



were conducted on the revised data to determine whether there was a significant increase in the proportion of low-birth-weight babies born in Ontario between 1987 and 1995.

The corrections to the data reduced the percentage of low-birth-weight babies from 6.06% to 5.87% in 1993 and from 6.54% to 5.93% in 1994 (Table 1). The 1995 percentage is 5.98%. The 1994–95 to 1987 ratio is, therefore, 1.11. But, despite the reduction in the 1993 and 1994 percentages, the statistical tests show that the increase in the proportion of low-birth-weight babies from 1987 to 1995 is still statistically significant. The hospital discharge data also indicate a statistically significant trend.

The differences in the proportion of low-birth-weight babies between the vital statistics and the hospital discharge data can be explained by 2 factors: (1) vital statistics include all births among Ontario residents, whereas hospital discharge data include only hospital births and only births among Ontario residents occurring within Ontario; (2) in the vital statistics, birth weights are reported by the mothers, whereas those in hospital discharge data are reported by the attending physicians.

Joseph and Kramer showed a significant increase in low-birth-weight babies in Ontario, but the results were somewhat constrained by the incorrect data. The corrected data, however, still indicate a significant increase. The trend is confirmed by the hospital discharge data. At the national level, the percentage of new-

borns of low birth weight was 5.78% in 1995, up from 5.44% in 1992.

Indira Singh

Deputy Registrar General
Ontario Ministry of Consumer and
Commercial Relations
Toronto, Ont.

Janet Hagey

Director
Health Statistics Division
Statistics Canada
Ottawa, Ont.

Bringing guidelines to the people

Dr. Nuala P. Kenny's article "Does good science make good medicine" (*Can Med Assoc J* 1997;157:33-6) commented on the distance separating health care knowledge and individual clinical practice. Perhaps the selling of clinical guidelines is no different from selling widgets. Successful entrepreneurs already know that a good idea is not a guarantee of commercial success: it must be supported by an effective distribution and sales campaign.

With this in mind, perhaps it is time for *CMAJ* to have a page that summarizes selected current guidelines. It should be designed by an advertising expert so that it has instant appeal. Names, doses and costs of appropriate medications should be provided, together with essential investigations. Each topic should be repeated at frequent intervals. *CMAJ* could also provide convenient plastic cards that we could keep on our

desks. The information could also be placed in the national press so that patients could participate in decision-making.

David C.F. Muir

Director
Occupational Health Program
McMaster University
Hamilton, Ont.

Residents and suicide: Lessons to be learned?

I read with much sadness the article "Manitoba suicides force consideration of stresses facing medical residents" (*Can Med Assoc J* 1997;156:1599-602), by Lynne Sears Williams. It discussed 3 recent suicides involving residents at the University of Manitoba.

Having recently completed residency and fellowship training, I can appreciate the comments expressed about stresses and anxieties faced by residents in the 1990s. These stresses are not specific to one area, although this recent rash of suicides happened at the University of Manitoba. Once is happenstance, twice is a coincidence, but thrice is enemy action. We have yet to identify the specific enemy in these cases.

It will not be easy to ascertain whether there are training-program flaws that precipitated these tragedies. Residents are unlikely to express concerns about their programs for fear of jeopardizing future references and employment. Attending physicians may be reluctant to investigate and

Table 1: Percentage of newborns of low birth weight,* by data source, Ontario, 1987 to 1995

Data source	Year; % of newborns with low birth weight									Ratio 1994–95 to 1987 (and 95% CI†)	1987 to 1994–95	
	1987	1988	1989	1990	1991	1992	1993	1994	1995		χ^2 ‡	p value
Vital statistics	5.36	5.46	5.29	5.35	5.55	5.52	5.87	5.93	5.98	1.11 (1.08–1.15)	124.7	< 0.01
Hospital data	5.21	5.40	5.32	5.31	5.48	5.44	5.66	5.76	–	1.11 (1.07–1.14)	53.1	< 0.01

*Live births of infants weighing 500 to 2499 g as a proportion of all live births of infants with stated birth weight of 500 g or more.

†CI = confidence interval.

‡ χ^2 (1 degree of freedom) for linear trend in proportions.



expose program weaknesses because this might disrupt what they consider an acceptable status quo, endanger career advancement or draw attention to problems that will reduce the attractiveness of training programs. This means that any analysis will require input from external sources.

It is in the University of Manitoba's best interest to appoint external experts to assess these tragedies and possible precipitating factors. In this way, similar tragedies might be averted, and the lessons learned could be applied in other centres.

Robert J. Fingerote, MD
Windsor, Ont.

Offshore medical schools

I read with interest Milan Korcok's article "After rejection in Canada, more Canadians pursuing career dreams at offshore medical schools" (*Can Med Assoc J* 1997;156:865-70), as I have been trying to gain entry to Canadian medical schools for a few years. The article certainly reflects the difficulties applicants are facing. However, I would like to add some information.

The article did not mention the situation regarding provincial resi-

dence requirements for applications to certain schools. Only a few medical schools are considered national schools. Others pick students from their province first and have only a few places for out-of-province students. These restrictions really limit the number of schools you can apply to, because the chances of getting an interview are slim to nonexistent unless you are a brilliant student.

Another problem is the large degree of variation in what is desired in candidates. The University of British Columbia wants people with research experience and graduate degrees. McMaster University is not interested in graduate degrees and does not give credit for having one because "everyone gets good grades in graduate school." The University of Western Ontario continues to use the medical college admissions test as a weeding tool, a use the test was never intended for.

These problems, coupled with the high cost of application fees, have ensured that well-rounded students with a B+ average have a long road ahead if they want to study medicine in Canada. I suggest that they apply to Irish medical schools. These schools have an extensive recruiting program for foreign students, and application fees are comparable to those

in Canada. The calibre of the education is high, and Irish medical degrees are respected around the world. I will be fulfilling my dreams there this fall, something that the Canadian system would not allow me to do.

Iana Porzecanski, BSc
Vancouver, BC
Received via email

Healing body and mind

Kudos to Julie Righter for discussing the value of psychotherapy for patients with chronic illness ("Psychotherapy and chronic illness," *Can Med Assoc J* 1997;156:1535). For those who decry the value of attention to "mind" problems in chronic illness, I recommend *The Psychobiology of Mind-Body Healing*.¹ There is a scientific basis for this type of adjuvant treatment.

Noel Hershfield, MD
Division of Gastroenterology
University of Calgary
Calgary, Alta.
Received via email

Reference

1. Rossi E, editor. *The psychobiology of mind-body healing*. New York: WW Norton; 1993.

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