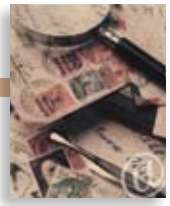
Letters
Correspondance



Resources for palliative care

As a former family physician who is now a full-time palliative care physician, I was more interested than usual in the April issue of *Canadian Family Physician.* An opportunity was missed, however, to mention a valuable resource for those providing palliative care—the Internet. A good place to start is **www.palliative.info**. Run by a palliative care physician in Winnipeg, Man, it provides basic information and links to many other sites.

Another excellent resource, this one from the United Kingdom, is **www.palliativedrugs.com**, which includes a palliative care drug formulary, albeit with a United Kingdom bias. (I understand that an American formulary is being developed.) The greatest benefit of this site is the bulletin board, which is an international discussion group. Registration is free, and you can learn a lot by following the discussions. Questions about management of challenging cases and discussions with ethical and philosophical slants are common.

—Mervyn Dean, MBCHB, CCFP
Corner Brook, Nfld
by e-mail

Role for primary care in epidemic surge capacity

I was delighted to read the editorial by Hogg and colleagues on increasing epidemic surge capacity, published in the May 2006 issue of *Canadian Family Physician.*[1]

Typically, pandemic planning has tended to focus on public health mobilization and institutional contingency planning. Primary care, particularly fee-for-service, private-practice physicians, can be overlooked. Yet this part of our health care system offers substantial potential for increased capacity and responsiveness.

While working at the Winnipeg Regional Health Authority in Manitoba during the severe acute respiratory syndrome (SARS) outbreak, I was pleased to be part of an initiative—a coordinated public health and primary care approach—that provided scripts for family physicians to give to office personnel to screen patients who telephoned for advice or appointments. This was, in part, a response to some physicians placing signs on their office doors advising sick patients to go directly to the local emergency room without any office triage or assessment by a physician, which could have had a substantial effect on patients and emergency rooms.

Although we collected no data, I like to think that through this initiative we helped family doctors and their staff increase their knowledge about SARS; helped office staff feel more comfortable with phone assessment, prioritization, and triage of patients; provided infection-control advice relevant to offices; minimized (needless) patient diversions from office to emergency room; supported the primary care system at a time when patients and providers alike tended to be intimidated by febrile respiratory illnesses to the point of avoiding contact; and strengthened links between public health and primary care.

During epidemics there will invariably be need for a responsive and capacious primary care system. In fact, the very survival of hospitals might depend on prehospital screening and prehospital and posthospital care. It is inconceivable that hospital emergency rooms can absorb all comers or that hospitals could admit and care for all the sick, alternative facilities notwithstanding.

Epidemic and pandemic planning present unique opportunities to enhance primary care capacity and to integrate primary care with secondary and tertiary care using public health principles and government administrative and resource infrastructure. This planning also helps keep primary care closer to patients' homes, care delivered by trusted and familiar family doctors.

Such contingency planning exercises become unique opportunities to move primary care renewal forward through innovative, community-based strategies, such as the one described in the article by Hogg et al.[1]

—G. Mazowita, MD, CCFP, FCFP
Vancouver, BC
by e-mail

Reference

1. Hogg W, Lemelin J, Huston P, Dahrouge S. Increasing epidemic surge capacity with home-based hospital care. *Can Fam Physician* 2006;52:563-4 [Eng], 570-2 [Fr].

Evaluating procedural skills

I have read with great interest the editorial about evaluation of procedural skills in family medicine training in the May 2006 issue of *Canadian Family Physician*.[1] The authors suggest 2 important goals regarding procedural skills training. The first is to ensure that core procedural skills are being taught

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and the second is to ensure that those skills are being formally evaluated.

I am a first-year resident in family medicine who plans to practise in an underserviced area and who has a strong interest in procedural skills. I agree that procedural skills should be an integral and structured part of family medicine training programs and that they cannot vary by preceptor or hospital, as happens now.

I have also noticed that some procedures (eg, circumcision, vasectomy) that were once a part of family medicine are fading away. I have had a hard time finding family physicians who still perform these procedures. It is even more difficult to find physicians willing to teach them. Specialists who perform these procedures daily are not eager to teach them to out-of-specialty residents. This is a substantial problem for those who want to provide comprehensive care in a rural setting.

With respect to the proposed formal examination of procedural skills, however, I believe that in-training observations and evaluations, as are done in surgical specialties, are a more realistic and efficient way of evaluating individual procedural skills. Objective-Structured Clinical Evaluations of procedural skills can only be done on models and do not facilitate realistic procedural skills evaluation.

It is essential that the College of Family Physicians of Canada introduce standard requirements for core procedures for residency training and reintroduce optional procedures (eg, sigmoidoscopy, endoscopy) to family medicine by formally recognizing them as part of family medicine's scope of practice. Furthermore, redefined training requirements could be evaluated during training through a continuous log of procedures performed and concurrent evaluations by supervisors.

—Val E. Ginzburg, MSC, MD
Toronto, Ont
by e-mail

Reference

1. Rivet C, Wetmore S. Evaluation of procedural skills in family medicine training. *Can Fam Physician* 2006;52:561-2 [Eng], 568-70 [Fr].

What's in it for me?

I was a full-time family physician in Canada for more than 10 years, and for most of that time was a Certificant of the College of Family Physicians of Canada. I am still a Certificant, but for the last 5 years I have been a full-time palliative care physician. As such, I find myself wondering how relevant the College is to me. I do not expect articles on palliative care every month in the journal, and, in fact, I am not sure what the role of the College is for me. Are there many members in a similar situation, and if so, is the College addressing this issue?

—Mervyn Dean, MBCHB, CCFP
Corner Brook, Nfld
by e-mail

Response

The issue brought forward by Dr Dean is of utmost importance for the College of Family Physicians of Canada. The College is well aware of the contributions made by many of our members in specific areas of community need, such as palliative care, emergency care, and care of the elderly. A substantial focus of our June Board meeting was to explore how we can better support family physicians involved in focused areas of care. We looked at how to best do this in such areas as education, credentialing, continuing professional development, and advocacy.

Feedback from the meeting will be communicated to our members through messages from Drs Cal Gutkin and Louise Nasmith in *Canadian Family Physician*, in *e-News,* and on our website. Stay tuned!

—Francine Lemire, MD, CCFP, FCFP
Associate Executive Director, Professional Affairs
College of Family Physicians of Canada
Mississauga, Ont
by e-mail

Correction

In the June issue of *Canadian Family Physician,* the article by Dr Schwalfenberg on omega-3 fatty acids (*Can Fam Physician* 2006;52:734-40) contained errors in Table 3 and Figure 1. In Table 3, the first section should have showed grams of EPA, DHA, or ALA per 15 mL and the ratio of omega-3 to omega-6 fatty acids for krill oil should have been 13:1. The correct **Figure 1** appears below. *Canadian Family Physician* apologizes for these errors and any confusion or embarrassment they might have caused.

Figure 1. Data from the final report of the Lyon Diet Health Study[7]