Residents' page

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Happy New Year and (for the purists out there) welcome to the new millennium! I hope you enjoyed your 5 consecutive days of holidays and are now ready to tackle the year 2001! This month and next month, the Residents' Page will bring you results from the National Family Medicine Resident Survey, conducted in the spring of 1999. I think that you will find the results interesting and, in some cases, surprising. The next survey will be distributed to current family medicine residents this spring. Tune in next month for survey results, Part 2!

National Family Medicine Resident Survey

Part 1: Learning environment, debt, and practice location

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The College of Family Physicians of Canada's (CFPC's) Section of Residents (SOR), made up of resident representatives from each family medicine program in Canada, deals with issues related to training family physicians nationally. For several years the SOR has conducted surveys of family medicine residents about their training.

In 1999, a comprehensive survey dealing with several areas (demographics, learning environment, choice of nation for practice, and future practice profile) was distributed among family medicine residents. The goal was to identify issues common to all residents, identify future trends in practice, and assess residents' general level of satisfaction with their training programs.

The survey was distributed by mail to 1500 residents with a response rate of 63.5% (n = 953) after a second mailing to those who did not respond initially. More than one third (39.7%) of respondents were in their first year, and 55.6% were in their second year. Most (60.5%, n = 577) were women; 34.6% (n = 330) were men. A few (4.8%, n = 46) did not specify their sex. Most respondents (71%) were between 25 and 30 years old; 41.7% were single, while 40.8% and 15.5% were married or living common-law, respectively. Most (79.3%) residents had no children, and very few had more than two children or other dependants. Only 9.5% of residents received their MD outside Canada.

Learning environment

Most residents were highly satisfied with their learning environment; 84.9% agreed that their family medicine education took place in an open, supportive, and collegial environment. Only 71%, however, thought their specialty experiences took place in such an environment. Many (66.8%) residents thought that their program was open and responsive to resident concerns, 17.8% were neutral, and 15.3% disagreed.

Specific responses from residents identified areas of dissatisfaction. Several respondents concurred on some issues. Residents commented consistently on heavy service during both specialty and family medicine rotations, out of proportion to the amount of teaching. Some residents believed this interfered with their learning.

Another recurring theme was that of leaving after on-call shifts. Most residents thought they were not encouraged to take advantage of their contractual right to leave after 28 consecutive hours on duty. Some believed that exercising this right could jeopardize their evaluations, a potent disincentive. Many also believed that some specialists disparaged family physicians as "second-class doctors." Residents expressed a

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desire to see the CFPC work toward recognizing family medicine as a specialty in its own right.

A third issue was lack of funding for training in special skills, including advanced life support in obstetrics, advanced cardiac life support, advanced trauma life support, neonatal advanced life support, and pediatric advanced life support. At present, availability of funding for residents to take additional courses is inconsistent between programs. Many residents believe these courses are necessary, especially for practice in emergency settings or outside tertiary care centres. Available funding ranged from $100 yearly to full coverage of all courses. Residents training under the auspices of the Canadian Armed Forces enjoy full coverage for all courses.

Residents reported a high level of intimidation and harassment. More than half (51%) said they knew of residents being intimidated or harassed, 79% of whom were in family medicine programs. The nature of the harassment was not specified, nor was the setting in which it occurred.

A smaller proportion, 20.5%, reported personal experiences of intimidation and harassment: 17.6% of men and 22% of women. This difference was not statistically significant. How these incidents were dealt with, if at all, is unknown. One third (34.5%) were unsure whether their university had a confidential mechanism to report these incidents, and 1.5% reported no such mechanism.

Resident debt and choice of practice location

Several questions in the survey examined the level of debt assumed by family medicine residents during the course of their training. More than half (53.8%) of respondents owed between $10 000 and $60 000, not including mortgages, car loans, or other debt unrelated to education costs. Nearly

half (45%) of residents had debts of more than $40 000, and 5.9% reported debts of more than $100 000.

Several (11.8%, n = 112) stated that they intended to leave Canada to practise in another country. Of these, 65 reported they were going to the United States. Reasons for leaving included higher earning potential and debt load.

Assuming high resident debt load is a potent impetus to leave Canada, one would expect to see a correlation between plans to leave and level of debt. When debt load was cross-referenced with intent to leave Canada, no significant correlation was noted. Between 10% and 15% of residents in all debt ranges intended to leave. Of those with debt loads above $100 000 (only 5.9% of all residents), 25% stated intent to leave. Subanalysis was performed on those who stated they intended to go to the United States. Again, no correlation with amount of debt was noted. These numbers suggest that, while debt load is important to residents, it is only one of many factors influencing their decision to leave Canada. Other possibilities include flexible work arrangements, a spouse's employment, US citizenship, or previous training in the United States.

A high percentage of residents reported being actively sought by American recruitment agencies. Most (60%) residents stated that such contact had been made, and another 4.8% said they had contacted such agencies themselves. Only half of residents who contacted recruitment agencies of their own accord, however, reported plans to leave Canada. Upon closer examination, 19.1% of residents planning to leave Canada had contacted American recruitment agencies themselves. Overall, most residents chose to remain in Canada despite recruiting efforts by American agencies.

Acknowledgment

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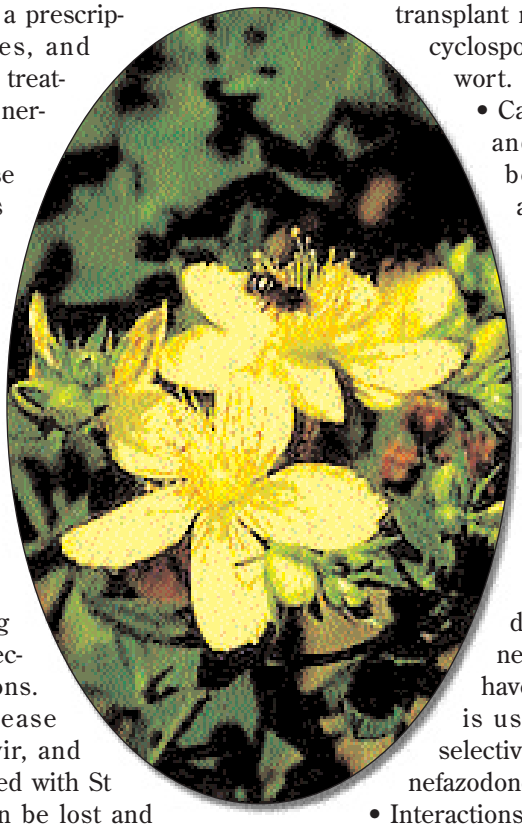
Drug interactions with St John's wort

Health Canada warns that certain prescription medications should not be used in combination with St John's wort (*Hypericum perforatum*). St John's wort, an herbal product available without a prescription at supermarkets, pharmacies, and health food stores, is promoted as a treatment for mild depression, insomnia, nervousness, and neuralgic pain.



St John's wort appears to decrease the blood levels of other drugs administered concomitantly and to affect their availability to neurotransmitters in the brain. It is important, then, that health care professionals question their patients about use of St John's wort before issuing drug prescriptions or while monitoring effectiveness of treatment.

Several drugs show characteristic changes when they interact with St John's wort. These changes could well affect all drugs in each drug classification. Combined use is not recommended for the following reasons.

- If plasma levels of HIV-1 protease inhibitors (eg, indinavir, ritonavir, and saquinavir) drop when administered with St John's wort, HIV suppression can be lost and drug resistance can develop.
- Because HIV non-nucleoside reverse transcriptase inhibitors (eg, delaviridine and nevirapine) are metabolized similarly to protease inhibitors, interactions with St John's wort are suspected on theoretical grounds.
- Plasma levels of digoxin are reduced when administered with St John's wort. Inotropic effect in heart failure or rate control in atrial fibrillation or flutter can be reduced.
- Cases of decreased plasma levels and acute organ transplant rejection have been reported when cyclosporine is administered with St John's wort.
- Cases of reduced anticoagulant effect and need for increased doses have been reported when warfarin is administered with St John's wort.
- Decreased plasma levels and need for increased doses have been reported when theophylline is administered with St John's wort.
- Cases of breakthrough bleeding (and thus a theoretical risk of unwanted pregnancy) have been reported when oral contraceptives are administered with St John's wort.
- Some cases of "serotonin syndrome" (nausea, vomiting, restlessness, dizziness, tremor, and headache) have been reported when St John's wort is used with such antidepressants as selective serotonin reuptake inhibitors and nefazodone.
- Interactions with antiepileptic drugs (eg, phenytoin, carbamazepine, and phenobarbital) are suspected on theoretical grounds.

On its own, St John's wort has not demonstrated substantial health risks. Experts recommend, however, that physicians routinely ask patients whether they are taking any over-the-counter medications or natural health products before prescribing drugs for them.