research and the lack of empirical evidence for Freudian concepts of repression, let us first condemn memory-retrieval techniques such as guided imagery, bibliotherapy (the reading of highly suggestive books), trance writing, dream work, body work, hypnotherapy, visualization, interviews conducted under the influence of amobarbital and other quackery. These have no basis in science.

Adriaan J.W. Mak
London, Ont.

[Dr. Penfold responds:]

In summarizing the arguments and evidence for both sides of the repressed-memory debate I hoped to raise awareness and promote understanding of the dilemmas that a practising physician may face. Although I am very concerned about parents who are falsely accused and victims who are erroneously disbelieved, the present state of knowledge about memory does not permit a black-and-white approach.

Although I agree with Dr. Tyroler that repression is an outmoded and unclear concept, we cannot throw out the baby with the bath water. As I emphasized in my article, there is evidence supporting the existence of both genuine recovered memories and fabricated memories. For instance, memory researcher Elizabeth Loftus, a member of the advisory board of the False Memory Syndrome Foundation, is the principal author of an article describing a study of women involved in outpatient treatment of substance abuse.[1] Of the women reporting childhood sexual abuse, 19% reported that they had forgotten the abuse for a period of time. The memory returned later.

Is this failure to remember childhood trauma due to "repression," "amnesia," "dissociation" or "forgetting"? The terms are not clearly delineated and are sometimes used interchangeably. The fact remains that some kind of traumatic forgetting happens, under some circumstances, to some victims. I do not believe that we are looking at 2 "irreconcilable views," but that shades of grey will exist in this area for some time, until much more research has clarified the many unknown aspects of memory.

P. Susan Penfold, MB
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University of British Columbia
Vancouver, BC

Reference

1. Loftus EF, Polonsky S, Fullilove MT. Memories of childhood sexual abuse: remembering and repressing. *Psychol Women Q* 1994;18:67-84.

In praise of commonplace conferences

I hope I speak for many physicians in this country when I say that I would like a list of meetings that could be practical at the bedside. In *CMAJ* I am offered a conference list that includes Pathways to Community Performance — Bringing Leaders from All Sectors Together to Build Community-wide Collaboration and Partnerships. As young people today would say, Hello? An alternative meeting that I could go to during the same week is Supporting Women, Supporting Ourselves — A Conference on Reproductive Psychiatry. Excuse me? How about Feminist Approaches to Bioethics? I do not think so.

Many of us are tired of being upbraided, put down, trivialized and treated arrogantly. In contrast, we are anxious to bring to our patients, whom we like and respect, medical wisdom that is up to date, affordable (unlike Transgenic Technologies — Producing Next Generation Therapeutics Conference) and what you would call pedestrian or commonplace (unlike 3rd Annual Novel Amplification Technologies Conference).

Could you please provide us with a few such meetings each month?

Donald P. Warren, MD
North Vancouver, BC

[The editor-in-chief responds:]

We have received several letters and calls about conferences, none as lively as Dr. Warren's, but all with a similar message. Our policy has been to publish at least once, and more often as space permits, all notices of conferences in the medical field that we receive. However, in light of the feedback from readers, we plan to re-examine this policy. We encourage readers to let us know what you think of our listings of conferences and continuing medical education courses to help us in this process.

John Hoey, MD
Editor-in-chief
Rédacteur en chef

The tobacco tragedy in Northern Canada

Thank you for calling attention to Dr. Richard Bargen's frustrated efforts to reduce smoking and smoking-related disease in the eastern Northwest Territories (*Can Med Assoc J* 1996;155:1383). When the Baffin, Kitikmeot and Keewatin regions become the Nunavut Territory in 1999, the issue of cigarette smoking, which Bargen brought very much to the fore, will remain a fundamental issue. Unfortunately, the smoking issue will not and cannot be resolved by the lone voices and hard work of medical officers struggling in isolation.

I recall well my first year as a federal medical officer working in a northern region. Chest diseases made

by far the largest claim on the 150-bed hospital's services — and at Christmas the administration's gift to patients was cigarette lighters!

Although there has been undoubted progress since then, the vast majority of illnesses and premature deaths in the North result from preventable conditions. Sadly, the causes remain underaddressed by physicians, nurses, social workers, hospital administrators and others.

It is important to draw attention to the tragically high smoking rates in the North, but at the same time we must recall that at least some physicians working in these jurisdictions are known to be addicted to tobacco, as are significant numbers of nurses, social workers and health care administrators. The result is an inconsistent message from people who should be role models.

Indeed, the thinking of health care and social service staffs — that their role is the expert diagnosis and treatment of illnesses and disorders, not the fundamental need to address causes — leaves people like Bargen practising in isolation.

Maybe it would be fair to add to your suggestion to the minister of health and social services an equally urgent plea to the universities that are contracted to provide medical specialists and family physicians to the Eastern Arctic (and who sit on regional health boards), and to nurses, social workers, health care administrators and everyone who cares, that they recognize the fight against cigarette smoking as their challenge and responsibility too.

Bargen's endeavour built on initiatives by the Inuit leaders of Nunavut and the Inuit Women's Association (Pauktuutit), and on innovative campaigns by Inuit community health representatives and others. We should also remember that when the federal government cut its tobacco taxes, the government of the Northwest Territories refused to follow suit. Perhaps more joint efforts in the future will help to overcome longstanding sins of omission and commission and to stop the tragedy of smoking-related disease in Northern Canada that was so troubling to Bargen.

F. Ian Gilchrist, MD, DPH
Chief Medical Health Officer
Northwest Territories Health and Social Services
Yellowknife, NWT

Declining sex ratios in Canada [correction]

In Table 1 of this article by Bruce B. Allan, Rollin Brant, Judy E. Seidel and John F. Jarrell (*Can Med Assoc J* 1997;156:37-41) the figures in columns 2 and 4 were inadvertently omitted during the final stage of production. The correct table appears below. — Ed.

Table 1: Logistic regression analysis of the year-to-year change in the sex ratio (male proportion*) from 1970 to 1990 by region of Canada and the estimated 20-year cumulative change in the male proportion per 1000 live births

Region	Slope	*p* value	Cumulative change in male proportion per 1000 live births (and 95% CI†)
West	−0.00028	0.20	−1.4 (−3.7 to 0.9)
Ontario	−0.00020	0.31	−1.0 (−2.9 to 0.9)
Quebec	−0.00041	0.09	−2.0 (−5.4 to 1.3)
Atlantic	−0.00112	< 0.01	−5.6 (−9.4 to −1.8)
Canada	−0.00044	< 0.001	−2.2 (−3.3 to −1.1)

*Proportion of live births that were male.
†CI = confidence interval.

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For prescribing information see page 441 →