Canadian Institute for Health Information (CIHI) in December show that the number of physicians dropped to 54 958 in 1996 from 55 006 in 1995. The decrease is consistent with declines that occurred in 1994 and 1995. (The total includes only active civilian physicians. Medical students, residents and retired and military physicians are not included.) Although the number of physicians dropped, there were 350 more specialists in Canada in 1996 than in 1995; the 26 737 specialists practising in 1996 accounted for 49% of the total. The 51%-49% split with family physicians has remained relatively constant for the last 20 years.

CIHI also reported that the national physician–patient ratio moved from 1:542 in 1995 to 1:548 in 1996; this compares with ratios of 1:395 in the US and 1:554 in the United Kingdom.

Newfoundland's unending attempts to solve MD shortages

Memorial University's Faculty of Medicine takes the problems of physician shortages in rural areas seriously, because it has sponsored annual rural health forums in each of the past 7 years in an attempt to find solutions.

Many of the issues discussed at Rural Health Forum '97 this fall were familiar, but some new initiatives were unveiled to deal with the ongoing problem of physician recruitment and retention. For instance, a new program to assess and upgrade family physicians was announced by the province's minister of health, and in the past year the province has increased salaries for rural doctors by 20% to 50%. Still, isolated areas continue to face severe shortages.

"While money is important, it's only part of the issue," said Joan Marie Aylward, Newfoundland's minister of health. "We have grave difficulty attracting sole practitioners and we have to build models of care that cluster professionals in practice centres."

She said pilot projects to establish primary care service and teaching units are being put in place in Twillingate and Port aux Basques, and services at the existing unit in Happy Valley-Goose Bay are being enhanced.

Although Rural Health Forum '97 allowed for discussion of problems and solutions in rural medicine, the men and women who actually do the job had issues of their own to discuss. When the forum ended, rural family medicine preceptors spent a long

AMA reveals inflation's bite

The Alberta Medical Association (AMA) says that not only are the province's physicians being "devalued" by low fees for physician services but also inflation is eating away at their income. Fees in Alberta have fallen 5% since 1993–94 and the AMA claims that the "significant gap" between fees and the cost of living continues to grow. In preparing for fee negotiations, the AMA recently produced a detailed list of the 100 services physicians provide most frequently. It compares current fees with those of 10 years ago, and factors in annual adjustments for inflation. The fee information was released as part of the AMA's Care to know how much doctors are paid? campaign to educate Albertans on how much physicians receive for each service provided.

Service	Jan. '87 fee	Jan. '97 fee	'97 fee if adjusted for inflation
Office visit (family physician)	$ 21.25	$ 21.54	$ 28.24
Chest x-ray	$ 20.50	$ 21.64	$ 27.24
Major consultation (psychiatry)	$ 98.40	$108.92	$130.76
Osteoporosis examination	$154.00	$162.19	$204.64
Cataract removal with insertion of lens	$572.00	$505.13	$760.10

McMaster University student Christopher Andrews took this photo of skulls and femurs in Murambi, one of the many sites where genocide occurred in Rwanda in 1994. It is estimated to have claimed 500 000 to 1 million lives. Andrews, who described his chilling visit to Murambi in an Experience article in the Jan. 13, 1998, issue of *CMAJ*, had been completing an elective in nearby Uganda when he visited Rwanda. He says the bodies, bones and body parts that have been gathered in an unfinished school at Murambi offer mute testimony to mass murder.

morning debating issues.

Memorial's dean of medicine, Dr. Ian Bowmer, met them to discuss emerging initiatives, and specifically the development of academic rural centres of health and the nurse-practitioner program. (The province is considering legislation that will regulate the role of nurse practitioners, who are currently being trained to supplement physician services in rural areas.)

"We have not recognized our rural preceptors appropriately, and that's the thinking that brought us to the academic centre concept," said Bowmer. "At such a centre everyone participates in a teaching environment and on-call duty is reduced."

He said the province jumped at the idea of interdisciplinary teaching units and the program has developed quickly, particularly at Port aux Basques. "The good news is that there is going to be new money for these centres, there is a source for some federal funds. The idea of the pilot centres at Twillingate and Port aux Basques is to demonstrate that these are a good idea and should be established all around the province."

Dr. Conleth O'Maonaigh, who practises on Fogo Island, has some major concerns about the pilot project. "What about preceptors elsewhere who don't get paid? How are they going to feel? And what if the pilot fails? What happens to the faculty who have been hired?" — *Sharon Gray*, information officer, Memorial University.

Research Update • Le point sur la recherche

Changing thinking about gestational diabetes

Targeting pregnant women with risk factors for gestational diabetes makes screening for the condition more efficient and lessens the test burden for many women, Toronto researchers have found (*N Engl J Med* 1997;337[22]:1591-6).

According to some existing guidelines, all pregnant women should undergo a blood glucose screening test at 24 to 28 weeks' gestation, followed by an oral glucose-tolerance test among women with positive results. The study suggests that a different strategy could save about a third of pregnant women the bother of the screening test and yet detect just as many of the women with gestational diabetes.

"The goal is to minimize the burden on women," explains Dr. C. David Naylor, study coauthor and chief executive officer at the Institute for Clinical Evaluative Sciences. There has recently been controversy over the need for universal screening and over the usefulness of treatment in preventing the effects of gestational diabetes — larger babies and a higher-than-usual risk of toxemia and cesarean section. However, identifying gestational diabetes has another benefit.

"Pregnancy amounts to a 'metabolic stress test' to find women who are at higher risk long term for diabetes," Naylor says. At least in theory, women with diagnosed gestational diabetes can receive care after pregnancy to lower body mass and modify other risk factors. However, Naylor cautions that research into the benefits of postpartum intervention to prevent diabetes is needed.

In the study, conducted at Women's College Hospital, the Toronto Hospital–General Division and Mount Sinai Hospital, more than 3000 pregnant women were given both the screening test and the oral glucose-tolerance test. Study data were then randomly divided. In one group, various demographic factors were examined to see which ones predicted gestational diabetes. The second group was used to validate the findings from the first group. The result was a variety of screening strategies based on age, body mass index (BMI) before pregnancy, and race.

The authors recommend that family physicians and obstetricians who currently conduct universal screening instead refer pregnant women for the screening test *unless* they are black or white *and* under 35 years old *and* have a BMI of 22 kg/m^2 or less before pregnancy.

Some of the strategies involve a lower blood-glucose level threshold than now recommended for women at high risk of gestational diabetes. Naylor suggests that physicians who wish to adopt the revised thresholds build them into test requisition sheets. — *C.J. Brown*

In the news . . .

Ankle bone connected to the knee bone

From the people who brought you the Ottawa ankle rules comes the Ottawa knee rule (*JAMA* 1997;278:2075-9), a prospectively validated guideline that saves time and money when physicians request radiographs for acute knee injuries. The guideline recommends requesting a knee radiograph only for patients who are 55 or older, have isolated tenderness of the kneecap, have tenderness at the head of the calf bone, cannot flex the knee 90° or cannot bear weight. After physicians in the study learned the rule, their ordering of knee radiographs fell 26.4%, and no fractures were missed as a result.