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Letters ❖ Correspondance

Letter sent from the College of Family Physicians of Canada to the American Academy of Family Physicians

On Wednesday, September 12, 2001, this letter went to Dr Douglas Henley, Executive Vice President; Dr Richard Roberts, President; and Dr Daniel Ostergaard, Vice President of International Activities of the American Academy of Family Physicians.

Dear Doug, Rich, Dan and all,

It is barely 24 hours since the horrific events of yesterday struck and changed all of our lives. As the news reports headlined the happenings, we realized it was truly "America—under attack." But it was and is more. This totally reprehensible act was an attack on all of us who love and cherish life and value the gifts of heart and mind and soul that we have been given. It was an assault on everything that is good and kind and decent. While using method and force that required elements of advanced technology, it sent us reeling backwards in our progress as a species deserving of inhabiting this planet.

We all pray with and for those who have been directly affected by this atrocity. We know that your nation will show the strength and resolve to recover from this and to lead the way in carrying out the appropriate action to ensure that America, and indeed the world, will not need to bear this type of senseless tragedy ever again.

We also know, and want you to know, that your friends in Canada are beside you as you traverse these difficult moments. As family physicians, we stand prepared to respond to any calls for medical help that you might feel is needed. As your brothers and sisters in the discipline of family medicine, we at the College of Family Physicians of Canada are ready to offer our help to the American Academy in whatever way we can.

Please extend our wishes and thoughts to all our friends and colleagues at the AAFP and to all Americans in this time of sorrow.

Never have we been so strongly reminded of the value of friends and colleagues like yourselves. May we all be blessed with better days ahead.

Sincerely,
—Cal Gutkin,
Executive Director and
Chief Executive Officer
Don Gelhorn, President
Peter Newbery, Past-President
Dominique Tessier, President-Elect
The Executive, Board, members, and staff of the College of Family Physicians of Canada

Make your views known!

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Faites-vous entendre!

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Percentages seem too high

It is quite astonishing to find in the paper by Woodward et al[1] that 91% of the 1989 to 1991 family medicine graduates were still practising family medicine in 1999. By applying a classic definition of family medicine as suggested by Dr Ian McWhinney in his editorial,[2] it is clear that only 80% of the graduates were actively practising family medicine. Even this percentage appears too high.

Family medicine instructors were observing in the early and mid-1990s that only about 50% of the graduates from that era, along with later graduates, became family physicians. Why is there such a discrepancy in the percentages given in this report and the anecdotal observations of family medicine instructors in the 1990s? Is it possible that the answer lies in the 53% response rate? It is tempting to speculate that those family medicine graduates who are not practising family medicine would be less likely to respond to such a questionnaire. While nonresponders in Ontario received a telephone call, it is not clear whether their type of practice was established at the time of the call. Without knowing the practice patterns

of the nonresponders, it is intuitively persuasive to suspect a significantly higher percentage of them were not practising traditional family medicine.

The importance of knowing more precisely the practice patterns of all non-specialists becomes readily apparent when trying to assess the problem of physician shortages and physician maldistribution in Ontario. The absence of information on the practice patterns of 47% on a survey of this type is unfortunate. While it is traditional to accept that a 53% response will reflect the patterns of all the members of the group, there are good reasons to suspect that those nonresponders might have included a higher percentage of members who no longer identify with family medicine and thus feel no obligation to respond to questionnaires. These observations and reflections promote the concept that accurate information on practice patterns be mandatory when submitting annual registration with provincial colleges of physicians and surgeons in order to better assess the problems of physician shortages and physician maldistribution.

—Ross McElroy, MD, CCFP
Tavistock, Ont
by mail

References

1. Woodward CA, Cohen M, Ferrier B, Brown J. Physicians certified in family medicine. What are they doing 8 to 10 years later? *Can Fam Physician* 2001;47:1404-10.
2. McWhinney I. Time, change, and family practice [editorial]. *Can Fam Physician* 2001;47:1365-7 (Eng), 1374-9 (Fr).

Response

The extent of bias created by nonrespondents in a cohort study is always difficult to determine. We sought to understand the likely bias created by nonresponse by examining the current medical field and location of all the members of the cohort using secondary sources. These sources included the Medical Directory, online services, such as the College of Physicians and Surgeons of Ontario's Find a Doctor page, and correspondence with licensing bodies in Canada and the United States.

There was no difference in the proportion who had entered specialties between the entire cohort of physicians and the respondents. The questionnaire was specifically designed and pretested to make it user-friendly for physicians who no longer were family physicians or who had restricted their practice within family medicine. Yet, we cannot rule out the possibility that family physicians who restricted their practices were less inclined to respond. We noted that a sizable group of respondents were either restricting their practice or thinking of doing so in the near future.

My co-authors and I concur with Dr McElroy's observation that routinely collected information on practice patterns would permit better physician human resource planning.

—Christel A. Woodward, PHD
Professor

Updates on the varicella vaccine

The editorial[1] on the varicella vaccine by Maureen Sullivan-Bentz in the July issue summarized well the recommendations and issues surrounding varicella immunization. I would like, however, to comment on two statements that were incorrect.

The article mentions that "Until a refrigerator-stable vaccine becomes available, however, varicella vaccine will not be incorporated into the recommended immunization schedule in Canada, as most family practice offices cannot maintain the vaccine in the recommended frozen state." In June 2000, Varivax™ II, a new refrigerator-stable formulation of the Oka/Merck® varicella vaccine was launched on the Canadian market. This vaccine can now be stored for up to 90 continuous days between 2°C and 8°C, allowing physicians and public health departments across Canada to stock varicella vaccine in the refrigerator. To date, the provinces of Prince Edward Island, Alberta, and the Northwest Territories have implemented universal immunization programs against varicella using the new refrigerator-stable vaccine. Varivax™ II is also available in many physicians' offices and pharmacies.

Ms Sullivan-Bentz also stated that "…costs for the vaccine will be reimbursed by neither the Ontario Health Insurance Plan nor private drug plans in Canada." A recent survey[2] among employers in Canada showed that at least 25% of Canadians are reimbursed under private drug plans for varicella vaccination. Physicians should be aware that certain private insurance plans might reimburse the cost of the vaccine.

—Didier Reymond, MD
Scientific Affairs
Merck Frosst Canada Ltd
Pointe-Claire-Dorval, Que
by e-mail

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1. Sullivan-Bentz M. Varicella. To be [vaccinated] or not to be: that is the question! *Can Fam Physician* 2001;47:1368-70 (Eng), 1377-9 (Fr).
2. Wyeth-Ayerst Canada Inc. *Canadian parents rank immunization as most important way to keep children healthy* [press release on Applied Management Report]. Toronto, Ont: Applied Management; 2001.

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Letter from Thailand

Sense of identity as a family physician

Applying the four principles of family medicine in a remote Thai village

Saipin Hathirat, MD Yves Talbot, MD, FRCPC, MCFP Niall Byrne, PHD

Four years ago, I worked as the sole doctor and director of a 10-bed district hospital in a remote area of northern Thailand with a population of 15 000. My time there coincided with the appearance of the first AIDS cases in that community and the beginning of the current epidemic in the same area.

Practising the four principles of family medicine: *A remote area of northern Thailand, population 15 000.*

A 33-year-old Thai woman came to the district hospital with a fever and dyspnea of 4 days' duration. She was a poor and illiterate woman from a small remote village of northern Thailand. When I was an academic fellow in family medicine at the University of Toronto in Ontario, I learned the four principles of family medicine.[1] As a Thai physician, I remembered these four principles when I treated this patient.

The family physician is a skilled clinician

I initially diagnosed the woman with acute community-acquired pneumococcal pneumonia. On the first day of admission, she rapidly became more distressed, although her chest x-ray film was only slightly hazy and non-localized in one lower lung. I realized then that this woman had an atypical form of pneumonia. I referred her to the provincial hospital, from which I did not get a referral letter back.

One month later, the woman returned to the district hospital with pneumonia again. That led me to call the provincial hospital and request information about her previous hospitalization. I was informed of her results, but I was not sure whether she knew about her HIV status. In my experience, many large hospitals screened for HIV without informing patients. She did not want to return to the referral hospital with her second bout of pneumonia because her village was very far away, and traveling was inconvenient for her and her family. So I treated her in the district hospital.

The patient-physician relationship is central to the role of the family physician

During counseling, she revealed that she was a prostitute. I recognized that my attitude toward her profession might interfere with our relationship. I tried to understand her experience of illness as well as I could and respect her need for privacy. I understood her difficulty in dealing with such a stigmatized condition in a small community. It came as a surprise when she chose to follow up with me instead of the more distant and anonymous provincial hospital. I developed a stronger and healthier relationship with her and her family as time went on.

As a result of our relationship, she became my teammate in a public education program on AIDS. She accepted my invitation to speak to the hospital staff (many of whom were leaders in the community) to increase awareness, knowledge, and empathy toward people with AIDS.

It was a very effective method of building trust with patient, family, and the community. After her talk, my team and I saw the healing

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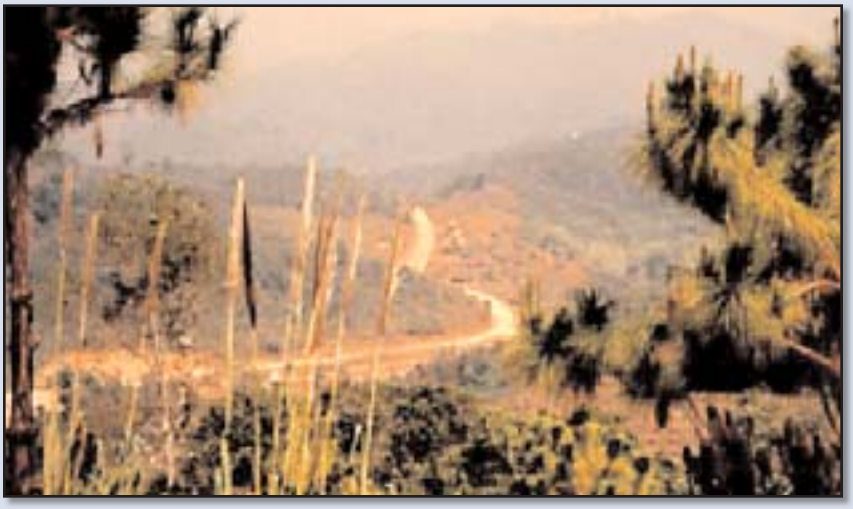
power of her presentation and the support she received from her community. As a result, she could be weaned off oxygen therapy, walked more steadily, and behaved with more confidence and spirit. I took care of her until she passed away a year later.

Family medicine is a community-based discipline

After I treated this patient, the community became fearful of the hospital as an AIDS institute. I promptly started the information program beginning with the district hospital staff and then with other community leaders, such as the sheriff, the police, teachers, students, and the head of each village. I told them to expect more cases of AIDS because, as a result of poverty, many women earned their money through prostitution in big cities such as Bangkok. Many men and women still engaged in risky sexual behaviours.

We surveyed the community's knowledge about AIDS (which highlighted many misunderstandings) and planned our community education program. It was very difficult to promote use of condoms in households because using a condom was viewed as a symbol of mistrust. We tried to convince the people to have safer sex and contraception at the same time. Although villagers knew the benefits of condom use, they were too shy to ask for them from health workers in the village. We opted to provide free condoms in open boxes outside the village health centre so that villagers could pick them up any time, as many as they wanted, without anyone knowing. There was a very thin line between confidentiality and community safety.



Practising the four principles of family medicine: *Public education program for AIDS—increasing awareness, knowledge, and empathy.*

Developing confidential team care in such a small community became very challenging. The team determined the criteria for referring patients to the appropriate places.

In order to develop a positive environment for AIDS care, we set up a series of conferences to update knowledge of AIDS and promote an empathetic attitude toward patients with AIDS and their families. Specialists encouraged me to refer patients to the provincial hospital where there were appropriate investigations and drugs available. They did not know what to offer AIDS patients in such a small community hospital, where there were only a basic laboratory and medicine.

Based on patients' needs, I practised in coordination with the provincial hospital to obtain their support. After developing trust with patients and the coordination team, I arranged for patients to receive regular home visits by health workers in the village. Patients would be referred from the village whenever appropriate.

During follow up and admission of my first AIDS patient to the district hospital from time to time, I prepared her and her family for the end of life. Counseling her and her husband was not as challenging as counseling her two daughters, ages 9 and 11 years, to accept the imminent death of their mother. Providing palliative care for this family was not limited to the team. All hospital workers helped support them as well. That made palliative care easier than I anticipated. All hospital workers and I went to her funeral in her village to show our respect to her and her family. This event was instrumental in raising awareness and acceptance of AIDS in the community. Two years later, 38 new cases were identified in 13 families.

The family physician is a resource to a defined practice population

Because of the delay in obtaining results from the referral hospital and an expectation of many more new cases of AIDS

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in the community, I considered having an HIV kit and counseling clinic in the district hospital to provide quicker and more accessible care to patients. My team had to deal with the problem of developing a confidentiality protocol in such a small community. Two nurses were selected and trained to work in the counseling clinic. We used a secret code for the HIV test, and a technician was blinded to the patient's name. We also developed confidential team care among the health care centre, the district hospital, and the provincial hospital. The team studied the epidemiologic data on AIDS cases in the community by mapping and studying the population at risk. We made a surveillance record, and I kept a complete record of each patient encounter, including the information from the provincial hospital. I contacted the provincial public health centre for their epidemiologic data and for their supports, including educational materials and a list of resource people.

To update my practice, I went to conferences about AIDS treatment and palliative care, consulted many specialists, and searched for information about non-governmental organizations that work for AIDS in Thailand. In addition to chart audits with the staff in the provincial hospital, I reviewed and planned for AIDS care, for individuals and families, with my team.

Conclusion

Learning about the four principles of family medicine in Canada gives me value and a sense of identity as a family physician. I can distinguish roles in providing comprehensive, patient-centred care differently from those of other specialists. These roles are not taught adequately in medical schools in Thailand. Many Thai general practitioners feel inferior to specialists in providing primary care in the community. This might be the first time in Thailand that we have recognized general practitioners' role as patient advocate by identifying with the four principles of family medicine in Canada.

Dr Hathirat *was an academic fellow from Thailand in the Department of Family and Community Medicine at the University of Toronto in Ontario when this article was written.* **Dr Talbot** *is Professor and Director of International Programs in the Department of Family and Community Medicine at the University of Toronto.* **Dr Byrne** *is Professor Emeritus from the Center for Research in Education at the University of Toronto.*

Editor's note: *This relates the experience of Dr Hathirat. Drs Talbot and Byrne assisted Dr Hathirat in developing the case for teaching the four principles of family medicine and in planning workshops on participatory action research (collaboration between family physicians and the community).*

Reference

1. The College of Family Physicians of Canada. *Residency program accreditation and certification*. Mississauga, Ont: The College of Family Physicians of Canada; 1997; p. 5-7.

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