

of Canada. We have also fought for increased flexibility within residency training programs, and (along with the university departments of family medicine) have done all we can to offer such flexibility to those wishing to transfer into family medicine from residency programs in other disciplines. Unfortunately the CFPC cannot control the lack of flexibility offered by other specialty programs.

In the practice milieu, we have explored and will continue to advocate for improved and better supported practice models as options for family physicians to consider. Contrary to Dr Whatley's insinuation, we have no interest in forcing any family doctor into any single model of practice.

We will continue to work with our members and our colleagues in other organizations to help create a high-quality, flexible system, one that will

improve the professional and personal lives of practising family physicians and attract increasing numbers of medical students to our branch of the medical profession. As we do so, we will also remain committed to helping Canada maintain the highest possible standards for training and life-long education of family physicians. I hope that what we are doing, will, in the long run, prove to be in the best interests of medical students, family doctors, and very importantly, Canadians who need well trained, well paid, professionally satisfied family physicians caring for them.

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Executive Director and
Chief Executive Officer
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of Canada

of rural background as a predictor of rural practice location.

We regret any misunderstanding that might have occurred and wish to set the record straight. A wording change in the various drafts of the paper appears to have conveyed something different than was originally intended.

We are grateful to our readers for their interest and thorough review of our paper and for pointing out this inconsistency. It is this process of open peer review that moves research forward.

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—Rodney A. Crutcher, MD, MMEDED,
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—R. Gordon Chaytors, MD, CCFP, FCFP
Edmonton, Alta
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Reference

1. Szafran O, Crutcher RA, Chaytors RG. Location of family medicine graduates' practices. What factors influence Albertans' choices? *Can Fam Physician* 2001;47:2279-85.

Correcting an apparent contradiction

A contradiction in two statements in our paper "Location of family medicine graduates' practices. What factors influence Albertans' choices?"¹ has been discovered by one of our readers.

The two statements are "Graduates tended to practise in communities the size of those they lived in until 18 years of age" and "...graduates who lived in rural communities until they were 18 years of age were no more likely to choose rural practice locations than those who had lived in metropolitan areas."

A closer look at our data reveals an association between community lived in until 18 years of age and current practice location. Of those who lived in a rural community until 18 years of age, 29.7% indicated that they were currently in a rural practice. Of those who lived in a metropolitan area until 18 years of age, 14.9% were in rural practice. Thus, our data are consistent with the findings of other studies that show the importance

Is a 5% decline in physician supply significant?

A recent study by the Canadian Institute for Health Information (CIHI) suggests that there has been a 5.1% decline in physician supply in Canada between 1993 and 2001 and a 7.0% increase in workload among GPs and FPs.¹ Given current perceptions of physician shortages and increasing numbers of GP/FP practices that do not accept new patients, it is hard to believe that less than 10 years ago, results of a survey conducted by Angus Reid for the Canadian Medical Association found that almost half the physicians in Canada said enrolment in medical schools should be cut.²

So what does a 5% decline from what was considered to be an oversupply situation really mean? What effect does a 7% increase in workload have on the daily lives of doctors? What

does this change in supply mean for Canadians who seek to visit doctors? Recent research conducted at the Manitoba Centre for Health Policy can be combined with findings from CIHI to answer these important questions.

In 1993-1994, there were 99 GPs and FPs per 100 000 people in Winnipeg. The average GP or FP conducted 3932 visits, worked 147 full-time days, and had 34.2 visits on an average full-time day at work. During that year, people in Winnipeg made 3.48 visits to a GP or FP on average. A 5% decline in physician-to-population ratios translates to 94 GPs and FPs per 100 000 population, which is, incidentally, identical to the level of GP and FP supply in Canada in 2000.³ This was the level of supply in Winnipeg in 1996-1997 when the average GP or FP conducted 4139 visits per year (an increase of 207 visits per year), worked 155 full-time days (an increase of 8 days), and had 34.3 visits on an average full-time day at work (up 0.1 visits per day). From a patient's perspective, the rate at which Winnipeg residents contacted GPs and FPs was 3.49 visits per year (up 0.01 visits). So, would a 5% decline in national physician supply between 1993 and 2001 (ie, CIHI's period of analysis) explain today's headlines about a shortage of doctors? It seems unlikely.

We can learn many things from CIHI's important work. But focusing on the causes of a 5% decline in

physician supply, when that decline per se is unlikely to have produced substantive changes in delivery of care, is not likely to be productive. The CIHI report reminds us that routine monitoring of intended and unintended consequences of public policy, and temporal effects unrelated to policy, is prudent.

We will soon be releasing a report that looks at 10-year trends in the supply, use, and availability of GPs and FPs in Winnipeg, and we believe this report will inform this important dialogue. We probed to determine whether vulnerable populations experienced declining visit rates over time. The answer seems to be no. We probed to see whether large cohorts of GPs and FPs provided significantly more or fewer visits now than they did in previous years. The answer seems to be yes: some provided more and some provided substantially fewer. Our report points to workforce trends unrelated to policies targeted at controlling the number of physicians. We should be concerned about the underlying causes of these trends.

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1. Chan B. *From perceived surplus to perceived shortage: what happened to Canada's physician workforce in the 1990s?* Ottawa, Ont: Canadian Institute for Health Information; 2002.
2. Bueckert D. Foreign MDs limit backed in survey: Canadian doctors feel job crunch. *Winnipeg Free Press* 1993 Jun 22;Sect. A:2.
3. Number of physicians per 100,000 population by physician type and province/territory, Canada, 1997 to 2001 [table]. Ottawa, Ont: Canadian Institute for Health Information 2002 October 29. Available from: http://secure.cihi.ca/cihiweb/en/AR14_2001_tab4_e.html. Accessed 2003 Mar 31.

Corrections

In the article "Prostate-specific antigen testing. Should we recommend it?" (Just the Berries, *Can Fam Physician* 2003;49:303-4), there was an error on page 304 in the second-last paragraph of the article. The sentence should read, "It also appears that a ratio of free PSA to total PSA of <25 to 30:1 increases the chance that the elevation is due to cancer."

Also, an author's name was incorrectly spelled in a Motherisk article, "Testing women for HIV," published in August 1997 (*Can Fam Physician* 1997;43:1349-51). The correct spelling is Dr S. Ratnapalan.

Canadian Family Physician apologizes to the authors, Dr John Hickey and Dr S. Ratnapalan, for any embarrassment or inconvenience the errors might have caused.