Letters ❖ Correspondance

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' Page[1] 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 underserviced 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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Residents in the Regina division moonlight in emergency and critical care areas, as well as in labour and delivery suites. These decisions have everything to do with physician manpower issues and nothing whatsoever to do with educational opportunities and goals.

The Saskatchewan Medical Association and the Provincial Association of Interns and Residents (PAIRS) have cosponsored a program to facilitate rural moonlighting, matching residents to communities. While this program no doubt minimizes administrative hassle for residents who want to moonlight, it does beg an important question.

The PAIRS negotiates limited on-call schedules for residents in training, arguing correctly that long hours of service and sleeplessness are counter-productive to good learning, healthy lifestyles, and safe patient care, but facilitates moonlighting arrangements that reproduce these same problems. How can service endanger learning when it is not remunerated and miraculously facilitate it when it is?

The residency training program has attempted to solve the many problems that have arisen with resident moonlighting by adopting policies to govern and limit it, but the problems have not been resolved.

The program director must approve any resident request for moonlighting privileges so as to limit moonlighting to residents performing satisfactorily in their residency training. However, resident evaluations are sometimes delayed or unavailable at the time this decision must be made. There has been conflict of interest when residents moonlight in or near communities in which they are doing rural rotations and are being evaluated.

The argument that rural moonlighting has a positive effect on later recruitment to rural practice could be very persuasive, if in fact it were true. Interestingly, residents enrolled in the University of Saskatchewan's rural stream of family medicine residency training, presumably those with the most interest and commitment to eventually practise rurally, are underrepresented in the ranks of residents who moonlight. These residents spend a 9-month block in a rural or remote setting during their second year of training, and most appear to be too busy acquiring the necessary skills for rural practice to take on extra moonlighting activities. In general, there does not appear to be any strong link between augmenting your residency income with moonlighting in rural areas and eventual site of practice.

Dr Yau does acknowledge that extra income for residents is a major benefit of moonlighting. With this there can be no argument. Residents can double their annual income by maximizing their moonlighting activities. Unfortunately, most physicians are only too familiar with the pernicious effects of pecuniary inducements on our lifestyles and quality of patient care.

The licensing body could certainly solve the issue of equity by restricting moonlighting privileges to residents who have successfully completed their LMCC part II, and this would also provide some uniform benchmark for competency to moonlight. It would not, however, address the main educational issues raised by moonlighting, issues that could and perhaps should be addressed on a national level by the accrediting bodies.

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Reference

1. Yau J. Residents' page. *Can Fam Physician* 2000;46:2274-6 (Eng), 2276-7 (Fr).

The forgotten refugees

I was happy to see the theme "Refugee stories" on the cover of the November 2000 issue of *Canadian Family Physician*. The qualitative research by Twohig et al[1] and the Reflections article[2] by Dr Frent illuminate early encounters between physicians and refugees to Canada.

I was, however, disappointed to see Ms Gibbs' ironic oversight of the plight of Angolan refugees in her article "Art and healing. Is there a connection?"[3]

There are 22.3 million refugees worldwide; however, there is a disparity in government response to refugees according to strategic importance. For example, in 1999 $120 per refugee was spent in the former Yugoslavia, which is more than three times the $35 per refugee spent in West Africa.[4] I worry that Ms Gibbs' lack of description of the Angolan refugee exhibit unintentionally perpetuates this disparity in response to refugees.

"Passages to Peace. Angolan Refugees in Zambia" is a photo exhibit sponsored by *Medecins Sans Frontieres*. It provides a provocative look at life in a refugee camp, a tragic reality for the Angolan people trapped in one of the longest, most miserable, and forgotten civil wars on the African continent. The humanitarian situation in Angola is precarious with 2.5 million displaced persons out of a total estimated population of 12 million. Violations of humanitarian and human rights law include pillage, rape, and killing by both warring parties. Seventy-six percent of the Angolan population lacks access to health care.[5]

Humanitarian agencies have access only to provincial capitals under government control, a mere 30% of the country. Angolans are unable to ensure their own subsistence due to increasing insecurity. Zambia's central location and relative political stability have attracted 10 000 refugees from Angola. Health emergencies, aggravated by AIDS, tuberculosis, malaria, severe malnutrition, and bad weather conditions have resulted in high