Letters
Correspondance

Training and practising in small communities

Due to the shortage of family physicians in many Canadian communities, the location and type of practice of graduating family medicine residents is of great interest. Godwin and colleagues provide important information on the choices of Ontario family medicine residents who completed their training in 1996 and 1997.[1] This work, along with previous research, suggests that medical schools and residency programs influence the practice locations of their graduates.[2-3]

I was surprised that the authors and editorial staff chose to highlight the number of graduates practising in "smaller communities of 50 000 people or fewer" instead of the more accepted definition of rural communities with populations of fewer than 10 000 people.[4] When the study data are examined using a more appropriate definition of smaller communities (less than 15 000 people), large differences between the percentage of family medicine graduates in these communities become apparent: Family Medicine North, 64.3%; University of Ottawa, 36.4%; Queen's University, 22.9%; University of Western Ontario, 22.2%; Northeastern Ontario Family Medicine Residency Program, 15.0%; McMaster University, 13.2%; and University of Toronto, 10.8%. Thus, the proportion of graduates practising in communities of fewer than 15 000 varies six-fold among Ontario programs.

Hutten-Czapski had similar findings when examining the practice locations of Canadian family medicine residency graduates from 1994 to 1998.[3] Fifty-one percent of Family Medicine North graduates located to communities with fewer than 10 000 people, compared with 24.6% of Queen's University graduates, 12.0% of Northeastern Ontario Family Medicine Residency Program and University of Ottawa graduates, 11.4% of McMaster University graduates, 10.8% of University of Western Ontario graduates, and 4.6% of University of Toronto graduates.

This raises an important question: If programs can influence the practice locations of their residents, what are the important features of Family Medicine North that encourage graduates to practise in smaller rural communities? Some related factors include use of communities across northwestern Ontario as training sites, an overall program goal to provide training appropriate for northern and rural practice, selection of residents who possess similar educational desires, family medicine rotations in rural centres of 5000 to 15 000 people (16 weeks) and in smaller communities of fewer than 5000 people (8 weeks), specialty rotations with family medicine—friendly specialists who work collaboratively with family physicians, and academic seminars that provide strategies for handling clinical problems where on-site specialists might not be available.[5]

As educators, it is crucial that we determine how and where our graduates practise. It is also important that we examine the key components of family medicine training that influence graduates' choosing specific practice locations.

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

References

1. Godwin M, Hodgetts G, MacDonald S, Seguin R. Short Report: Ontario family medicine residents. Practice choices in 1998 and 1999. *Can Fam Physician* 2004;50:1407-9.
2. Rosenblatt RA, Whitcomb ME, Cullen TJ, Lishner DM, Hart LG. Which medical schools produce rural physicians? *JAMA* 1992;268(12):1559-65.
3. Hutten-Czapski P, Thurber AD. Who makes Canada's rural doctors? *Can J Rural Med* 2002;7(2):95-100.
4. Rourke J. In search of a definition of "rural" [editorial]. *Can J Rural Med* 1997;2(3):113-5.
5. Goertzen J. Making rural docs in Northwestern Ontario (FMN: NWO Program) [letter]. *Can J Rural Med* 2002;7(3):217-8.

Covering for a colleague: more than a medicolegal issue

The question of responsibility for reviewing a colleague's orders for nursing home patients was raised in the February 2005 issue of *Canadian Family Physician* in the context of agreeing to "assist" a colleague during an illness lasting several months.[1]

← FOR PRESCRIBING INFORMATION SEE PAGE 736

When I stand back and look at this from a distance, I see a different picture. The questioner admits to having difficulty finding time to cover for his or her colleague because of an already excessive workload.

In this context, I think that covering for a colleague during illness has a number of undesirable side effects that are often overlooked.

First, increasing the workload of an already overburdened physician makes medicolegal mishap more likely. The physician is effectively being blackmailed to review the colleague's orders, "or the patients will not be able to get their medications." I suggest that this is a system failure that has been compounded by physicians' acquiescence in covering for their colleagues. A colleague's patients do not become your responsibility, nor do you have a duty of care, until you agree to cover for this colleague.

As a profession, we are already stretched very thin. When we almost unthinkingly agree to cover for a colleague during illness, we stretch ourselves even thinner. If there is a medicolegal consequence, we will be the ones who suffer, not the nursing home administrator, not the Ministry of Health and Long-Term Care or its bureaucrats.

As long as we agree to be stretched thinner, this will continue to be the case. Thus, we prevent the problem from becoming visible *and* expose ourselves to medicolegal risk.

Perhaps it is time for us to look at the consequences of our collegial behaviour in covering for colleagues. When we agree to do this, we contribute to the underfunding and demise of our health care system and, at the same time, expose ourselves to increased medicolegal risk.

—Brian J. Penney, MD
Smiths Falls, Ont
by e-mail

Reference

1. Winkelaar PG. Medicolegal file. Reviewing a colleague's orders [Clinical Practice]. *Can Fam Physician* 2005;51:205.

FOR PRESCRIBING INFORMATION SEE PAGE 758 →