graduation. The second is the positive correlation between intent to have a rural practice and obstetrical interest. And finally, the strong positive correlation that we found between interest in obstetrics prior to residency and intent to practice obstetrics on graduation.

These findings have strong implications in how we structure our undergraduate and postgraduate programs. Exposure to family practice obstetrics in the undergraduate curriculum may enhance interest in this field for new residents. Those with an interest in rural practice may need to have customized programs to provide them with tools needed in that setting. This opens the discussion around increased streaming within the family medicine residency programs. Lifestyle issues related to balancing professional and personal responsibilities in an effective and sustainable manner are important and may become even more so with the "feminization" of obstetrical practice. We must model these effectively as teachers to empower our trainees for the future.

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[One of the authors responds:]

My collegues and I agree with James Ruderman's assessment that several studies have now shown consistent results in the areas he mentioned. What we think was the most critical finding in our study is that while undergraduate experience is important and affected residents' stated intentions to practise obstetrics when they entered residency, something negative happens during the 2 years of residency. Fifty-two percent of residents planned to do obstetrics at the beginning of residency and only 17% by the end of residency. This needs to be addressed. We believe that streaming is one very important option, as Ruderman suggests. Rather than trying to get all residents to practise obstetrics, let's take the 50% who are so predisposed at the start of residency and make certain they have role models and mentors, experience continuity of care as practised by family physicians, and, most of all, get lots of experience in intrapartum obstetrics. As well, we should make certain this group has the opportunity to do the ALARM/ALSO courses and, where available, a third year in obstetrics in which they learn to handle higher-risk cases and even do cesarian sections. Residents need to feel prepared to do obstetrics at the end of a 2-year residency. If we can keep the 50% of residents who start residency interested in obstetrics still wanting to deliver babies at the end of their residency, we will have increased the rate of new residents doing obstetrics by 3 times what it is now.

We thank Ruderman for his comments.

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