ment (OECD).[1] Although the OECD and other international organizations such as UNICEF publish international comparisons using data they obtain from Statistics Canada and other national bodies, their estimates are sometimes erroneous.[2] For instance, the OECD reported the 1996 infant mortality rate in Canada to be 6.0 per 1000 live births. In fact, in 1996 the infant mortality rate in Canada was 5.6 per 1000 live births,[3] whereas that in the United States was 7.3 per 1000 live births.[4] In 1997, infant mortality rates in Canada and the United States were 5.5 and 7.2 per 1000 live births respectively.[5,6]

International comparisons of infant mortality are compromised by a lack of standardization with regard to birth registration practices. Studies have documented wide variation in the rate at which extremely small babies at the borderline of viability (e.g., < 500 g) are registered in different countries.[7,8] In fact, recent secular trends and interprovincial comparisons of infant mortality within Canada are also affected by such differences in birth registration.[9] As a potential solution, the World Health Organization has recommended that international comparisons of infant mortality be restricted to live births in which the newborn weighs 1000 g or more.[10] Such a restriction would eliminate a substantial proportion of neonatal deaths from the infant mortality counts of most industrialized countries, however. This and other challenges inherent in birth-weight-specific comparisons mean that international infant mortality rankings will continue to be based on crude rates and will favour industrialized countries, which tend not to register extremely small live births.

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Youngest medical graduate

I too was only 22 years old when I graduated from medical school[1] in Scotland in 1966. After a 1-year rotating internship (this was before the start of family medicine training programs), I became a rural family physician in a group practice when I was aged 23 years.

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The last trial of a Nazi doctor

We read with great interest the news item on the last trial of a Nazi doctor.[1] The following question arises in this connection: What is the role of the political and medical community? Health professionals working in situations of widespread human rights abuses can face significant personal risks in carrying out their duties. In the early 1980s in Central America numerous health care workers were targeted because of their professional activities.[2,3] In 1994 in Iraq, doctors were required by law to amputate the ears and brand the foreheads of deserters. They were told that if they refused, they would suffer the same fate. One doctor was executed and many were imprisoned for their refusal to exercise medicine punitively.[4] This example underlines the vulnerability of the individual health care practitioner in the absence of strong collective refusal to compromise ethical and professional standards.

Is Dr. Heinrich Gross really the last physician of his "kind"? What about physicians who have contributed or still contribute to corporal punishment? There should be more precise international standards including but not limited to medical associations taking steps against the participation of medical staff in corporal punishment and in carrying out the death penalty.

Some steps have been taken by the World Medical Association,[5] but a much more active commitment by professional bodies to defend human rights and oppose abuses is required, such as the establishment of human rights representatives in each national medical association who would visit and report on a regular basis to the World Medical Association and the Amnesty International medical office.

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