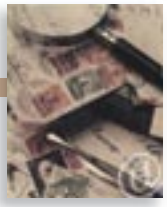
Letters
Correspondance



Making the most of our time

Thank you for the editorial "Maximizing available time. Family doctors' challenges with dementia" in the February 2006 issue of *Canadian Family Physician.*[1] It is about time family doctors acknowledged that benefits of the medications available for Alzheimer disease are very limited compared with those of "providing information, educating, and supporting patients, families, and caregivers."[1] Treatment for Alzheimer disease illustrates how standards of care evolve without full assessment, including evaluation of clinical significance versus statistical significance.

Recently, I had in my practice a patient with early Alzheimer disease who was still capable of decision making. I discussed the risks and benefits of the available drugs, and the patient decided not to take any medications. In spite of full documentation of this discussion and decision prominently displayed in the chart, a locum tenens physician found this patient "untreated" for Alzheimer disease and promptly started the patient on one of the cholinesterase inhibitors. This illustrates how widely accepted these drugs are among family physicians, even though the benefits are so limited.

As family doctors we should focus our efforts for our patients with Alzheimer disease on areas like psychosocial interventions and family support, and we should lobby governments to fund effective interventions for patients with Alzheimer disease and their families, instead of funding drugs of minimal benefit.

—Catherine Oliver, MD
Toronto, Ont
by e-mail

Reference

1. Nazerali N. Maximizing available time. Family doctors' challenges with dementia. *Can Fam Physician* 2006;52:157-9 [Eng], 162-4 [Fr].

I enjoyed reading Dr Nazerali's editorial in the February issue of *Canadian Family Physician,* as well as the accompanying articles. I have submitted the results of my own research in this area, but the timing was such that it will be published in a future issue of *CFP.*

I led a group of researchers in the Dementia-NET group as we audited the practices of 160 family physicians in Ottawa, Ont; Toronto, Ont; and Calgary, Alta, to evaluate the extent to which family physicians follow the 48 key recommendations of the 1999 Canadian Consensus Conference on Dementia (CCCD). What we discovered, notwithstanding the limitations of chart audits, was interesting and perhaps disturbing. We found that family physicians had a very high referral rate (>80%), mostly to neurologists and geriatricians. This reflects, perhaps, family physicians' lack of comfort in managing dementia or, perhaps, family members' pressure to refer patients to specialists. We also discovered that few physicians assessed caregiver coping, which is a predictor of early institutionalization. Finally, few physicians assessed driving status and safety (about 13%). As a practising family doctor, however, these results do not surprise me, and they fit with some of the issues that Dr Nazerali raised in her editorial.

First, time pressures are enormous for family physicians and are getting worse as we deal with more elderly patients with chronic illnesses.

Second, the CCCD guidelines were passively disseminated with the *Canadian Medical Association Journal*, a sure-fire way to ensure that a guideline is ineffective. I agree that guidelines are very important in aiding family physicians to care for complex patients, but they need to be generated differently. We should not rely on a top-down approach from our specialist colleagues. There needs to be far greater input from family physicians about both content and process. There should also be more input from patients and their families. Further, passive dissemination does not work. Guideline makers need to develop tool kits that offer family physicians several options for implementation in their practices, as Dr Nazerali mentioned.

Finally, there must be greater discussion, within the medical profession and within the community, about models of care. Among the options that need to be considered are shared-care models versus specialty-care models. The situation is becoming even more complex as primary care reform progresses. In family health teams, for example, which might have other providers available, the role of the family physician will need to be clarified.

The next phase in our research, which we have just started, is to conduct focus groups with family physicians aimed at exploring all of the questions that Dr Nazerali raised in her editorial, including the role and structure of guidelines and models of care that might help family physicians to define and optimize their role in dementia care. We hope that over time our research will improve care for dementia patients and the lives of family physicians.

Thanks for highlighting these important issues for Canadian family physicians.

—Nick Pimlott, MD, CCFP
Toronto, Ont
by e-mail

Residents only, please

I was concerned when I realized that the author of the Resident's Page in the latest issue of *Canadian Family Physician* was not in fact a resident.[1] Those who are new to practice certainly face a unique set of issues, but these

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issues are quite different from those faced by residents. The message sent by having the column written by someone who has been working for 2 years is that either no resident is capable of writing the piece or the editors did not look very hard for a resident to write it. I know of many talented residents who would have loved to have written that piece and for whom it would have been a career highlight—please do not deny them future opportunities.

—Sarah Giles, MD
First-year resident, Family Medicine North
Thunder Bay, Ont
by e-mail

Response

Thank you for your letter. I am sorry you felt that the Residents' Page should be written only by current residents. Our goal was to have a place in the journal where issues pertinent to residents could be assessed. This article was submitted by a recent graduate and discussed experiences during residency that I thought would resonate with residents. We did not solicit the article, but we believed it fit well into our issue on palliative care. It certainly did not displace other articles by current residents. In fact, we are usually looking for articles from residents and can offer publication to most that are submitted. If you know talented resident writers, please encourage them to submit to the journal.

—Tony Reid, MD, MSC, CCFP, FCFP
Scientific Editor, Canadian Family Physician

Family medicine as a specialty

I strongly agree with Dr Gutkin's thoughts on recognizing family medicine as a specialty in Canada.[1] It has long been overdue, and Canada is probably one of the few Western countries that does not have this specialist designation.

I cannot think of one valid reason family medicine should not be recognized as a specialty.

The often negative perception (both of the general public and of other specialists) that anybody can practise general medicine after graduation without further (re)certification, regulation, and continuing medical education, and that generalists are sort of second-rate or second-best doctors, has been very damaging to the image of family medicine in Canada. No wonder students do not want to be associated with family medicine.

I think it is paramount for the College of Family Physicians of Canada to make an effort to change this perception and to clarify and regulate the distinction between generalists (those who are not Certificants of the College) and family medicine specialists (those who are Certificants).

As in other countries, the recognition of family medicine as a specialty is not only in the best interest of the general public but also of family medicine and its practitioners. There should be obvious benefits, including remuneration and status, that would attract physicians to enter and specialize in family medicine.

I am recognized as a specialist in family medicine in Norway and the United Kingdom, but moving to Canada did not allow for unconditional recognition of my European specialization. So another important task is to see how equivalent specialist training in family medicine internationally can be transferred across borders. This would also make it easier for foreign-trained doctors to access the Canadian job market without too many impediments.

In Norway, being a recognized specialist in family medicine had very tangible financial benefits as well. In Norway, with a well functioning public-private mix of health care provision, specialist recognition meant you would earn about $25 000 more yearly than doctors without this specialist designation, and the discrepancy in earnings between specialists and family medicine specialists has eroded over the years.

—Noordin Virani, DHA, MSC
Taber, Alta
by e-mail

Reference

1. Gutkin C. The specialty of family medicine in Canada. *Can Fam Physician* 2006;52:403-4 [Eng], 402-3 [Fr].

The problem is that we are truly specialists in the field of generalism. Our problem is not that we don't know who or what we are but that the language of medicine has constrained our descriptors. To the lay public a specialist is a Fellow of the Royal College of Physicians and Surgeons of Canada. Even the Royal College has problems describing the non-specialist specialist—the international medicine graduate consultant without "Canadian papers." In fact, what the Royal College should define is consultants, not specialists; specialist then refers more appropriately to a field of expertise, which we in fact have in spades.

—Bob Miller, MD, CCFP, FCFP
St John's, Nfld
by e-mail

I support the March 2006 Vital Signs proposing recognition of family medicine as a specialty for all the reasons Dr Gutkin cited.[1]

An important issue, which he did not emphasize, is money. As we know, Canadian family practice sees itself at the brink of oblivion. As a specialty, we could more plausibly argue for better remuneration.

One concern we would have to address is length of training. Some would

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