

## Abortion training at the University of Saskatchewan highly sought after

We write to congratulate Drs Myran and Bardsley on their recent Residents' Views article.<sup>1</sup> It highlights the absence of exposure to abortion counseling and provision in family medicine residency training even now, decades after abortion has become a common and essential medical service in Canada. Half of all pregnancies in Canada are unplanned and half of those end in therapeutic abortion. This makes abortion a more common problem (14.5 per 1000) in the health care of women than myocardial infarction (1.5 to 2 per 1000) or breast cancer (1.3 per 1000) are.<sup>2-4</sup> Consequently, the authors are correct in calling the College of Family Physicians of Canada (CFPC) to account for the complete absence of this topic in its curricular guidelines. It is high time the CFPC corrected this omission in its curricular guidance for Canadian family medicine training.

The authors point out that when residents do receive exposure they report positive responses and more competency in provision of abortion counseling and intention to provide services. In that vein, our experiences in the University of Saskatchewan family medicine training program in Regina are a happy exception to the national paucity of training and exposure. For more than a decade the program has made exposure to women seeking pregnancy termination a mandatory residency training activity. All residents attend at least one counseling session at the Women's Health Centre, where a multidisciplinary team provides abortion counseling and services. Those who have an interest can increase their exposure to both surgical and medical abortion with elective time, eventually establishing abortion provision as a recognized competency in their training. Such elective experiences in our residency training program are highly sought after and fully subscribed to.

While Saskatchewan's northern and rural citizens still experience the access barriers common elsewhere in Canada, often traveling many hours to Regina for abortion services, this situation has improved. Anecdotally, this improvement is in no small part owing to family medicine residents' abortion exposure during training, and their resulting willingness to counsel women and provide abortion once graduated into practice in the

province. The Women's Health Centre abortion service is now staffed largely by family physicians, many of whom have come through the residency training program to establish their competency. In fact, several of these providers travel from their rural or regional practices to provide surgical abortion services on an itinerant basis. Many more former residents are providing medical abortion services in their communities, thanks again in part to their residency training experience.

Drs Myran and Bardsley have correctly identified a gaping hole in family medicine residency training in women's health, and we join them in calling on the CFPC to rectify this by adding abortion counseling and medical abortion exposure as a core competency in family medicine residency training in Canada.

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—Megan Clark MD CCFP  
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### Competing interests

None declared

### References

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## Resistance does not exist

I am so grateful to see motivational interviewing presented in our journal,<sup>1</sup> especially in regard to helping people with chronic pain make healthy changes. I would encourage the authors to read the most recent edition of *Motivational Interviewing* by Miller and Rollnick,<sup>2</sup> because they explain resistance as either sustain talk or discord in the therapeutic relationship. "Your clients will tell you when you are doing it right. If you hear change talk, do more of what you've been doing. If you encounter increasing sustain talk and discord, try something different."<sup>2</sup>

—Graham Blackburn MD CCFP

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4. **Clinical Review:** Approach to tinnitus management (July 2018)
5. **Clinical Review:** Approach to developmental disabilities in newcomer families (August 2018)

**Competing interests**

None declared

**References**

1. Crawley A, Murphy L, Regier L, McKee N. Tapering opioids using motivational interviewing. *Can Fam Physician* 2018;64:584-7 (Eng), e341-5 (Fr).
2. Miller WR, Rollnick S. *Motivational interviewing. Helping people change*. 3rd ed. New York, NY: The Guilford Press; 2012.

## Provincial screening bonuses

I read with interest and agreement the article by Dickinson et al titled “Screening: when things go wrong,”<sup>1</sup> which encourages family doctors to have transparent and evidence-based conversations with our patients about preventive screening. Rather than simply telling our patients to complete the screening, we should engage with them in evidence-based shared decision making.

It caused me to wonder what effect provincial bonuses to family doctors might be having on these discussions with our patients. As a family doctor in Ontario, I receive a substantial annual preventive care bonus that is scaled to the percentage of my patients who have completed breast, colon, or cervical cancer screening. Patients count toward my annual bonus only if they have decided to complete their screening. When I take the time to engage my patients in a discussion of the risks and benefits of screening, those patients who ultimately decide against screening detract from my annual bonus.

What effect are provincial bonus structures like this having on our discussions with patients? As much as I

would like to think I will do the right thing for my patient regardless of how I get paid, we are all still financial actors. In my view the bonus structure incentivizes a paternalistic “just get it done” approach over the shared decision-making strategy Dickinson et al advocate for.

—Jason Booy MD CCFP  
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**Competing interests**

None declared

**Reference**

1. Dickinson JA, Pimlott N, Grad R, Singh H, Szafran O, Wilson BJ, et al. Screening: when things go wrong. *Can Fam Physician* 2018;64:502-8 (Eng), e299-306 (Fr).

## Correction

In the English translation of the editorial that appeared in the August issue of *Canadian Family Physician*,<sup>1</sup> the term *stage* should have been translated as *rotation*, rather than *clerkship*, and the term *étudiant* should have been translated as *learner*, rather than *student*.

*Canadian Family Physician* apologizes for the error and any confusion it might have caused.

**Reference**

1. Ladouceur R. Assessment of family medicine residents. *Can Fam Physician* 2018;64:560 (Eng), 561 (Fr).

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