

Letters Correspondance

Third year in family medicine: headed for disaster?

In discussing the optional third year in family medicine training, Dr Danielle Saucier has proposed in her editorial¹ a universal third year for all residents. I believe this plan will spell disaster for family medicine in Canada.

Ben Chan's² analysis of physician shortages developing in the late 1990s showed that the largest factor in this decline was the additional years of training after elimination of the rotating internship. This 1-year cohort is a permanent loss to the physician work force. Adding another year will further compound this shortage.

It requires a truly dedicated physician to go into a family medicine program for 3 years when another 1 or 2 years will earn specialist certification, with its higher income and perceived status. This will further decrease the number of applicants to family medicine.

We will be left with a shrinking elite group of highly trained family physicians, many with special interests and less interest in daily comprehensive care to serve a growing and aging population.

Just as the method of introduction of the current 2-year program caused numerous systemic problems, so we predict similar serious imbalances would develop subsequent to adding a third year to training.

—Stanley Lofsky, MD, CCFP, FCFP
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Ontario Human Resources Committee
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by e-mail

References

1. Saucier D. Second thoughts on third-year training [editorial]. *Can Fam Physician* 2004;50:687-9 (Eng), 693-5 (Fr).
2. 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.

I am very surprised at the suggestion¹ of adding a third year of residency training to family medicine. Yes, more residents are choosing to do third-year programs; this is, for the most part, to get away from providing comprehensive care. The Canadian Association of Interns & Residents (CAIR), along with all the provincial medical organizations for residents, have strongly opposed adding any additional training years to any programs—Royal College or family medicine. By adopting a 3-year program, more problems would be created. Many residents feel the 2-year program is too long as it is, never mind adding more training.

First, adding a third year would further cause a shortage of family physicians for a 1-year cycle as it is implemented. Second, medical students faced with deciding between a 3-year family medicine residency versus a 4- or 5-year Royal College residency would probably be more inclined to put in an extra year to become specialists. Third, there is no evidence that, if we went to a 3-year training program, residents would not want to do a fourth year in emergency medicine or palliative care or sports medicine. Finally, a 3-year program is too similar to the American model. We all know that family physicians are not the only specialty to provide primary care in that country, in contrast to Canada, where most primary care is provided by family physicians and general practitioners.

If the College of Family Physicians of Canada wants to instil more confidence and respect into family medicine, we have to stop discussing making the residency a 3-year program. We must start focusing on the comprehensive 2-year training program that we have and teach residents the skills of lifelong learning and a sense of humility. We cannot be everything to everybody. We have to be physicians for our patient population.

—Robert W. Webster, MD, CCFP(CANDIDATE)
Fort Frances, Ont
by e-mail

Reference

1. Saucier D. Second thoughts on third-year training [editorial]. *Can Fam Physician* 2004;50:687-9 (Eng), 693-5 (Fr).

I just read Dr Danielle Saucier's article "Second thoughts on third-year training."¹ I strongly disagree that the trend to third-year training programs could do a great disservice to family medicine.

Dr Saucier's attitude is symptomatic of an insular "circle the wagons" type of mentality that is all too common in academic family medicine. That anyone could ever suggest that more education and more advanced training could be anything but positive for our residents is incredible.

Whether Dr Saucier likes it or not, many residents graduate from our family medicine programs wanting greater skills in a particular area of family medicine, such as palliative care, geriatric care, or emergency medicine. Rather than be intimidated by this trend, leaders in family medicine need to embrace it, encourage our residents to seek further training in areas of their interest, and do everything we can to promote and nurture their advanced training.

Not all family physicians want to do all aspects of family medicine—and that is OK. Let us do everything we can to foster and nurture advanced educational programs, and take pride in the leadership positions that are often assumed by family physicians who complete extra years of training.

Extinction comes to those species unwilling or unable to adapt to their changing environments.

—Eric Letovsky, MD, CM, MCFP(EM), FRCP(C)
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by mail

Reference

1. Saucier D. Second thoughts on third-year training [editorial]. *Can Fam Physician* 2004;50:687-9 (Eng), 693-5 (Fr).

I read Dr Danielle Saucier's article¹ "Second thoughts on third-year training" with interest. Dr Saucier expressed a well-balanced view about third-year programs and pointed out legitimate concerns that a proliferation of third-year programs might bring to family medicine.

I offer alternative views on a few issues raised in the article:

- 1) As a resident and representative to the Section of Residents, I do not see that graduates of the 2-year program feel inferior to those who do some form of advanced training. We seem to view this entirely as a personal choice. I agree that some residents who enter a well-rounded family practice after 2 years of training find it challenging but not necessarily more challenging than those who enter their field of practice after some form of advanced training.
- 2) Dr Saucier's real concern is that third-year programs "turn out physicians geared toward practising in a single field." My rebuttal is that many other important factors determine one's field of practice after residency training, and third-year programs likely do not play an important role. Let us examine emergency room (ER) work, for example. Before the era of the Alternate Payment Plan, many Ontario hospitals had difficulty keeping their ERs open. This issue is much less contentious now because this payment scheme is more lucrative than fee for service. This undoubtedly affects the practice patterns of graduates. Second, family physicians are generally unable to work in ERs in tertiary care centres because these departments require either RCPC or CCFP(EM) certification. This common policy leaves little choice for family medicine residents who prefer to do some form of ER work in urban areas. Further, graduates who invest only 2 to 3 years of training but choose to limit their scope of practice might have self-selected themselves into a family medicine residency. It is likely that these graduates would employ other forms of training, such as continuing medical education. In fact, many physicians who used to practise comprehensive family medicine have chosen to limit their scope of practice despite not having any advanced training in their chosen area of expertise.

For these reasons, even the most drastic measure—not having any advanced training programs—will not prevent certain family medicine graduates from limiting their scope of practice due to financial, lifestyle, and other personal reasons. This logic will likely apply even to a

3-year family medicine residency. We must ask why physicians do not want to enter or have left comprehensive family practice before we can devise meaningful solutions.

- 3) The most promising ways to attract more graduates into comprehensive family practice would be to enhance remuneration and develop alternative funding formulas so that comprehensive family practice is reasonably competitive with limited scope practices in terms of lifestyle and sustainability. Non-remunerated time spent on office-related paperwork and overhead costs must be addressed in this process.
- 4) It is important to remember that one of the greatest selling features of family medicine is the availability of flexibility and choice. We must not sacrifice this in the name of promoting family medicine or a single aspect of family medicine, as we might face a further decrease in interest in this area as a career.

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Reference

1. Saucier D. Second thoughts on third-year training [editorial]. *Can Fam Physician* 2004;50:687-9 (Eng), 693-5 (Fr).

Family physicians' increasing workload

I read with interest the editorial by Dr Flook¹ regarding family physicians' responsibility for managing gastrointestinal disease. It raises a number of important points for family physicians, who are now extremely overworked, underpaid, and overloaded.

First, I think it is a given that family physicians are overworked. We have so many guidelines on managing every major illness that it

is impossible to keep up with the reading. These guidelines will be accepted as standard of practice if a case should slip through the diagnostic sieve.

Second, one of the reasons I emigrated to Canada was the universality of health care; I dreaded having to explain to patients that treatment or tests were beyond their means. I find I lack the training to explain that the carbon-13 urea breath test (¹³CUBT) is not covered, although recommended. If a patient cannot or will not pay, what guidelines do I follow? The same can be said in dealing with serologic diagnosis of celiac disease, when two out of the three screening tests again are not covered by provincial health insurance plans.

Third, patients are being led to believe by the media (and rightly so) that they should have regular screening. But as Dr Flook points out, the manpower is not available. This gap between reality and practicality produces dissatisfied patients, increases the risk of missing curable illnesses, and certainly exposes family physicians to serious medical and legal sequelae.

Fourth, as we continue to experience marked shortages in specialists available for referrals and increasing populations needing to be seen, delays in referrals are increasing. I find it frustrating to beg or to exaggerate a case to squeeze a patient in. It is also extremely frustrating for specialists who are working at increasingly high volume.

These points have to be taken into account in drawing up criteria in all illnesses, in accepting standards, and in medical and legal and disciplinary cases. Funding cuts over the past decade have exposed the population to declining health care—

not the fault of physicians. The problem will only increase in the future as we develop more sophisticated technology.

Last, as a practising family physician, albeit with a light load, I find downloading of work on family physicians to be escalating. At one time, consultants' offices used to make appointments. Now we fax referrals, appointment times are faxed back to us, and we notify patients