retention in rural areas is improved by this interdisciplinary elective. We hope that providing appropriate background and developing skills among students who are already interested in working in rural areas will lead them to stay longer in rural practice and give them greater satisfaction in their lives there.

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James Rourke outlines many useful strategies to promote enrolment of students of rural origin in medical schools.[1] Alex McPherson also raises several interesting issues related to the concept of rural training.[2] Once students are in medical school, however, they need opportunities to learn in the geographic areas where we ultimately want them to practise.

Ontario now has 5 Distributed Medical Education (DME) programs, all funded by the Ministry of Health. Based in Thunder Bay, Sudbury, Collingwood, London and Perth, these programs have grown from their origins as coordinated opportunities for community-based medical school electives, and they now place both core and elective learners in high-quality sites with faculty-appointed preceptors.

The Collingwood-based program, the Rural Ontario Medical Program (www.romponline.com), was established in 1988 and operates in partnership with the 5 (soon to be 6) Ontario medical schools. ROMP offers community-based rotations ranging from several weeks to well over a year in duration. Educational rotations are offered starting in the first year of medical school and continuing into clinical clerkship and residency; short-term and long-term rotations in family medicine and specialist programs are also offered. During their rotations in the communities, trainees may visit high schools to encourage rural students to consider a medical career. At the end of their formal education, we offer new physicians placement opportunities through our Community Development Office (www.cdoprogram.com). Once new graduates have been placed, we work with them to identify opportunities for them to become teachers for the program.

The DME programs have been successful in providing one solution to the rural physician shortage. A 10-year retrospective analysis in 2001 showed that 98 (47%) of the 209 participants in ROMP are now practising in rural or underserviced communities. The 2 northern programs (based in Thunder Bay and Sudbury) have similar success rates.

As noted by the WONCA Working Party on Training for Rural Practice,[3] "After a rural background, the next strongest factor associated with entering rural practice is undergraduate and postgraduate clinical experience in a rural setting." The opportunities offered by Ontario's DME programs will play a vital role in the future sustainability of community medical practice.

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Perspectives on drug withdrawals

Physicians are the ultimate decision-makers in the use of prescription drugs, but we depend on the integrity of pharmaceutical companies. We spend much of our time modifying risk factors for vascular disease, but in the past few years, 2 major classes of drugs have proven to be contributors to vascular disease. The first to fall were the menopausal replacement hormones, and now we are dealing with the fallout related to COX-2 inhibitors.[1]

When the COX-2 drugs arrived on the scene, I actually stopped prescribing older nonsteroidal anti-inflammatory drugs, because of the risk of upper gastrointestinal bleeding. I began to have doubts about the COX-2 inhibitors when some patients experienced gastric or intestinal problems anyway, and others seemed to experience rather severe hypertension.

The drug representatives showered me with so many samples that I seldom had to write a prescription. One rep gave me an entire case, which lasted for months. I tended to favour whichever COX-2 inhibitor was in my sample cupboard, but they are a hard sell now that 2 of them have been banned. Patients read newspapers too, but surely we physicians deserve to get bad news about drugs from the manufacturers well before it hits the papers.

My fear now is that those of my patients who received COX-2 inhibitors and who now have vascular disease may question my treatment, just as my menopausal patients have questioned replacement hormone therapy. Patients are surprisingly forgiving, but there is un-