



for whom I was told sexual activity often starts at age 11 or 12, needs much improvement. High school graduates asked me if I believed that AIDS existed. The government has avoided taking responsibility. Political and tribal leaders and traditional doctors must play a role through educational radio programs and village visits. More medical staff is needed. The hospitals should make more educational videos about HIV, AIDS and STDs, featuring local residents, and show them on battery-powered televisions in hospitals and villages.

Drugs might start as gifts, such as those used for tuberculosis in Lesotho's mission hospitals. For example, I am sending recently outdated drugs. If only zidovudine were available for HIV-positive pregnant women, even for short periods.<sup>3</sup> Unfortunately, a diagnosis of HIV can mean violence if the woman's husband finds out, and without treatment such a diagnosis yields no benefit.

Considering the drug-related improvement in AIDS mortality in the US<sup>4</sup> and the worsening statistics in most developing nations, which bear over 90% of the world's HIV/AIDS burden (a reflection in part of social inequities<sup>1</sup>), governments, pharmaceutical companies, international agencies and philanthropists will have to give very generously if this pandemic is to be controlled.<sup>1</sup>

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#### Marathon's success

One objective of a small group within Ontario's Ministry of Health in the 1970s was to develop a type of group practice for Northern Ontario communities that would not wither and die after a few years. The underserved-area program of the time did not venture into a long-term plan for Northern health care, so the article "A Marathon session: A town's MDs develop a philosophy to call their own" (*CMAJ* 1998;158[11]: 1516-7), by Michael O'Reilly, about the family physicians in Marathon, Ont., cheered me immensely.

Their success has been made possible, in part, by the local hospital. Doctors in another Northern paper town had an opportunity in the 1970s to integrate doctors, hospital and community care in a single organization to provide coordinated service. It was too radical a move for the doctors — the Ontario Medical Association nearly had a seizure!

The use of small-town hospitals as walk-in clinics is not confined to Northern communities, as I noted recently.<sup>1</sup> In places like Marathon the doctors' offices belong in the hospital unless there are specific distances to overcome. The duplication of facilities wastes money and effort, and so does the separation of medical and hospital services. Night phone calls need go only to the duty doctor in the hospital, since all doctors would be familiar with most patients in a small town (aided by computerized records, of course).

Seven doctors may be a little much for the 5500 would-be patients in Marathon, but I agree that a major cause of failure of previous efforts to provide care in the North has been a shortage of doctors. An underserved, isolated community does not need a doctor: it needs doctors. Any medical group in the North must be able to function effectively with one doctor away consistently.

My praise for Dr. Gordon Hollway and all the family physicians in his group, and to Dr. George Macey and the entire community of Marathon — your creativity and energy are heartening.

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#### Understanding Quebec's policy on nursing training

I was surprised by the reaction to Quebec's new proposal to reduce the level of nursing training, as described in the news brief "Dumbing down' of Quebec RN education irks nurses, MDs," (*CMAJ* 1998;158 [10]:1262), by Barbara Sibbald. This proposal, which goes against the current worldwide trend to increase the level of nursing training, is perceived as being unsound, a policy that can only lead to an overall reduction in the quality of care offered to Quebecers.

However, the critics forget that this new policy is perfectly consistent with Quebec's current efforts to control health care spending. Few of those who graduate as nurses from junior college programs will find it cost-effective to complete an additional 4 years to earn a degree, to end up with only a modest increase in overall income. What better way to control health care costs than to keep absolute control over a body of minimally trained health care workers who are among the lowest paid in the world but are forever stuck in Quebec because their credentials are not transferable. Similar policies affect Quebec physicians: their training options are restricted, and they receive profes-