

A step in the right direction

As a family physician in rural southern Alberta, I was delighted to read your article on training rural family practitioners in advanced maternity care.¹

It is time that the organizing and licensing bodies of the country back up their verbiage with a real training program and provide recommendations and guidelines for those wishing to advance their skills. So far we have in place in Alberta: 1) RPAP that provides money for training, 2) hospital and teaching units that provide the opportunity, and 3) physicians who have the desire to take training. This article has given us guidelines on what the training should be and how it could be structured.

Another item that would be an asset is providing relevant certification of the skills acquired. For example, in Australia and New Zealand a diploma in obstetrics and gynecology is given for candidates who train and demonstrate ability at a certain level. This diploma is transferable across the country due to its recognized standard of training. Could not a similar diploma be awarded with its accompanying recognition that such a person is proficient in the skills required in the relevant area? Perhaps a physician with a diploma in obstetrics and gynecology would have advanced skills in such areas as cesarean section, forceps and vacuum extractions, 3-to-4 degree repairs, manual removal of placenta, postpartum tubal ligation, and dilation and curettage.

Similarly, a physician with a diploma in surgery would be proficient at performing such procedures as hernia repair, appendectomy, vasectomy, tonsillectomy, sigmoidoscopy, and endoscopy. Perhaps a physician with a diploma in internal medicine could have advanced training in electrocardiograms and provide elective cardioversion for atrial fibrillation, provide better treatment for acute

myocardial infarction, and have endoscopy skills.

I am not suggesting that each small community should have its own angiogram suite or anything like that. There are obvious limits for physicians trained in several specialties, and care would be given to ensure they worked within these limits. But by providing some essential services in rural sites, physicians would reduce the load on regional centres for situations that can be handled safely at home. Perhaps by giving rural physicians the skills and accreditation to support themselves in their remote areas, they will feel less isolated and helpless.

For instance, in a community with four family physicians, if each were trained in special skills in relevant specialties in separate areas, (obstetrics, surgery, internal medicine, pediatrics), they would function as a unit and provide support for each other. In such a setting the loneliness and remoteness of practising rural medicine might not discourage new graduates.

The importance of this was pointed out to me recently when a friend (non-medical) asked me what would happen if his wife needed an urgent cesarean section, given that the closest centre is 40 minutes away. I could only think that her life or the baby's would be in jeopardy, but if that service were provided in our community, they both might be saved.

As a family physician in a rural setting, I believe that providing structured training programs for rural physicians is essential and recognizes the need we have in our country to provide care for all people in all areas. If that care can be provided within patients' own communities, we will all benefit.

—Lloyd T. Clarke, MD, CCFP
Cardston, Alta
by e-mail

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Supply and distribution of family physicians

It is easy to look at "numbers" in the international arena when considering the shortage of general practitioners and family physicians (GPs/FPs) in Canada. Whitcomb¹ does it, selecting the United Kingdom "because health care system analysts believe that the United Kingdom has the best primary care system in the world." It might be, at least according to Starfield's² "primary care score" (1.9 for the United Kingdom, 1.2 for Canada, 0.3 for France).

But the comparison might be unfair, because there are two areas to consider: number and distribution of GPs/FPs. In Canada there is no "patient list" or "primary care organized by defined geographic area." The distribution of GPs/FPs is not uniform, especially in countries with no defined practice population, such as Canada (and Australia, Austria, Belgium, Germany, France, Japan, and Switzerland); health services seem to be much more available in and around cities. In countries with patient lists, such as the United Kingdom (and Denmark, Italy, the Netherlands, Portugal, Spain, and parts of Finland, Ireland, and Norway) or with primary care organized by defined geographic area, such as in the Scandinavian countries (and rural Greece), the distribution of GPs/FPs is uniform across the whole country because each "unit" of population has its own GPs/FPs.³

The Canadian population might have problems meeting primary care needs not because of the number of GPs/FPs (93 per 100 000 population

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compared with 65 in the United Kingdom) but because of their distribution. It is important to see the problem from this point of view because numbers are only part of the issue and because “patient list” and “primary care organized by defined area” might help meet the primary care needs of all Canadians living in urban or rural areas, in rich or poor regions.

— *Juan Gervas, MD, PHD*
Madrid, Spain
by e-mail

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