Mitchell Levine wonders how often physicians in the study missed cases of group A *Streptococcus* infection that would have been caught had the score approach been used. These data were omitted from the final version of the article to meet the word limit requested by *CMAJ*'s editors. We did, however, note that the physicians missed substantially more cases of streptococcal infection in children (20%) than if they had used the score approach (6%, $p = 0.006$).[2]

In the study, physicians identified 85 of 102 cases of streptococcal infection (83.1%).[2] The false-negative rate of 16.9% for physician judgement is not less than the 15% rate for the score. In addition, this estimate for physician sensitivity is somewhat higher than the 50-75% estimate generally reported in other studies.[3–5] However, all family physicians in the present study were provided with an article about the sore throat score and a laminated pocket version of the score for quick reference; this may have affected their performance.

In the original study, in which no information about the score was provided, the sensitivity of usual physician care was 69.4% compared with 83.1% for the score ($p = 0.06$).[6] This result is more in keeping with published reports and suggests that physicians miss 25%–50% of cases of group A *Streptococcus* when they rely on their clinical judgement. As a result, front-line practitioners can be reassured that they are likely to miss fewer cases of group A *Streptococcus* when they use the score approach than when they rely on their clinical judgement.

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2. McIsaac WJ, Goel V, To T, Low DE. The validity of a sore throat score in family practice. *CMAJ* 2000;163(7):811-5.
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Remote versus urban medical training

It is reassuring and not surprising to see that residents trained in remote or rural settings achieve Medical Council of Canada Qualifying Examination scores comparable to those of residents trained in urban settings.[1] Of greater interest would be information on the skill set and scope of practice maintained by candidates trained in remote and rural settings once they establish their practice and information on where they choose to set up practice.

Candidates trained outside of urban areas are more likely to include inpatient care, emergency medicine, obstetrics, basic office procedures and a variety of other skills in their practice. It is also evident to me that residents who are exposed to rural and remote settings are more likely to establish their practice in an underserviced area.

There are many nonurban regions in this country desperate for capable, well-trained physicians willing to practice without the urban subspecialty safety net. Programs based outside of urban areas produce physicians with the skills and comfort level required to work in these areas. It seems logical that the College of Family Physicians of Canada, universities and other interested parties should shift their training focus to meet the needs of our health care system. If these groups fail to meet these needs, it is only a matter of time before another type of health care practitioner assumes the role of primary care provider to Canadians living outside of urban areas.

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Reference

1. McKendry RJ, Busing N, Dauphinee DW, Brailovsky CA, Boulais A-P. Does the site of postgraduate family medicine training predict performance on summative examinations? A comparison of urban and remote programs. *CMAJ* 2000;163(6):708-11.

As a 24-year veteran of a family medicine training program based in a rural setting, I find it unfortunate that Robert McKendry and colleagues did not offer a description of the rural training programs in their article,[1] for example, the number of months of speciality training conducted in towns with less than 30 000 people. I would have found a table describing the site rotations, with information on the number of trainers per site, helpful in deciding if the the results of this study are applicable to our situation in Newfoundland.

One of the strong points of rural clinical teaching rotations is that the resident is often trained in a one-to-one situation with a clinical teacher. A good teacher makes a great rotation but the same site with a poor teacher makes no rotation at all. The process of recruiting rural clinical teachers and saying goodbye to departing ones is both delicate and constant. More information is needed concerning the differences between rural and urban rotations before we can determine the value of the results of McKendry and colleagues. In addition, if there was a difference in examination results between the residents trained in rural and remote settings and those trained in urban settings, perhaps, as the authors note, we should examine the examination.

On another note, I spend a bit of time in a canoe and I was appalled at the picture on the cover of the Sept. 19, 2000, issue of *CMAJ*. The canoeists

were not wearing personal flotation devices. Every year dozens of Canadians drown because they were out on the water underprotected like the 2 people on the cover of our official journal. What next? An article on the joy of driving with a picture of drivers not wearing seat belts?

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Reference

1. McKendry RJ, Busing N, Dauphinee DW, Brailovsky CA, Boulais A-P. Does the site of postgraduate family medicine training predict performance on summative examinations? A comparison of urban and remote programs. *CMAJ* 2000;163(6):708-11.

[One of the authors responds:]

Russell MacDonald raises 2 important issues concerning rural practice not addressed in our study: maintenance of skills and scope of (rural) practice, and practice location.[1] Perhaps, in the future, maintenance of skills and scope of practice could be evaluated using the results of the relevant and validated recertification process. A career tracking study of the graduates of the 2 family medicine training programs in northern Ontario suggested that approximately 50% to 70% of graduates begin practice in a rural or remote setting. In comparison, only 4–14% of all graduates of Ontario medical schools practice in a rural or remote location.[2] Incomplete responses from graduates of family medicine training programs and a lack of standard definitions for terms such as "rural" and "retention" are among the problems encountered in researching an accurate answer to this important question.

William Eaton was disappointed that our description of the rural training programs was limited to 2 sentences contrasting urban and rural teaching settings. This information was sacrificed to stay within the prescribed word limits. We will put Eaton in touch with the directors of the 2 rural training programs in northern Ontario for a more informed description of the programs.

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1. McKendry RJ, Busing N, Dauphinee DW, Brailovsky CA, Boulais A-P. Does the site of postgraduate family medicine training predict performance on summative examinations? A comparison of urban and remote programs. *CMAJ* 2000;163(6):708-11.
2. McKendry R. Physicians for Ontario: too many, too few for 2000 and beyond. Report to the Ontario Minstrity of Health and Long-Term Care. Toronto: The Ministry; 1999. p. 52

Unwanted freebies

In the very week in which Patrick Sullivan's article about the fines incurred by drug companies for improper continuing medical education (CME) events appeared,[1] we each received a large, 3-kg box full of more prescription pads than we will need between now and our funerals. Every psychiatrist we have talked to has received a similar freebie, including a colleague in another province. There are interleaved advertisements for an antidepressant, as well as a bunch of ads in the holders for the pads.

These pads were not solicited. None of the colleagues we have spoken to want them. One has already had his shredded.

Across the country environmentalists are concerned about the destruction of our forests. Clear-cutting in Nova Scotia has contributed to the collapse of salmon angling in 2 of our most famous rivers and many more of our minor ones. We object to these unsolicited, unwanted pads being sent to us.

When a new formulation of this antidepressant was introduced we, along with many others, were stupid enough to accept an invitation to attend a meeting in Montreal. It was of the kind that, judging by Sullivan's article, would today have led to a fine. It included the best seats for a lavish stage musical. Such was our shame on returning home that it took us about 2 years before we prescribed the drug.

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Reference

1. Sullivan P. Freebies to MDs targeted as drug industry starts publicizing CME fines. *CMAJ* 2000;163(6):749.

A drug by any other name

In *CMAJ*, drugs are described by their generic name only. However, many physicians, myself included, often know drugs by the most common proprietary name. It would be helpful if the proprietary name was always included after the first mention of the drug in question.

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[The editor of *CMAJ* responds:]

We agree that most physicians are more familiar with the brand names of the drugs they prescribe than with the generic names; their patients and colleagues often refer to drugs by their brand name. For a medical journal, however, identifying drugs by their brand name is problematic. First, a given drug may have several brand names. Second, readers of *CMAJ* in other countries might not know the brand names used in Canada, as drugs are often marketed under different names in different countries. Thus, unless the brand name is critical to the manuscript (for example, a case report in which a particular brand of a drug is implicated), we prefer to use only the generic name.

John Hoey