed to producing uncontrollable mirth in his students, apparently by some Pavlovian reflex. Do not conceitedly declare that your hosts are lacking a sense of humour: there is no greater insult. People would much rather be accused of cheating, stealing, or other moral depravity. Did you ever know of anyone who admitted to not having a sense of humour? Quite apart from that, you should be astute enough as a clinician to acknowledge cultural variation. Dylan Thomas spoke of the "barrier of a common language" and thinking you know what something means is very dangerous. I don't wish to exaggerate this problem. Just proceed with caution and don't assume that all you have to do is to shout a little louder.

Income and outgoings

The following is the current annual salary scale for residents (registrars) in teaching hospitals in Ontario.

		\$	£
Resident I		13 515	7950
Resident II		14 575	8573
Resident III		15 635	9197
Resident IV		16 695	9820
Resident V		17 755	10 444

Sterling equivalents are calculated on the basis of £1=1.70 Canadian dollars. Both currencies "float" and so the actual rate varies from day to day. To set the above salary in context the minimum legal wage is between \$2.40 and \$3.00 an hour according to province and the wage of the average Canadian worker is \$11 960 annually (November 1976). Research fellows might expect salary within the resident scale. The remuneration of locums will vary with the circumstances.

It is difficult to make valid or useful statements about relative costs of living. Not all the items which go into official calculation of these things are relevant to the temporary resident. In this city, an unfurnished two-bedroom apartment with living room and separate kitchen and bathroom in a new highrise block may be rented for \$300 a month. The apartment is relatively luxurious and comes carpeted throughout, and complete with cooker and refrigerator. The rent includes central heating, light and electricity, and the use of a heated garage. The apartment block has facilities for washing and drying clothes and for storage, and is immediately adjacent to a shopping complex which is open 12 hours a day six days a week. Less luxurious accommodation is available for substantially less. Petrol is currently 82c a gallon, ground coffee \$3.00 a pound. A man's shirt costs from \$10.00 and his haircut \$5.00. A pair of women's shoes might be \$40.00 and her shampoo and set \$7.00.

Just in case you thought inflation, high unemployment, price and wage controls, soaring energy costs, and a general lack of confidence in the future are peculiar British phenomena you should realise that all these unpleasant happenings are present here too. Canadian levels of unemployment are much higher than those in Britain. Federal and Provincial Governments are determined to halt, if not cut back, the escalating costs of health care. Money for medical research is much tighter than in previous years with the Medical Research Council forced to make major cutbacks, and other agencies are severely affected by inflation. Nevertheless, misery and privation are relative. Inflation in Canada has never approached recent British rates and the standard of living is much higher.

Means of entry

Opportunities in resident training programmes and research units are best discovered and secured by direct personal contact with a named individual. Physicians in teaching and research units in Britain and Canada are frequently known to one another. The young doctor should have little difficulty in finding a senior colleague to help in identifying a suitable unit or individual in Canada, and preferably to write a letter on his or her behalf. Each medical school in Canada has an assistant dean or other senior person in charge of postgraduate training who may be able to advise on opportunities. If you write directly, don't be too self-effacing in describing in what you have to offer: remember that the North American curriculum vitae is an example of the hard sell. In the present climate, however, a speculative circular letter to "Director of Postgraduate Education" is unlikely to provoke a favourable response. Don't neglect the classified advertisements of the *Canadian Medical Association Journal* and others. These will usually be more appropriate for locum and other positions outside teaching and research programmes.

The non-immigrant may enter Canada as a visitor, student, or

on an employment visa. It is not normally possible to convert from one type of visa to another after entering the country, and it is not possible to apply for immigrant status from inside the country having entered as a non-immigrant. It is important, therefore, to get things right from the start. If any kind of work is undertaken—even if payment is in the form only of accommodation or meals—an employment visa and work permit are required. Thus intending residents, research fellows, or locums all need employment visas.

If your preliminary contacts in Canada result in a job offer, you should ask the prospective employer to send you a more-than-usually detailed written job offer setting out precisely what the job entails and how your particular qualifications and abilities are appropriate. You should then take this letter to the Manpower and Immigration Section of the Canadian High Commission in London or to one of the Canadian consulates in several of the larger provincial cities and apply for an employment visa. Manpower and Immigration will seek evidence showing that the employer has made efforts to find a Canadian citizen or landed-immigrant to fill the position and that no such person is available. This requires communication between the prospective employer and his local office of Manpower and Immigration in Canada. If the job includes the clinical practice

of medicine, Manpower and Immigration also requires assurance from the appropriate Provincial College of Physicians and Surgeons that it will grant the applicant a restricted licence on its educational or other appropriate register. This may not be necessary for certain research positions not demanding practise as a physician. Finally, for resident positions in some provinces it is necessary to show that the provincial Ministry of Health approves the appointment of a non-Canadian. To get through this bureaucratic obstacle course requires patience and persistence and inevitably takes time. At least it gives ample opportunity to reconsider any hasty decisions. At a practical level you should plan well in advance allowing several months for all the official paper work to be completed. Don't lose heart at this stage.

I have tried to be realistic and, as a result, have been long-winded in setting out prospects for John and Jane in Canada today. If you have something to offer this country, then the country may give you an opportunity to work and learn and, above all, to enjoy the experience. Those Manpower and Immigration officials will not paint an unrealistically rosy picture so you will not be disappointed if the Minister of National Health and Welfare and the President of the CMA are not there to greet your flight at Toronto International.

Clinics in General Practice

A case of confusion and sciatica

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The trainee's problem

The patient is one of a large family of Italians, most of whom work locally in the restaurant and café trade. She is now 48 and, like most of her family, excitable, emotional, and overweight. She and her sister married brothers, and have the same name, which is the beginning of the story because I have been guilty of getting the two sisters mixed in my mind. One of my first consultations in the practice was with the sister, who was recovering well from having an intervertebral disc removed.

When I saw the present patient five weeks ago with acute sciatica I assumed that she had had a postoperative relapse and sent her home to bed to rest for a week. I must confess to neither taking a proper history nor reading her past notes, and it was only after a further fortnight that it became clear that my present patient was having back trouble for the first time. She recovered her straight-leg raising fairly quickly—never having any motor loss and only slight sensory abnormality and reduction of ankle jerk—but two days ago after returning to her share of café duties (before she had my approval) she had a relapse and is now back to square one.

The patient has not asked for a specialist opinion yet, and I do not know whether to give nature another chance, to send her to outpatients for an x-ray examination to keep everyone happy, or to arrange for a domiciliary orthopaedic opinion.

General practitioner's comments

The way this problem is presented indicates that the doctor's problems have been compounded by his acknowledged guilt in not appreciating the relevant background to the initial consultation. This is not surprising when considering the present state of most general-practice record-keeping. A doctor who is new to general practice may not find it easy to obtain the past history of patients. This indicates how important it is to maintain a summary of diagnoses and treatment within the notes and to continue pressing for a more suitable record system for general practice.

What is surprising, however, is that a young doctor has started treatment without inquiring into past history and without examining the patient's back. One appreciates the difficulties this may entail, particularly when dealing with patients of a different cultural background to one's own, but basic mistakes of this kind indicate either being very rushed (which as a trainee he should not be) or not appreciating the necessity to examine properly (which signifies poor training). The guilt engendered by these mistakes should initiate a review of his consultation techniques together with that of the record system and the speed of consultation. Too often the guilt one feels after clinical mistakes is not used to improve constructively the doctor's method of working but is dissipated in self-justification.

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