Letters

Correspondence

Mitchell Levine wonders how often physicians in the study missed cases of group A Streptococcus infection that would have been caught had the score approach been used. These data were omitted from the final version of the article to meet the word limit requested by CMAJ’s editors. We did, however, note that the physicians missed substantially more cases of streptococcal infection in children (20%) than if they had used the score approach (6%, \( p = 0.006 \)).

In the study, physicians identified 85 of 102 cases of streptococcal infection (83.1%). The false-negative rate of 16.9% for physician judgement is not less than the 15% rate for the score. In addition, this estimate for physician sensitivity is somewhat higher than the 50–75% estimate generally reported in other studies. However, all family physicians in the present study were provided with an article about the sore throat score and a laminated pocket version of the score for quick reference; this may have affected their performance.

In the original study, in which no information about the score was provided, the sensitivity of usual physician care was 69.4% compared with 83.1% for the score (\( p = 0.06 \)). This result is more in keeping with published reports and suggests that physicians miss 25%–50% of cases of group A Streptococcus when they rely on their clinical judgement. As a result, front-line practitioners can be reassured that they are more in keeping with published reports when they rely on their clinical judgement.

Donald E. Low

University of Toronto

Remote versus urban medical training

It is reassuring and not surprising to see that residents trained in remote or rural settings achieve Medical Council of Canada Qualifying Examination scores comparable to those of residents trained in urban settings. Of greater interest would be information on the skill set and scope of practice maintained by candidates trained in remote and rural settings once they establish their practice and information on where they choose to set up practice.

Candidates trained outside of urban areas are more likely to include inpatient care, emergency medicine, obstetrics, basic office procedures and a variety of other skills in their practice. It is also evident to me that residents who are exposed to rural and remote settings are more likely to establish their practice in an underserviced area.

There are many nonurban regions in this country desperate for capable, well-trained physicians willing to practice without the urban subspecialty safety net. Programs based outside of urban areas produce physicians with the skills and comfort level required to work in these areas. It seems logical that the College of Family Physicians of Canada, universities and other interested parties should shift their training focus to meet the needs of our health care system. If these groups fail to meet these needs, it is only a matter of time before another type of health care practice assumes the role of primary care provider to Canadians living outside of urban areas.

Russell MacDonald

Assistant Professor of Emergency Medicine

Faculty of Medicine

University of Manitoba

Winnipeg, Man.

References

were not wearing personal flotation devices. Every year dozens of Canadians drown because they were out on the water underprotected like the 2 people on the cover of our official journal. What next? An article on the joy of driving with a picture of drivers not wearing seat belts?

William Eaton
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St. John’s, Nfld.

Reference
1. McKendry RJ, Busing N, Dauphinee DW, St. John’s, Nfld. Memorial University of Newfoundland Faculty of Medicine Department of Family Medicine

[One of the authors responds:]

Russell McDonald raises 2 important issues concerning rural practice not addressed in our study: maintenance of skills and scope of (rural) practice, and practice location.1 Perhaps, in the future, maintenance of skills and scope of practice could be evaluated using the results of the relevant and validated recertification process. A career tracking study of the graduates of the 2 family medicine training programs in northern Ontario suggested that approximately 50% to 70% of graduates begin practice in a rural or remote setting.1 Perhaps, in the future, maintenance of skills and scope of practice could be evaluated using the results of the relevant and validated recertification process. A career tracking study of the graduates of the 2 family medicine training programs in northern Ontario suggested that approximately 50% to 70% of graduates begin practice in a rural or remote setting.1

Incomplete responses from graduates of family medicine training programs and a lack of standard definitions for terms such as “rural” and “retention” are among the problems encountered in researching an accurate answer to this important question.

William Eaton was disappointed that our description of the rural training programs was limited to 2 sentences contrasting urban and rural teaching settings. This information was sacrificed to stay within the prescribed word limits. We will put Eaton in touch with the directors of the 2 rural training programs in northern Ontario for a more informed description of the programs.

Robert J. McKendry
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References

U nwanted freebies

In the very week in which Patrick Sullivan’s article about the fines incurred by drug companies for improper continuing medical education (CME) events appeared,1 we each received a large, 3-kg box full of more prescription pads than we will need between now and our funerals. Every psychiatrist we have talked to has received a similar freebie, including a colleague in another province. These pads were not solicited. None of the colleagues we have spoken to want them. One has already had his shredded.

Across the country environmentalists are concerned about the destruction of our forests. Clear-cutting in Nova Scotia has contributed to the collapse of salmon angling in 2 of our most famous rivers and many more of our minor ones. We object to these unsolicited, unwanted pads being sent to us.

When a new formulation of this antidepressant was introduced we, along with many others, were stupid enough to accept an invitation to attend a meeting in Montreal. It was of the kind that, judging by Sullivan’s article, would today have led to a fine. It included the best seats for a lavish stage musical. Such was our shame on returning home that it took us about 2 years before we prescribed the drug.

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Sackville, NS
William McCormick
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The Nova Scotia Hospital
Sackville, NS

Reference

A drug by any other name

In CMAJ, drugs are described by their generic name only. However, many physicians, myself included, often know drugs by the most common proprietary name. It would be helpful if the proprietary name was always included after the first mention of the drug in question.

Allen Gold
Endocrinologist
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[The editor of CMAJ responds:]

We agree that most physicians are more familiar with the brand names of the drugs they prescribe than with the generic names; their patients and colleagues often refer to drugs by their brand name. For a medical journal, however, identifying drugs by their brand name is problematic. First, a given drug may have several brand names. Second, readers of CMAJ in other countries might not know the brand names used in Canada, as drugs are often marketed under different names in different countries. Thus, unless the brand name is critical to the manuscript (for example, a case report in which a particular brand of a drug is implicated), we prefer to use only the generic name.

John Hoey