

guideline, if implemented (as it was by some governing authorities), could decimate maternity care in Canada.

T.B. MacLachlan is correct in saying that our results from a well-resourced teaching hospital ought not to be generalized to rural Canada. We made that point strongly ourselves.¹ We acknowledged that our study had internal but not necessarily external validity. However, there are settings in rural Canada and elsewhere that have fewer than 25 births per year and good birth outcomes.²⁻⁴ We are now working with colleagues in small-volume settings to continue to study these relations.

We do not agree with MacLachlan's final point. It is not appropriate for the SOGC to be prescribing standards for settings where obstetricians do not practise. The SOGC felt comfortable in rescinding the previous guideline, based on our work and the work of others as well as our joint position paper on rural maternity care.⁵ This kind of partnership between our 3 organizations is a positive for the women and families of Canada.

Although statistically correct, Lindbloom and LeFevre's critique has focused only on our multivariate tables. We also reported unadjusted outcomes. They revealed 5-minute Apgar scores of less than 7 for low- versus high-volume family physicians (4.0% v. 3.7%) and NICU/SCU admissions of 11.6% versus 11.3%. Regarding procedures, the rates for episiotomy were 22.7% versus 19.1%, for instrumental deliveries 14.4% versus 13.3% and for cesarean sections 17.5% versus 16.3%. We find it difficult to believe that these minimal differences are clinically important, and it is unlikely that more study power would materially change the results in either of our reported formats.

Moreover, low-volume family physicians are a heterogeneous group made up of people with various career backgrounds. This also overshadows the minimal differences. Certainly, policy decisions ought not to be made on the basis of such differences. More important, if policy decisions were made, as they have been, on the unsupported belief that low volume is a problem, the denial of access to maternity care to large numbers of ur-

ban and rural women would lead to genuine adverse outcomes.

We do agree that more data on low-volume deliveries would be desirable. Thus we will pool data from urban, rural and remote settings to examine infrequently occurring events. And we are pleased to draw attention to a recent publication based on all births in Alberta, also showing low-volume maternity care to be a non-issue.⁶

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[The SOGC responds:]

During the preparation of the article by Michael Klein and colleagues,¹ the SOGC executive committee and council, in consultation with the CFPC and the SRPC, published a joint policy statement dated April 2002, which declared that competence in obstetrics care is not dependent on the number of births attended annually, but is based on hospital privileges that are determined by quality assurance programs and individual participation in self-directed maintenance-of-competence programs.²

The SOGC is now developing a new quality-assurance program entitled

MORE (Managing Obstetrical Risks Efficiently). This program will be delivered simultaneously to obstetricians, family physicians and midwives across Canada and therefore will promote collaborative practice among all health care providers.

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Scouting mishaps

We were pleased to see Erica Weir's article on injuries associated with scooters.¹ It is good to inform readers of the causes of injuries, how they can be prevented and where further information can be obtained.

The Canadian Hospitals Injury Reporting and Prevention Program (CHIRPP) is an emergency department-based injury surveillance program and is a good source of information on the circumstances in which injuries occur. However, the CHIRPP data are not population based and cannot be used to calculate injury rates.

In the CHIRPP report on scooter injuries, Weir has unfortunately misinterpreted information from the first table as rate of injuries per 100 000 people. The number of cases per 100 000 is actually the number of scooter injuries per 100 000 reported injuries of all kinds for people in each age group. This calculation is done to compensate for (1) the skewed age distribution of the CHIRPP data that results from collecting data in 10 pediatric and 5 general hospitals and (2) the use of age groupings of unequal range. It is therefore possible to identify the age group or groups in which the rele-