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.

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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.

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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.

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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

were conducted on the revised data to determine whether there was a significant increase in the proportion of low-birth-weight babies born in Ontario between 1987 and 1995.

The corrections to the data reduced the percentage of low-birth-weight babies from 6.06% to 5.87% in 1993 and from 6.54% to 5.93% in 1994 (Table 1). The 1995 percentage is 5.98%. The 1994–95 to 1987 ratio is, therefore, 1.11. But, despite the reduction in the 1993 and 1994 percentages, the statistical tests show that the increase in the proportion of low-birth-weight babies from 1987 to 1995 is still statistically significant. The hospital discharge data also indicate a statistically significant trend.

The differences in the proportion of low-birth-weight babies between the vital statistics and the hospital discharge data can be explained by 2 factors: (1) vital statistics include all births among Ontario residents, whereas hospital discharge data include only hospital births and only births among Ontario residents occurring within Ontario; (2) in the vital statistics, birth weights are reported by the mothers, whereas those in hospital discharge data are reported by the attending physicians.

Joseph and Kramer showed a significant increase in low-birth-weight babies in Ontario, but the results were somewhat constrained by the incorrect data. The corrected data, however, still indicate a significant increase. The trend is confirmed by the hospital discharge data. At the national level, the percentage of newborns of low birth weight was 5.78% in 1995, up from 5.44% in 1992.

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Bringing guidelines to the people

Dr. Nuala P. Kenny's article "Does good science make good medicine" (*Can Med Assoc J* 1997;157: 33-6) commented on the distance separating health care knowledge and individual clinical practice. Perhaps the selling of clinical guidelines is no different from selling widgets. Successful entrepreneurs already know that a good idea is not a guarantee of commercial success: it must be supported by an effective distribution and sales campaign.

With this in mind, perhaps it is time for *CMAJ* to have a page that summarizes selected current guidelines. It should be designed by an advertising expert so that it has instant appeal. Names, doses and costs of appropriate medications should be provided, together with essential investigations. Each topic should be repeated at frequent intervals. *CMAJ* could also provide convenient plastic cards that we could keep on our desks. The information could also be placed in the national press so that patients could participate in decision-making.

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Residents and suicide: Lessons to be learned?

I read with much sadness the article "Manitoba suicides force consideration of stresses facing medical residents" (*Can Med Assoc J* 1997;156:1599-602), by Lynne Sears Williams. It discussed 3 recent suicides involving residents at the University of Manitoba.

Having recently completed residency and fellowship training, I can appreciate the comments expressed about stresses and anxieties faced by residents in the 1990s. These stresses are not specific to one area, although this recent rash of suicides happened at the University of Manitoba. Once is happenstance, twice is a coincidence, but thrice is enemy action. We have yet to identify the specific enemy in these cases.

It will not be easy to ascertain whether there are training-program flaws that precipitated these tragedies. Residents are unlikely to express concerns about their programs for fear of jeopardizing future references and employment. Attending physicians may be reluctant to investigate and

Table 1: Percentage of newborns of low birth weight,* by data source, Ontario, 1987 to 1995

	Year; % of newborns with low birth weight									Ratio 1994–95 to 1987	1987 to 1994–95	
Data source	1987	1988	1989	1990	1991	1992	1993	1994	1995	(and 95% CI†)	χ^2‡	*p* value
Vital statistics	5.36	5.46	5.29	5.35	5.55	5.52	5.87	5.93	5.98	1.11 (1.08–1.15)	124.7	< 0.01
Hospital data	5.21	5.40	5.32	5.31	5.48	5.44	5.66	5.76	–	1.11 (1.07–1.14)	53.1	< 0.01

*Live births of infants weighing 500 to 2499 g as a proportion of all live births of infants with stated birth weight of 500 g or more.
†CI = confidence interval.
‡χ^2 (1 degree of freedom) for linear trend in proportions.