More thoughts on third-year training

Third-year training programs have positive and negative effects on the pool of family physicians available to serve Canadians. As Dr Saucier notes, some third-year programs produce graduates who limit their scope of practice to a specialized area of family medicine. An example of this is the emergency medicine programs that were initially established to better prepare family physicians to work in emergency departments on a part-time basis in rural Canadian communities. Unfortunately, research indicates that most graduates from these programs practise emergency medicine full time in Canadian cities. Thus, emergency medicine programs decrease the number of available generalist family physicians.

I agree with Dr Saucier that all third-year advanced skills programs should continue to ground trainees in the undifferentiated broad scope of family medicine. This could be done by requiring third-year residents to maintain some responsibility for the care of family medicine patients through a half-day back or parallel arrangement with a practice. I encourage the Accreditation Committee of the College of Family Physicians of Canada to explore this principle and consider establishing guidelines for advanced skills programs.

Although Dr Saucier states that advanced skills training does not augur well for the discipline of family medicine, I am not convinced that her suggestion to develop core 3-year family medicine residency programs is the best response to this dilemma. Ten years of experience has shown that a well-designed 2-year northern and rural family medicine residency program can produce competent and confident graduates who are ready to face the challenges of rural practice. In addition, we have found that flexible third-year programs of varying length that allow residents to design rotations to meet a practice goal are as important as traditional programs, such as anesthesia (12 months). Within our program, only a few residents take advantage of third-year training options even though most of our graduates practise in rural or northern communities.

As educators, we need to critically examine how we can more effectively train family physicians during a 2-year residency. Lengthening the 2-year programs might reflect decreased learning and skill acquisition among many graduates. Instead, we need to examine the key features of family medicine programs that produce a high proportion of generalist family physicians and apply what we learn to less successful programs.

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References

I would like to add my views to the debate on third-year training for family practitioners.

When I qualified in Glasgow, Scotland, in 1961, there was no training for general practice available; indeed, the powers that be did not seem to think there was such a profession. Compulsory residency had been introduced only a few years before I went to university.

As an embryonic surgeon, I spent 6 months in orthopedic and casualty (emergency), then general medicine, obstetrics and gynecology, thoracic surgery, general surgery, and then 3 months in urology. Then I spent a year in Lagos, Nigeria, doing a mixture of general and tropical practice before coming to Canada to set up a solo rural practice in Lévis, Que. With my surgical skills and knowledge of anesthesiology, and a 10-bed hospital all to myself, I thought I had died and gone to heaven. With the assistance of colleagues from neighbouring solo