consistent with our own. However, the results should not be used—and we do not believe it was their intent—to minimize the extreme difficulties many people in northern communities have in accessing primary care services.

The Ontario Medical Association (OMA) believes that the method used by Coyte and associates offers promise as the basis of a much-improved approach to determining comparative oversupply and undersupply of general practitioners and family physicians in the province. However, we believe it must be applied to smaller catchment areas to realize its full potential.

— Darrel J. Weinkauf
Executive Director, Economics, OMA
Toronto

Reference

1. Coyte PC, Catz M, Stricker M. Distribution of physicians in Ontario. Where are there too few or too many family physicians and general practitioners? *Can Fam Physician* 1997;43:677-83,733.

Practice intensity: urban vs rural

I must express my concerns about the conclusions reached in the article[1] by Coyte et al in the April issue of *Canadian Family Physician*. In particular, I question the validity of the statement, "No evidence supported the contention that patients in remote regions were seriously underserved," and the title of a press release issued by the authors "Ontario's north not under served by physicians."

The researchers have attempted to produce "adjusted GP densities" by looking at physician fee service claims in various counties and modifying them by incorporating data on physicians' age and sex, and the age-sex composition of the population. This resulted in a rather complex statistical analysis, which only academics could hope to appreciate.

However, as is often the case in research such as this, the practicalities facing rural residents and physicians are completely ignored. The figures seemed to suggest that three physicians are sufficient to look after a population of 3000 people or less. However, patients in urban areas are looked after by a combination of family doctors and specialists, always with the assistance of a fully staffed emergency department. In rural areas, a limited number of doctors provide both primary- and secondary-level medical services (both in and out of hospital), obstetrical services, and of course 24-hour emergency service. I think the comments of those three overworked and underpaid rural physicians would be a most interesting addition to the discussion in this paper!

I also question the validity of attempting to use OHIP fee service claims to develop a "practice intensity equivalent index" because practice styles in urban and rural areas are different. For example, rural doctors tend to spend more time away from their offices, providing complex, time-consuming services in hospitals, nursing homes, and patients' homes. Unfortunately, the fee codes are often the same as those used by physicians who work only in their offices, in walk-in clinics, or in patients' homes during housecalls. The reality of just how "intense" a rural practice can be is completely missed.

Indeed the question of how many physicians are needed in a particular rural area is a major stumbling block in addressing the issues of recruitment and retention of rural doctors. The hopelessly outdated Underserviced Area Program definitions, with their rigid limits, are still being used by the government in an effort to establish direct and group contracts; this is severely hampering efforts to improve the working conditions of rural doctors. It is unfortunate that this study simply compared counties instead of including a detailed analysis of rural versus urban needs.

The revelation that areas of southern Ontario are underserviced is hardly news. The OMA Section on Rural Practice has argued, during recent negotiations with the government, for appointing a Community Relations Officer to address this very issue.

Finally, I must seriously question the decision of the researchers to provide a press release with such a sensational and potentially damaging title before publication of the article and before allowing others the opportunity to debate these conclusions.

— C.R.S. Dawes, MD
Chair, OMA Section on Rural Practice
Barry's Bay, Ont

Reference

1. Coyte PC, Catz M, Stricker M. Distribution of physicians in Ontario. Where are there too few or too many family physicians and general practitioners? *Can Fam Physician* 1997;43:677-83,733.

Response

Mr Weinkauf highlights the methodologic contribution of our research. He suggests that our methodology might be used in physician supply management policies, and agrees that our empirical findings are consistent with those of the OMA.

Mr Weinkauf and Dr Dawes share two further observations. First, they both agree that too much emphasis was placed on our inability to detect a statistically significant shortfall of physicians in some northern regions of Ontario. Second, they recommend that the methodology be modified so that it is applicable to catchment areas that are smaller than counties and that our measure of physician supply be combined with other pertinent information.

We agree with the points raised by Mr Weinkauf and Dr Dawes, which we believe support the general thrust of our paper. We do, however, maintain our conclusion that, because almost 90% of all inhabitants in areas found to have significantly lower