Residents' page

Jason Chang, MD

The value of visiting actual program sites during the Canadian Resident Matching Service (CaRMS) application process was demonstrated in my exposure to such places as McGill University's St Mary's Hospital. It is a community-based teaching hospital primarily run by family doctors and residents, which I had not seen before. This feature was intriguing, along with a chance to immerse myself in French culture and language, while working with world-famous French-Canadian nurses (previewed in the movie *The English Patient*)—vive la multiculturalism!

Because of scheduling at the time, I was unable to visit the Montfort Hospital when I interviewed at Ottawa, Ont, the site where Dr Kendall Noel currently trains. Dr Noel delivers an informative and insightful article that reflects the May 2001 theme of *Canadian Family Physician*, Hospital Inpatient Care.

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If not the North, then what?

Kendall A. Noel, MD CM

With the development of rural streams for family medicine training, a debate over which environment (rural vs urban) is best suited for training family doctors has begun. While no hard data have shown that one environment is better than the other, anecdotal evidence suggests that the rural stream is best suited, because it offers one-on-one teaching in an environment free of specialty residents.

Both rural and urban training address specific needs. Yet most family medicine residents would probably prefer to train in the more welcoming environment—but what of those not prepared to relocate to the North? Is there any hope for them? Undoubtedly, the answer is yes, in the form of a family medicine residency program based out of a primary or secondary care community hospital.

The literature is surprisingly lacking in articles examining the difference between family medicine educational experiences in community-based hospitals and large university centres. One study, in 1990, found that residents' overall satisfaction with their training and their perception of the adequacy of their preparation for practice lessened with increasing university affiliation. Further, the study demonstrated that family medicine residents based at university hospitals were much more likely to report being treated as second-class citizens than their community-based colleagues; that statement probably holds true even today. The 1999 SOR resident survey found that, while 84.9% of residents thought their family medicine experience took place in a supportive and collegial environment, only 71% could say the same thing for their specialty rotations.[1] One can surmise that the feeling of being second-class citizens is at least partially responsible for these statistics.

While few data exist in the public domain, discussions about which milieu is better have been taking place behind closed doors for many years. In fact, in 1991, during a meeting of the Associate Members Group of the College of Family Physicians of Canada, a workshop examined family practice residency in the 21st century. On the question of which location (community, rural area, or urban teaching hospital) was best suited for training family doctors, the group remained undecided and could not even conclude what proportion of time should be spent in each centre.[2]

Residents are encouraged to e-mail article submissions, resident issues, any comments, and questions to sor_cfpc@yahoo.ca.

Residency in a family medicine–run hospital

Many programs offer family medicine training in secondary and primary care hospitals, run primarily by family doctors (including McGill's St Mary's Hospital and Ottawa's Montfort Hospital). My own experience has been as a family medicine resident at the Montfort, a small community hospital in the east end of Ottawa, serving a predominantly French-speaking population. Despite a slight language barrier (most of my medical training took place in English at McGill), I have found the hospital's patients, support staff, and physicians to be quite helpful.

As family medicine residents, we do many of the same rotations that our colleagues at university-based hospitals do, namely internal medicine (general, allergy, cardiology, endocrinology, respirology), orthopedics, emergency medicine, obstetrics, gynecology, and various electives (surgery, anesthesia, critical care, dermatology, etc). What is different is that, on each of these rotations, our residents are paired one-to-one with a preceptor and an occasional medical student. Much of the learning takes place during consultations (on the floors, in outpatient clinics, in private offices). The preceptorship model allows many residents to enjoy excellent working relationships with specialists, a rapport we see exemplified in the relationships between our attending physicians and their specialist colleagues.

For our family medicine component, residents are paired with two or three community preceptors, of whom at least one has admitting privileges at the Montfort. Many of the program's preceptors, in addition to having an active hospital patient base, also find time to provide full obstetric services. A handful are also involved in emergency room work, surgical assisting, nursing homes, and hospital administration. The result is that residents work in an environment with role models who exemplify the principles of family medicine and yet manage to balance them with an enviable (or at least feasible) lifestyle.

For residents who consider role modeling essential, this community hospital is ideal. Like our counterparts in the North, education is valued over service, a point made clear to us when the attending physician is required to do call duty without a resident! Indeed, comparisons can be made between the Monfort Hospital's preceptors and those of a rural stream program, given the broad scope of patient care delivered by both. Now don't get me wrong: we have many of the same problems that occur elsewhere, but this is residency, after all.

The Montfort Hospital is but one example of a family medicine program based in a community hospital. The common characteristic shared by these programs is that family medicine residents make up the largest (and in some cases the only) group of residents in the hospital. With no specialty residents to compete with, many family medicine residents find themselves called upon to do more procedures and are gradually given more responsibility than they might otherwise experience. The one-on-one teaching during specialty and family medicine rotations offers many rewarding learning experiences. The cordial relationship demonstrated between family doctors and specialists contrasts greatly with that seen in tertiary care centres.

Taking a closer look

Clearly rural and community hospital streams have much in common, especially when compared with tertiary care hospitals. Yet if, as indicated in some studies, family medicine residents feel better about their experiences away from a tertiary care milieu, then perhaps it is time not only to take a closer look at the environment in which family medicine training occurs, but also to do something about these intangible differences.[3] At the very least, we can begin to define why those training in tertiary care centres are less content.

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References

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2. Finney B, Mattu G. National Family Medicine Resident Survey. Part 1: learning environment, debt, and practice location. *Can Fam Physician* 2001;47:117-20 (Eng), 126-8 (Fr).
3. The Associate Members Group of the College of Family Physicians of Canada. *Proceedings of the Workshop on Family Practice Residency into the 21st Century.* Mississauga, Ont: College of Family Physicians of Canada; March 18, 1991.