

Cause of distress

The article "Emotional distress among couples involved in first-trimester induced abortions"¹ is an important, thoughtful report. One conclusion missing, however, is that the distress levels 3 weeks after the abortion are much lower than preoperative distress levels, indicating that it is the decision to abort and not the abortion itself that caused distress.

I would like to know the statistical significance of the differences between preoperative and postabortion distress rates.

—Ellen Wiebe, MD, CCFP, FCFP
Vancouver, BC
by e-mail

Reference

1. Lauzon P, Roger-Achim D, Achim A, Boyer R. Emotional distress among couples involved in first-trimester induced abortions. *Can Fam Physician* 2000;46:2033-40.

Response

We fully agree with Dr Wiebe's interpretation. Distress was operationally defined as an Ilfeld score above the 80th percentile of a reference group of same age and sex from the same general population.

The association of distress with psychological predictors, such as ambivalence, already identified the psychological situation as a strong determinant of distress. That the intervention itself contributes much less, if at all, is indeed reflected by the observed decrease in incidence of distress after the abortion. The decrease from 55.6% to 41.3% is significant among the 126 women with Ilfeld scores both before and after the abortion: 26 changed from distressed to normal while eight changed in the opposite direction ($P=.003$, exact two-tailed probability).

The decrease from 44.8% to 31.3% of distress among the 67 men with both scores is, however, not significant by a

two-tail test: 16 changed from distressed to normal and seven changed from normal to distressed ($P=.0933$).

—André Achim, PHD
Montreal, Que

Moonlighting by residents

In the November 2000 issue of *Canadian Family Physician*, Residents' Page¹ featured a discussion by Dr Jennifer Yau of moonlighting by family medicine residents as it currently occurs in the training program at the University of Saskatchewan in Saskatoon.

In her piece she paints a rather rosy view of the benefits of moonlighting,

arguing that, in addition to providing needed relief to rural doctors and underserved sectors, moonlighting gives residents experience and exposure to rural practice, provides additional income and familiarity with the business side of family medicine, and adds needed resident clinical experience and confidence. All of these, she suggests, can have a positive effect on recruiting residents to rural practice.

While Dr Yau's experience has apparently been positive, her piece overlooks certain aspects of moonlighting, particularly the difficulties that we in the residency training program in Saskatchewan have experienced.

In allowing residents to moonlight, the University of Saskatchewan is clearly out of step with most other family medicine training programs in the country. In most programs in Canada, moonlighting is not permitted, either by virtue of program policy or, in some instances, by licensing authorities refusing locum tenens privileges to trainees. Not so in Saskatchewan, where the College of Physicians and Surgeons allows some family medicine residents limited locum tenens licences. While physician shortages might underlie this decision, there is no clearly consistent rationale in the approval of locum tenens licences for trainees in Saskatchewan.

Such inequities are only one inconsistency. While the College of Physicians and Surgeons grants locum tenens licensing privileges to residents to moonlight in rural communities or urban emergency rooms and critical care areas, it will not allow residents to moonlight in outpatient birth control clinics, where levels of responsibility are far lower.

Licensing inconsistencies are compounded further by inconsistencies within the residency training program itself. Residents in the Saskatoon division moonlight only in rural communities.

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