# Letters
# Correspondance

## Dutiful delivery

As someone committed to the education of family practitioners, and who also chairs the Committee on Accreditation of the College of Family Physicians of Canada, I read with interest the commentary by Dr Susan MacDonald, "Duty to Deliver," in the January 2007 issue.[1]

As Dr MacDonald indicates, there is a serious problem with the falling numbers of family physician accoucheurs in this country. She correctly suggests that it is the duty of the Committee on Accreditation, which sets the standards for postgraduate education programs in family medicine, to encourage residency programs to develop new models of providing obstetric care in Canada. Beyond this, however, the Committee must also give residency programs, through the accreditation process, the clout to go to hospitals and other funding bodies for the resources to do so.

I could not agree more about the importance of finding innovative models of providing obstetric care to family medicine patients and of incorporating family medicine residents into those models. In some programs and in some settings, the traditional model of family physicians providing full obstetric care to patients in their personal practices with minimal sign out can be adapted to resident training; in others it is simply not feasible, and other formats are developed. Dr MacDonald mentions the Maternity Centre in Hamilton, Ont, on which some sites of McMaster's residency program rely for family medicine obstetric experience. Another example can be found at the University of Alberta, where teaching units have partnered with low-risk obstetric groups to provide a solid family medicine obstetric experience. Other examples exist across the country. Innovative models and the integration of family medicine residents within them are supported by accreditors, and such programs are fully approved by the accreditation process. The programs in serious accreditation difficulty in this area are those with sites in which family medicine residents are not able to provide intrapartum obstetric care for family medicine patients, particularly when there are no efforts being made to develop new models or when that obstetric experience is very scanty and offers few family physician role models.

Written accreditation standards can sometimes appear inflexible and, by their nature, might appear to inhibit innovation. The Committee on Accreditation is sensitive to the tension between the standards and the changing environment and resources with which residency programs struggle and is open to discuss and put into context any standard that is questioned. Although we have endeavoured to interpret the current standards with flexibility, it is clear this particular one should be reviewed and updated so that it is clearly consistent with what is now common practice for both the programs and the committee.

I thank Dr MacDonald for her interest in and concern for this important area of family medicine education.

*—Allyn Walsh MD CCFP FCFP*
*Chair, Committee on Accreditation*
*College of Family Physicians of Canada*
*Hamilton, Ont*
*by e-mail*

**Reference**

1. MacDonald S. Duty to deliver. Producing more family medicine graduates who practise obstetrics. *Can Fam Physician* 2007;53:13-5 (Eng), 17-9 (Fr).

## Sweet success

We congratulate Daren Lin and colleagues for their proactive approach to improving diabetes management in their community.

We too have found that simple tools can substantially affect both testing frequency and metabolic outcome measures. We have been operating a program in the Central Okanagan region of British Columbia for people with diabetes and their physicians since January 1, 2002. The program is administered by Valley Medical Laboratories, a community medical laboratory. Planning is done with the assistance of an advisory group of 7 family physicians. By creating a registry and offering a program that is well received by both physicians and those affected by diabetes, we believe that diabetes management has been positively influenced in the Central Okanagan.

Although most new patient registrations come directly from physicians' offices, twice yearly we inform

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physicians of potential candidates identified by review of laboratory test results. Once registered, people with diabetes who choose to participate in the program are scheduled for testing according to the 2003 Canadian Diabetes Association Guidelines. Those who fail to attend as scheduled receive up to 2 reminder letters by mail. Those who do attend receive a personalized patient progress report by mail within 1 week of laboratory testing. The report includes the following:

- the 2 most recent $A_{1c}$ results,
- the most recent systolic blood pressure measurement,
- the most recent lipid results (low-density lipoprotein, risk ratio),
- explanations of the different tests, including targets,
- a reminder of the next scheduled testing date, and
- a reminder of the importance of an annual eye examination.

Since inception, our program has achieved the following:

- 91% of the presumed number of people with diabetes in the Central Okanagan have been identified and registered,
- 69% of those registered participate actively in the program,
- 98% of family physicians practising in the area actively participate,
- 90% of participants had 2 or more $A_{1c}$ tests in 2006 (compared with 35% of non-participants), and
- 65% of participants' $A_{1c}$ results were ≤7% in 2006 (compared with 55% of non-participants' results).

A laboratory-administered program that supports self-management by offering simple reminders and direct reporting of results to people with diabetes seems to enhance achievement of recognized metabolic targets and of testing frequency recommendations.

*—Duncan Innes MB*
*—Andrew Farquhar MD*
*—David Cameron MD*
*Kelowna, BC*
*—Hugh Tildesley MD*
*Vancouver, BC*
*by e-mail*

**Reference**

1. Lin D, Hale S, Kirby E. Improving diabetes management. Structured clinic program for Canadian primary care. *Can Fam Physician* 2007;53:73-7.

## Culture-oriented health care

Policies on health care access and related issues have been undergoing many changes over the past several years in industrialized countries. Primary health care with specialist support as a baseline is now an accepted method in many places. This and other approaches are the result of and are subject to ongoing evolutionary processes based on the political, economic, and educational levels of each society.

As a physician who has had the opportunity to work in different health care systems, I have realized that cultural beliefs and societies' perceptions of their medical systems are important aspects of health care access. Copying one relatively successful health care system and applying it in different countries with very different cultural backgrounds and beliefs is subject to many pitfalls and failures. A 2-m by 3-m carpet can be made by a machine in less than 5 minutes or handmade in more than 6 months. They can be used for the same purpose and cover the same surface area, but, no matter how many hours of lecture you deliver, you are unlikely to convince any Iranian-origin family to accept a carpet in their room that was not made by hand. It will not happen. This is something respected as a heritage and signature of that country.

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