ical services for rural and isolated communities.

There is more to the formula for developing a good retention program, but Marathon has the basics right. Let's make sure they get the support to keep it that way.

Peter Newbery, MDiv, MD
Director
United Church Health Services
Hazelton, BC

We were certainly proud to have been featured on the cover of the June 1 issue of *CMAJ* and to provide evidence that all is not doom and gloom when it comes to rural recruitment. OReilly's article did a good job of outlining the recent events in Marathon. We feel, however, that one aspect that did not receive the attention it deserved was the central role of our group's philosophy toward recruitment and retention.

Early in the recruitment phase, our group met to devise a philosophy that was instrumental in cementing the recruitment. It incorporated group practice, consensus-based decision-making, emphasis on quality of patient care and lifestyle, use of alternative health care providers, a commitment to continuing education, and sustainability. We realized that sustainability might not always mean that our group consisted of the same faces, but would mean that it would continue to share the same philosophy. Ironically, we included the concept of ease of exit as a means to sustainability. Our reasoning was that, in a group that allowed physicians to leave to pursue other life goals, those physicians would be likely to assist in recruiting their replacements.

We are not satisfied with our current arrangement. We still hope to negotiate a fair means to free ourselves from fee-for-service payment (we have not already negotiated an alternative payment plan, as the article implied). We are recruiting an additional 1 or 2 family physicians because our waiting lists are still too long and our workloads still threaten our commitment to a fulfilling northern lifestyle.

Incidentally, Dr. Rupa Patel is a graduate of the Queen's Rural Family Medicine Program and not the Northwestern Ontario Medical Program, as stated in the article.

We feel that herculean recruiting efforts and serendipity in finding the right individuals are insufficient to address the problems of recruitment and retention. Only by combining these with a sustainable group philosophy will rural communities have a realistic chance of finding a solution.

Gordon Hollway, MD
Ruby Klassen, MD
Steve Klassen, MD
Sarah Newbery, MD
Eliseo Orrantia, MD
Rupa Patel, MD
Mike Sylvester, MD
Marathon, Ont.

Making career choices easier

I empathize with the difficulties Dr. Chris Feindel faces in choosing future residents ("Know your residency applicants well" [letter], *Can Med Assoc J* 1997;156:977-8). However, if students who have not spent elective time in a program are excluded from consideration (or "placed at a disadvantage," as Feindel phrased it), qualified candidates will be overlooked.

Students face financial constraints and limited amounts of elective time. Because career choices must be made at an early stage, students must explore as many avenues as possible. It is shortsighted and unreasonable to believe all interested students will spend elective time with a given program. The wise director realizes that the student with exposure to several areas will make a better informed choice. Students will apply to many programs in several specialty areas — to believe otherwise is naïve. The competing programs to which a student applies are none of the program director's business.

Where does the solution lie? Students must not be expected to disclose dealings with rival programs. The interviewer's sensitivity and common sense will prevent students from being placed in awkward positions that evoke either deceit or damning silence. To ease pressure on students, the flexibility to change programs midstream and a common postgraduate year 1 must be built into our present system. This will reduce uncertainty and the pressure to choose a specialty prematurely.

David Omahen, BSc
Class of '99
University of Ottawa
Ottawa, Ont.

Error corrected, conclusions the same

In the article "Recent trends in infant mortality rates and proportions of low-birth-weight live births in Canada" (*Can Med Assoc J* 1997;157:535-41), Drs. K.S. Joseph and Michael S. Kramer identify a possible error in the birth weight data from Ontario for 1993 and 1994. The error was traced to improper keying (data capture) of a small number of records. For birth weights reported in pounds and ounces, the second digit of the ounces was omitted, e.g., 5 pounds 10 ounces became 5 pounds 1 ounce.

Since we were made aware of this problem, the data have been rekeyed to correct the error for 1993 and 1994. As well, 1995 data are now available. Finally, to validate the vital statistics data, they were compared with birth weight data from hospital discharge abstracts, which are available up to 1994. The same statistical tests used by Joseph and Kramer