RPAP has had a positive impact remains unchanged, and we base this belief on the facts presented in the evaluation report and on our own experiences. However, we do recognize that many challenges remain and will continue for some time, particularly in the area of physician retention.

RPAP does not have a mandate to address certain issues. The payment of physicians for clinical services, including on-call payments, is outside its scope but is currently being discussed in the negotiations between Alberta Health and the AMA.

Training in emergency medicine is only one component of Alberta's Special Skills Training Program. Those who have received training in anesthesia, obstetrics and surgery have predominantly entered rural practice, although not necessarily in Alberta. The recognition that not all of the residents who took this training were entering rural practice led to a change in policy in 1996–97. Special skills trainees must now obtain a return-in-service agreement from a rural regional health authority. Whether the new policy will be successful remains to be seen.

The drive to recruit physicians from South Africa and elsewhere is a new initiative. There was little discussion with the RPAP Coordinating Committee or with physician groups before the initiative was announced. We believe that this return to a traditional approach to recruiting physicians for rural Alberta will create significant difficulties for Canadian graduates wanting to practise in rural areas and that this continued reliance on international graduates will perpetuate the historical problems.

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Complementary medicine in the hospital

After reading a recent article by Anita Elash, "Move into hospital sector another sign of complementary medicine's growing popularity" (*CMAJ* 1997;157[11]:1589-92), I thought of Dickens' observation that we live in the best of times and the worst of times. In these closing years of the 20th century, physicians enjoy the results of the last 70 or 80 years of scientifically based medical practice, and there is a strong impetus to pursue evidence-based practice as much as possible. At the same time, our society — and physicians are part of society — is drowning in a tidal wave of irrationalism. Leaving aside the public appetite for astrology and the like, we can focus on the issues of prime importance to physicians: most (but not all) of the beliefs and practices described by the terms alternative and complementary medicine.

According to the article, Sunnybrook Health Science Centre in Toronto now allows all manner of professional and nonprofessional staff to practise "techniques such as aromatherapy, iridology, reflexology and magnetic therapy as part of a patient's regular care." A long time ago, I spent a rewarding year as a senior medical intern at Sunnybrook. It was only a hospital then and not a "health science centre," so we didn't have all these wonderful complementary therapies.

The article reports that Dr. Donald Livingston thinks that if these therapies are not offered in hospitals,

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we are denying patients access to them. This is nonsense. What we are doing by making them available in hospitals is lending them an aura of scientific respectability.

Our forebears must be rolling in their graves.

Paul C.S. Hoaken, MD
Bath, Ont.

Dr. McCrae's expensive war medals

Perhaps it was patriotic, but on another level it was rank folly to pay $400 000 for Dr. John McCrae's medals, as described in the article "McCrae's war medals stay in Canada" (*CMAJ* 1997;157[11]:1501). The Guelph museum will now need to insure, in perpetuity, $100 worth of bronze for $400 000! Lieutenant-Colonel McCrae was rightly famous for his poem, not his decorations.

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Increase in Alzheimer's disease: Artifact or real?

Reading the excellent article "Alzheimer's disease: current knowledge, management and research," by Dr. Serge Gauthier and associates (*CMAJ* 1997;157[8]:1047-52), I was struck by what to me is a remarkable feature of this disease, one that merited only 2 lines in the article: the incredible increase in its incidence over the past few years. Asthma, particularly in the very young, is the only other disease that has seen a comparable increase.

My concern is that our increasing life expectancy is being blamed for the increase in incidence when there may be some other cause. I remember being told as a student that the increase in cases of lung carcinoma was an illusion because the disease had previously been grossly underdiagnosed. We are now being told that Alzheimer's disease used to be passed off as "dementia" or "senile decay," but I wonder. In 12 years of general practice in England I encountered only one person with a condition resembling my wife's Alzheimer's disease, and in a town of 30 000 that woman was famous for her dementia. If Alzheimer's disease had been as common then as it is now, she would not have been exceptional. I also came across very few cases of "senile dementia."

The 1991 survey[1,2] cited in the article reported that 28.5% of those over 85 years of age have Alzheimer's disease, but in nearly 25 years in rural practice, I met only 3 people with confirmed cases. Since then, I have worked mainly in walk-in clinics, and now there is scarcely a patient who hasn't a relative or a friend with this disease.

I can think of only 2 possible reasons: environment or nutrition (and the latter is unlikely because of the world distribution of Alzheimer's disease). My own feeling is that instead of worrying about PCBs and DDT, we should be looking at far more common pollutants, such as detergents, trace elements and radioactive waste, relative newcomers on the atmospheric scene.

Philip Rutter
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References

1. Canadian Study of Health and Aging Working Group. Canadian Study of Health and Aging: study methods and prevalence of dementia. *CMAJ* 1994; 150:899-913.
2. Ebly EM, Parhad IM, Hogan DB, Fung TS. Prevalence and types of dementia in the very old: results from the Canadian Study of Health and Aging. *Neurology* 1994;44:1593-600.

[One of the authors responds:]

Dr. Rutter's impression, based on his clinical experience, of an increasing incidence of dementia above and beyond that which could be accounted for by the aging of our population may be validated by ongoing incidence studies involving large randomized samples, such as the Canadian Study of Health and Aging.

Although predisposing genetic factors have attracted a great deal of interest in recent years, acquired factors in both our inner and outer environments are very important in the age at onset of Alzheimer's disease. Knowledge of these acquired, potentially modifiable factors could lead to effective prevention strategies.

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Correction

In the article "Guidelines for antiretroviral therapy for HIV infection" (*CMAJ* 1998;158[4]:496-505), by Dr. Anita R. Rachlis and colleagues, the financial disclosure section included incorrect information for Dr. Susan M. King. Dr. King should have been listed among those researchers who have received honoraria as consultants or grants for conducting clinical trials from one or more of the pharmaceutical companies mentioned.