



that our current success in preventing heart attacks and strokes comes from treating on the basis of office blood pressure readings.

There are now blood pressure testing machines in many drugstores, and many patients also take their own readings at home with equipment we recommend. In virtually every case, the systolic numbers are at least 20 mm Hg lower than what I find at the office.

I advise patients that the office readings, taken in a more stressful situation than most ambulatory settings, demand attention. This may be contrary to current teaching that physicians should base treatment on the lower levels of blood pressure, but life is a compromise. So we may split the difference, shaving a few mm Hg from the top readings. This leaves everybody happy.

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Reference

1. Spence JD. Withholding treatment in white-coat hypertension: wishful thinking. *CMAJ* 1999;161(3):275-6.

Foreign graduates deserve better

The acute shortage of physicians we face is due not only to government shortsightedness but also to parochialism within the medical profession. For instance, specialists with many years' experience in another province and possessing Royal College certification are not, as a rule, considered fit to practise in Ontario. Are Ontarians more delicate than others or are we more equal than others?

Forty years ago the Malayan Medical Association used excuses such as maintenance of the standard of care to keep people out of practice. My medical degree from Taiwan was a useless piece of paper back in 1959. I was forced to teach high school at a time when the physician-population ratio in my own country was 1 in 10 000. My hometown and its 30 000 people did not have a single practising doctor, yet my wife and I

had no opportunity to return to practice because of our foreign qualifications — a plight faced by many foreign medical graduates in Ontario today.

The concern that foreign-trained physicians are inferior is prevalent. To limit foreign medical graduates to a minuscule number of training positions is in itself a form of institutionalized discrimination.

I would like to present a cohort's experience to illustrate a point. Seventy-two students entered the premed class at the National Taiwan University in 1952, and eventually 26 of them completed postgraduate training in North America. One graduate became professor and chief of the Department of Microbiology at Uniformed Services University of Health Sciences in Washington, DC, while another is the chair of cardiovascular surgery at McGill University. Two others became professors at George Washington University in Washington, and another is a professor at the University of Missouri. Only 6 of us ended up doing general practice in North America — everyone else is a board-certified specialist.

If we had arrived in Canada today, we would be consigned to a life of servitude washing bottles and dissecting rats in laboratories. I think the experience of this cohort is proof that foreign medical graduates deserve a fair chance to serve the public.

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Ticklish distinctions

The *CMAJ* case report of concurrent babesiosis and Lyme disease in Ontario by Claudia C. dos Santos and Kevin C. Kain¹ contains some incorrect information.

First, the authors state that "205 cases of Lyme disease were reported in this country between 1984 and 1994." In fact, the "205 cases" were in Ontario, not all of Canada.²

Second, they state that *Ixodes scapu-*

laris and *I. pacificus* ticks "have been identified in about 250 locations in Canada." The "250 locations" refer to the distribution of the blacklegged tick, *I. scapularis*, not *I. pacificus*. In the original reference², there is no mention of the western blacklegged tick, *I. pacificus*. This tick has only been documented in British Columbia.

Third, Long Point peninsula is not in Point Pelee National Park. These 2 locations are approximately 200 km apart — a 3-hour car drive.

Finally, the common name of *I. scapularis* is blacklegged tick, not deer tick.³

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References

1. dos Santos CC, Kain KC. Two tick-borne diseases in one: a case report of concurrent babesiosis and Lyme disease in Ontario. *CMAJ* 1999;160(13):1851-3.
2. Banerjee SN, Christensen CI, Scott JD. Isolation of *Borrelia burgdorferi* on mainland Ontario. *Can Commun Dis Rep* 1995;21:85-6.
3. Keirans JE, Hutcheson HJ, Durden LA, Klompen JSH. *Ixodes (Ixodes) scapularis* (Acari: Ixodidae): redescription of all active stages, distribution, hosts, geographical variation, and medical and veterinary importance. *J Med Entomol* 1996;33:297-318.

[The authors respond:]

We thank John Scott for identifying a typographical error in this report: the sentence that mentions Long Point peninsula should have read "... Long Point peninsula *and* [not *in*] Point Pelee National Park."

We did not claim that there were exactly, or only, 250 locations where either *I. scapularis* or *I. pacificus* has been found, nor is this relevant. The point is simply that although ticks capable of transmitting *Borrelia burgdorferi* or *Babesia* spp. or both have been found in a number of locations in the country, they are only established in a few.

Scott is incorrect that blacklegged tick is the only commonly used name for *I. scapularis*. The term deer tick remains in common use in the medical literature and lay press (in fact, the Centers for Disease Control refer to them as deer ticks in their public infor-