

# Letters Correspondance

## 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<sup>1</sup> 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.<sup>2</sup> 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,<sup>1</sup> 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.<sup>3-5</sup> 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.

—James Goertzen, MD, MCLSC, CCFP  
Thunder Bay, Ont  
by e-mail

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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 Lafleche, Sask. With my surgical skills and knowledge of anesthetics, 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

practices, we did a range of surgical procedures and virtually all our own obstetrics.

Yet I soon found that, although I was experienced in caring for my patients from the neck down, I was woefully inadequate from the neck up. I had only my rudimentary undergraduate knowledge when it came to ears, noses, throats, eyes, and rashes—as we had done only one term of each, one or two clinics each week. Being in professorial teaching units, we got the most obscure cases and no sense of the tautology of family practice that “common things occur commonly.”

So, to me, the system of an accredited 2-year residency leading to certification came as a revelation of what should be. Undergraduates are encouraged to think positively about family practice as a worthy career. As a rudderless would-be surgeon who simply drifted into rural practice after 5 years of flailing in the dark, however, I would not like to see the practice-qualifying route lost, as this could make us exclusive where I believe we should be inclusive. There must be many who have made a false start down another road and others who have been ill or (for one of a multitude of reasons) have come late into family practice. We need these doctors.

As someone who has had more than 4 years of residency training, I see no reason we should not have a third year of voluntary residency (and it should be voluntary). That third year could be profitably spent doing 3 months each of otolaryngology, ophthalmology, dermatology, and obstetrics and gynecology, all preferably taught from the generalist's standpoint, not a specialist's.

—Lewis Draper, MB CHB, LMCC, CCFP, FCFP  
Lumsden, Sask  
by fax

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Je dois reconnaître au D<sup>re</sup> Saucier<sup>1</sup> le mérite d'avoir fait valoir certains aspects positifs indéniables des formations complémentaires. Toutefois, la solution qu'elle propose ne peut

qu'accentuer la pénurie de médecins de famille au Québec et au Canada. En balkanisant des sphères traditionnelles de la médecine de famille comme l'urgence, l'hospitalisation, l'obstétrique ou la gériatrie, on les constitue en petites bulles imperméables les unes aux autres, favorisant ainsi la fragmentation des pratiques. Plus on se sent compétent dans un domaine, plus on cherche à s'y confiner et à se réfugier dans sa zone de confort, avant même de commencer à exercer.

Je crains qu'on émaille cette troisième année d'une foison de *stages tendance* ne servant qu'à pousser des pointes d'expertise dans des secteurs sans liens apparents, déchiquetant de plus en plus le tissu de la médecine familiale au lieu de le renforcer. Le glissement pernicieux vers les concentrations confortables pendant la résidence ne peut se traduire dans la pratique que par une baisse de la polyvalence et un effritement de la continuité des soins. Le dévoiement des résidents sera consacré lorsque qu'ils se rendront compte eux-mêmes que leur engagement ne sera plus envers des personnes ou des familles, mais plutôt envers des corpuscules de compétences éclatées. Peuvent-ils en mesurer toute l'absurdité: ils auront étudié plus longtemps pour apprendre finalement à en faire moins.

Réduit à l'essence de son engagement envers des personnes sur la courbe espace-temps, le médecin de famille est un grand accompagnateur. Sans accompagnement, on fait toutes sortes de belles choses et on les fait d'autant mieux qu'on ne fait que cela, mais ce n'est plus de la médecine de famille. Comment les départements en sont-ils arrivés à renier ce qu'ils ont eux-mêmes érigé avec tant d'efforts depuis 30 ans. Mais surtout comment justifier à la face de la société qu'ils

contribueront ainsi à accentuer la pénurie de médecins de famille au cours des années à venir, puisqu'ils n'auront plus de la médecine familiale que le nom. Plutôt que l'usurper, je propose de leur substituer l'appellation *départements des sous-spécialités non patentées*.

—Daniel J. Marleau, MD, CCFP, FCFP  
Rouyn-Noranda, Qué  
par courriel

## Référence

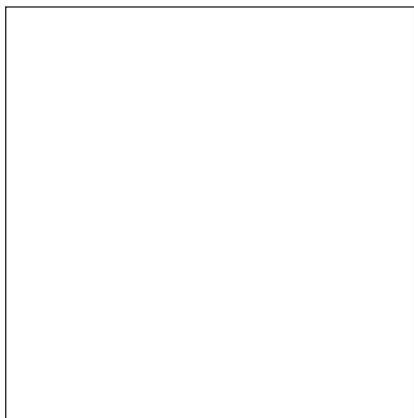
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## Home care critical part of health care

I was pleased to see the July issue of *Canadian Family Physician* focus on family physicians as a resource to the community.

As a national voice for home care, the Canadian Home Care Association recognizes that a strong and effective home care sector is a critical component of Canada's health care system. It endorses an approach to health care planning, design, and implementation that emphasizes collaboration to make "continuity of care" a reality. Two of the Association's priorities for 2004-2005 are identifying and sharing good practices in acute home care and managing chronic diseases through primary health care and home care linkages with other components of the health care system.

The editorial "Acute hospital services in the home"<sup>1</sup> is particularly timely. Although this country lacks specific "hospitals in the home," all home care programs do provide care for patients who would otherwise require hospital care. Physician involvement in these cases is essential. Governments and home care programs must understand and support physicians' active participation in acute home care as outlined in the editorial. Credit should be given to the New Brunswick Extra-Mural Hospital for its pioneer work in developing the hospital in the home.



The article "Enhancing primary care for complex patients"<sup>2</sup> describes multidisciplinary interventions that enhance communication between primary care providers. The Canadian Home Care Association has begun a project funded through the Primary Health Care Transition Fund that will focus on helping primary health care providers, notably family physicians, home care case managers, and other community services develop a stronger role in coordinating and integrating health care services for patients with chronic diseases. This initiative will build upon current primary health care activities in Ontario and Alberta.

The Canadian Home Care Association is committed to working with family physicians and others in moving home and community care from its marginal position into the mainstream of Canada's health system.

—Murray Nixon, MD, CCFP, FCFP  
President, Canadian Home Care Association  
Ottawa, Ont  
by mail

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