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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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

mortality rates in the Angolan refugee population (personal communication from Coppens K, Medecins Sans Frontieres, Holland, August 29, 2000).

Angolans are among the 200 000 refugees that Canada accepts each year. There are no "pods" being set up for their arrival and little media or political attention. Are family physicians interested in providing primary health care to these individuals? Angolans will arrive in our offices speaking unfamiliar languages and with a variety of health beliefs. Are we trained to appreciate disease and emotional distress associated with war and loss of family, friends, and cultural milieu? Are we prepared to welcome these refugees with the principles of family medicine, in particular the principle of continuity of care, that will be necessary for the long and often painful adjustment of refugees?[6]

Exhibits at the Bruyere Gallery in Ottawa, Ont, strive to promote health and social awareness within our community, a community that includes Angolan refugees. The photos of this exhibit are but a small reminder of the forgotten refugees that will enter our family medicine offices.

—Kevin Pottie, MD, CCFP
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by e-mail

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Response

Thank you for describing the situation of Angolan refugees. We all need to be reminded from time to time about the appalling conditions under which some refugees have lived. Unfortunately, I think we tend to forget about certain groups of refugees once they are out of the news.

There was, however, no ironic oversight in failing to elaborate on the plight of Angolan refugees in Ms Gibbs' article, "Art and healing. Is there a connection?" The article explored the possible healing powers of art and did not purport to elaborate on or plead the cause of any particular refugee groups. We simply hope that by bringing readers' attention to "Passages to Peace. Angolan refugees in Zambia" we have opened their eyes to yet another way to healing.

—Primrose Ketchum
Managing Editor

Who do you serve?

I am concerned with the tone of Dr David Mathies' response[1] to Dr Nicholas.[2] His assertion that the Ontario College of Family Physicians "… can find a better model of collaboration than the one being proposed by our nursing colleagues" might be valid. I believe, however, that "the 75% of people who resist change…" might share more insight than his small cadre of independent thinkers who are clamouring for reform.

It is the principle behind democracy, after all, that the majority have a wisdom that is greater than that of the intelligentsia, or of other political factions. Quoting "change theorists" is poor justification for pushing unpopular reform on the doctors of this province and feeds our suspicions that our leaders are not listening to the rank and file. Resisting change is not necessarily inertia, but might be based on considered opinion. Yes, we applaud our officers in their innovations and the courage of their convictions. Always remember, Dr Mathies, that you serve the community, not these ideas that you have embraced. Speak from your heart, stand up and be counted, but do not become too attached to the outcome lest you lose sight of your duty to serve the majority.

—Dennis Seguin, MD
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by e-mail

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Making housecalls: great fun!

I read with great interest the editorial[1] by Bill Eaton on why family physicians do not make housecalls.

When I lived "down home" in Newfoundland, I often crossed paths with other family physicians as we braved the elements to do home visits. We were not paid very much considering the efforts we put into providing this service. So why did we do it? I believe Dr Eaton touched on the reason in his article: because it was fun.

Today it seems that being a doctor is not as much fun as it used to be. Increasing litigation, burdensome paperwork, shrinking autonomy, and all of the other things mentioned in the editorial take a lot of the fun out of medical practice. But mark my words: housecalls are fun.

The best times I have shared with patients have been during home visits. The hardest I have laughed with my patients has been during home visits. The kindest that my patients have treated me has been during home visits. "No hurry, sit awhile, would you like a cup of tea?" "Did you have supper?" "Oh doctor, what would we do without you coming over?" To be given the blessing of being invited into the private lives of those we care for, to be trusted with all they have is to be at home with them.

Think of the things that you do for enjoyment. Most of them are expensive, time consuming, and might even involve risk. If we show our residents and our colleagues that housecalls are