[Dr. Marshall responds:]

Dr. Anderson correctly concludes that I endorse accountability for the provision of care if it is based on accurate data. My plea was to avoid careless use or labelling of unvalidated data, since such practices bring the use of administrative databases for accountability into question. I agree that researchers, like surgeons, have a learning curve, but like surgeons they also have an obligation to minimize the damage they do during that learning process. I believe that in this instance the researchers minimized the damage by not identifying hospital sites when the data they had were unvalidated. Unfortunately, the same could not be said of the press.

W. John S. Marshall, MB, ChB
Associate Dean
Faculty of Health Sciences
Queen's University
Chief of Staff
Kingston General Hospital
Kingston, Ont.

Rural medicine: real action needed

I found that the paper "Alberta's Rural Physician Action Plan [RPAP]: an integrated approach to education recruitment and retention" (*CMAJ* 1998;158[3]:351-5), by Dr. Douglas R. Wilson and colleagues, was one-sided, lacked outcome measures and might have left readers with the impression that this program has been successful. At least 3 problems were either glossed over or left unmentioned.

The article makes a passing reference to the independent review of RPAP's effectiveness[1] but fails to mention the reviewers' strong criticism of the program mix. Although rural Canada needs infrastructure to support training for anesthesia, cesarean section and general surgical procedures, these areas have not been emphasized by the training programs. Even though there is no significant need for full-time emergency physicians in rural Canada, much of the training has been in this area. The reviewers pointed out that most of the physicians who received this training under the plan subsequently left to work in urban emergency departments.

The paper also failed to mention that the plan itself may consider the measures described inadequate. Why else would Alberta be going to Africa to recruit 25 to 40 doctors this year?[2] These doctors are to be ghettoized in rural Alberta through restricted licensure — until they can prove they are competent!

The most damning criticism of RPAP is that from January 1994 to January 1998 the number of rural GP/FPs in Alberta dropped from 442 to 292 (Lynda Buske, Canadian Medical Association: personal communication, 1998).

Training doctors for rural practice is an important part of any solution. However, when no attempt is made to make rural medicine attractive, even the best physicians with rural training may eventually set up shop in the city. A truly integrated action plan would also offer significant retention incentives to overcome the opportunity costs of doing necessary but low-volume work in obstetrics, emergency medicine or other areas.

Peter Hutten-Czapski, MD
Chief of Staff
Temiskaming Hospital
New Liskeard, Ont.
Received by email

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1. MacDonald CA and Associates. *Evaluation of the Rural Physician Action Plan*. Edmonton: Alberta Health; 1996.
2. Lindsay P. Rural physician recruitment and retention. *Alberta Sect Rural Med Newsl* 1997;Dec:1.

After reading this article, I find it difficult to see how such a well-conceived, integrated approach could fail to succeed. Still, 7 years after RPAP was launched, objective evidence of its success is lacking.

Current events indicate that the plan is a failure or, at best, inadequate. This year it is to receive an extra $1 million, which will be spent on the urgent recruitment of 40 physicians from other provinces and overseas.[1] In the 2 years since the evaluation mentioned in the article, the number of rural physicians in the province has declined substantially.[2] The decline suggests that Alberta is not doing any better than provinces without "plans" that are undergoing similar health care restructuring.

This article leaves the impression that RPAP is bringing the problem of rural physician recruitment under control, and it is unfortunate that it appeared in the midst of the AMA's negotiations with Alberta Health. The province's rural physicians had hoped that the problems of rural recruitment and retention would be dealt with adequately during those negotiations.

David P. O'Neil, MD
Trochu, Alta.
Received by email

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1. *RPAP news*. Edmonton: Rural Physician Action Plan; Jan 1998.
2. Quarterly physician manpower statistics. Edmonton: College of Physicians and Surgeons of Alberta; 1997, 1998.

[The authors reply:]

Our paper was intended to describe the development and characteristics of RPAP and to present some early indicators of success. One problem in preparing a paper for publication is the gap between completion of the manuscript and publication; many events can occur during that period. Our opinion that

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.

David G. Moores, MD
Professor and Chair
Department of Family Medicine
University of Alberta
Edmonton, Alta.
Douglas R. Wilson, MD
Professor
Department of Public Health Sciences
University of Alberta
Edmonton, Alta.
Sandra C. Woodhead-Lyons, BSc(HEc)
Woodhead-Lyons Consulting
Edmonton, Alta.

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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