actually under-represents the true difference in access to medical care.

Paul Mackey
Rural Physician
Fort St. John, BC

Reference
1. Gagnon L. Stats Can: 14% of Canadians have no family doctor. *CMAJ* 2004;171(2):124.

Competing interests: Member, Rural Issues Committee of the British Columbia Medical Association.

DOI:10.1503/cmaj.1041293

[Mr. Hamel responds:]

In the 2003 Canadian Community Health Survey, released in June 2004 and summarized in *CMAJ*,[1] about 4.5% of Canadians residing in urban areas and 5.5% of those in rural areas reported not being able to find a regular medical doctor. Proportionally speaking, these numbers are very similar. However, in terms of population, the 4.5% in urban areas represented about 965 000 of the 1.2 million Canadians (12 years of age or older) who reported that they were unable to find a regular medical doctor.

In analyzing these results, definitions matter. Our analysis was based on the definition of rural areas used for the Canadian census. Thus, we did not differentiate between rural and remote areas, for which the picture might be different. Also, having a regular family doctor does not imply better access to care, and our analysis did not examine the relation between having a regular medical doctor and the process of accessing care. Although we looked at the profile of people with and without a regular medical doctor in terms of some health care services such as routine tests (e.g., blood pressure check, mammography) and use of emergency departments, the survey did not measure issues related to primary care access such as those described by Paul Mackey.

Marc Hamel
Chief, Canadian Community Health Survey
Health Statistics Division
Statistics Canada
Ottawa, Ont.

Reference
1. Gagnon L. Stats Can: 14% of Canadians have no family doctor. *CMAJ* 2004;171(2):124.

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Not a middle-of-the-road position

I cannot understand how Dr. Ursus[1] can claim to have a "middle-of-the-road" position on abortion when he clearly supports abortion on demand. He may deeply regret the necessity of abortions; however, by performing these procedures or referring patients for them, he's chosen against his smaller, defenceless patients. He is on that side of the road.

Donald S. Stephens
Physician
Stratford, PEI

Reference
1. Query. *CMAJ* 2004;171(11):1420.

DOI:10.1503/cmaj.1041752

Strains and toxins of *Clostridium*

Jacques Pépin and associates[1] have reported an epidemic of *Clostridium difficile*-associated diarrhea (CDAD) associated with an increased case-fatality rate. They hypothesize the presence of a more virulent strain.

The genus *Clostridium* consists of gram-positive, anaerobic, spore-forming rods and is notorious for causing human and animal diseases by producing various extracellular toxins. *C. difficile* exerts its effects through toxin A, an enterotoxin, and toxin B, a cytotoxin, which result in colitis and pseudomembranes.[2] The development of a more virulent circulating strain could occur, in part, through the acquisition of a novel gut-specific toxin, possibly from another clostridial species.

The manifestations of severe CDAD described by Pépin and associates[1] (i.e., megacolon, perforation, shock or rapid death) resemble those of another clostridial-related disease, enteritis