The demise of the rotating internship and family practice program expansion

View from the trenches

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In July 1988, the Quebec government abolished rotating internship and it became impossible for new physicians to obtain licences to practise medicine without having completed a 2-year training program. The legislation followed the Archambault Commission in 1985[1] and the Rochon Report in 1988,[2] which recommended that these 2 years of postgraduate training be provided under the aegis of family medicine.

The government aimed to change the ratio of specialists to general practitioners from 60:40 to 40:60,[1] with the expectation that the general practitioner would provide most of the common services more cheaply. McGill University, however, has traditionally emphasized classic specialization, rather than general practice, and its students are less inclined to enter family medicine. Of the 16 departments of medicine at various universities across Canada, the McGill Department of Family Medicine is the youngest, being established in 1974.

In spite of McGill's emphasis on specialization and problems with relative underfunding and undervaluing experienced elsewhere in Canada and North America,[3] the McGill Department of Family Medicine has grown and thrived. By 1987, 13 years after formation and before expansion, McGill's family medicine department was beginning to mature and enter a new era of growth, well-funded research, and national and international recognition.

Although the McGill family medicine faculty did not actively promote this change, the elimination of the rotating internship was welcomed. As a group, we always felt a strong pride in the quality of family medicine–trained physicians and believed that a 2-year program in family medicine produced a more well-rounded family doctor. New information suggests that the product is indeed an improved one.[4-7]

Thus, despite some reservations, as a faculty we consciously decided to view this development positively. The change from a 1-year flexible route to practice to an obligatory 2-year family practice training route has, however, caused some expected difficulties and conflicts, including:

- serious service problems in teaching hospitals, because of the cutbacks in rotator positions;
- some shift in the control and allegiance of large numbers of residents from specialties to family medicine units;
- some change in the attitude of specialties toward family medicine and an alteration of the power structure within the hospitals;
- concurrent, unprecedented interprovincial licensing barriers for doctors moving to Quebec, as a result of new, unique Quebec postresidency examinations;
- difficulties in recruiting new family medicine faculty from other provinces because of new examination requirements;
- a reduced pool of workers for "moonlighting" because residents have no access to licensing until completion of their training;
- possible change in the type of resident choosing family medicine because those that would have taken a rotating internship are now having to do a 2-year program, and there are fewer specialty positions available; and
- massive, rapid increases in family medicine resident numbers, resulting in an enormous teaching, staffing, financial, and environmental impact in the family medicine unit.

This is by no means a comprehensive list of the difficulties and challenges encountered as a result of the changes in requirements for licensure in Quebec. This article elaborates on these eight issues and explores the dramatic changes in family medicine and residency training in Quebec. These conditions are, for the time being, unique to Quebec, but other provinces are expected to move to a 2-year licensing requirement in the near future. Thus, the following analysis can assist those concerned with the future of family

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Table 1. **FILLED POSITIONS FOR CLINICAL TRAINING WITHIN FIRST YEAR OF GRADUATION FROM MCGILL UNIVERSITY[a]**

TRAINING POSITIONS	1987	1988
Rotating and mixed interns	75	0
Family medicine	44	76
Straight interns	65	66[b] (+28)
TOTAL	184	170

[a] *Figures were obtained from the Dean of Postgraduate Medical Education, McGill University, July 1990.*

[b] *Sixty-six positions received straight funding. Twenty-eight positions received funding on the condition that graduates practise in outlying areas.*

medicine in other provinces in anticipating and planning for analogous changes.

Service problems: cutbacks in rotator positions

Family medicine at McGill expanded from 44 positions in 1987 to 76 positions in 1989. There was a greater loss, however, in rotator positions and of residents in certain key specialties as the specialist to family physician ratio was altered and other political issues influenced McGill's attractiveness as a training site (*Table 1*). As well, there has been a shift in specialty resident staff in the three tertiary care hospitals[2]: the Royal Victoria, the Montreal General, and, to a lesser degree, the Jewish General. Two smaller teaching hospitals, the Queen Elizabeth and the St Mary's lost their specialty residents while maintaining large family practice units.

Teaching hospitals have always relied on the skills and easy availability of rotators and house staff to provide inpatient care. The reduced number of rotators has forced reorganization in order to maintain adequate patient care. As a result, more than ever before, family physicians are now being recruited by teaching hospitals to fill the void, and specialists are, in some cases, functioning more and more as consultants and in other cases are taking on the roles previously performed by house staff.

In recent years, the diminishing role of the family physician in the hospital has been an area of grave concern for family medicine,[8-11] and our role in McGill teaching hospitals has not been an exception. Feeling unappreciated, if not alienated, many of the previously trained general practitioners and family physicians retreated to the safety of their offices, and many lost their ward skills. Meanwhile, specialty residents, assisted by the rotators, became responsible for care on the wards. Our recent graduates, on the other hand, are more familiar with hospital work and seem more open to a new in-hospital role for family doctors.

Similarly, nurses in teaching hospitals have been excluded from providing many services. Nurses in community hospitals often have greater responsibility and are called upon to provide many more primary services. One initial potential solution to the shortage of residents in McGill teaching hospitals was to train nursing staff to provide some of the primary medical services as nurse-clinicians or nurse-practitioners. This solution was fraught with problems. Nursing itself is experiencing unprecedented shortages. Furthermore, the nursing profession is attempting to solve its staffing problems by offering work with more job satisfaction. This has been accomplished by trying to move away from being physician's assistants to having a more defined and respected independent role.

Increasing responsibility for nurses without increasing load by shifting some of the more menial tasks to nurse aides and orderlies is being attempted with some success. The development of academic nursing could, however, in the end, prevent these solutions from being implemented on a large scale. The delegation of certain tasks to nurses, in order to reduce residents' workload, is being explored.

Shifting control of training residents

Until 1988, it had been difficult for family medicine programs to negotiate an educational experience relevant to the needs of future family physicians within some of the specialties, as the specialties enjoyed the services of large numbers of their own interns and rotators. In addition, many faculty in the traditional specialties believed that the numbers of residents in family medicine did not justify creating a special curriculum to address their specific needs. While the specialists occasionally provided an excellent experience for family practice residents, it was more common for the family practice resident to be supernumerary and not integrated into the ward team. At times, he or she was viewed as an annoyance or obstacle to the real business of the specialty department: training their own residents. The removal of the rotators, cutbacks in the numbers of specialty residents, and an increase in the numbers of family practice residents all conspired to turn the tables dramatically, and new, more educationally pertinent curricula for family practice began to be implemented.

Rotators' experiences in the medicine, surgery, obstetrics, psychiatry,

and pediatric services had been co-ordinated by those specialties when on those rotations, and the overall rotator program was managed by the hospital director of professional services. At McGill, however, the family medicine resident continued to care for a practice of patients even while he or she was on specialty rotation and mandatorily attended the family medicine core education program under the educational control of the family medicine unit. The resident was required to return to the home unit for at least two half-days a week; one to see his or her patients and the other for the core teaching curriculum.

Furthermore, family medicine residents spent less time on some rotations compared with the time spent previously by rotators. Unlike the previous rotators, family practice residents are often more experienced and in their second year. They might therefore have specific expectations of their teachers and strong and conflicting objectives for their rotation. In one example, the Sir Mortimer B. Davis Jewish General Hospital lost 22 rotators in 1988 and gained only six more family practice residents. This meant that not only had the control of the residents' activities and education shifted from the specialties to family medicine, but that fewer residents were available, and they spent less time on the wards as a result of their family medicine obligations.

Not surprisingly, conflict between family medicine and specialties increases when they are competing for space, budgetary preference, and patients.[12] In Quebec, the specialties' sudden dependency on family medicine to provide residents fostered a new spirit of co-operation in some hospitals, as well as a much improved understanding of the educational needs of family medicine residents. In others, there was anger and frustration and, rarely, threatened withdrawal of specialty teaching.

At the same time, the understanding in all specialty programs was that, even for their own residents, "medical education must now return to the ambulatory setting."[13] This realization may have assisted relations between family medicine and the specialties, who now must develop outpatient experiences for their own residents.

Changing attitudes and power structures

As is the case in the United Kingdom,[14] few Quebec specialists knew of the skills of the family physician and the rich advantages they can bring to hospitalized patients, even though family physicians account for about half of the medical profession. Because there is an emphasis on specialization at McGill, the relative absence of impressive family practice mentors profoundly influences students' attitudes and eventual career choices.

Until recently, few residents and students were exposed to community family physicians caring confidently and comfortably for their patients in the emergency room, in the obstetrical services, and on the hospital wards. Bringing the family physician back into McGill teaching hospitals has undoubtedly positively altered the relationships that we have with our specialist colleagues. In order to deal with overall house staff shortages and preserve teaching for all trainees, innovative models have been tried in different hospitals. These include nonteaching family medicine and medicine wards, part-time participation of family physicians on teaching wards, and the hiring of family physicians to run wards.

Initially the specialists might have felt somewhat threatened by the new role of the family physician, but for some this has changed along with growing reciprocal need and respect. Fee negotiations in Quebec are currently attempting to encourage the family physician to work again in the hospital. In the future, family physicians might even be more generously compensated for caring for their patients in the hospital than they are now, and perhaps at more favorable rates than in their offices. The impact of changes in McGill students' attitudes to family medicine engendered by these occurrences should be monitored.

Licensing barriers

While other provinces have wrestled with the idea of a 2-year requirement for licensure through the Royal College, family medicine, and through a third route,[15,16] Quebec has taken a more dramatic stand: only two routes to licensure, certification as a specialist or as a family physician. The third route will allow graduates a license to practice general medicine after 2 years of training without meeting the certification requirements for either family or specialty practice. In these situations, some rotating internship positions will be retained.

The new Quebec arrangement, aimed at examining terminal skills for the purposes of licensure, requires that residents pass three examinations: the certification examination in family medicine, being used for the first time as an examination for licensure; a "Quebecitude" examination, which will test candidates' knowledge of the health system in Quebec administratively and legally; and a multi-module objective structured clinical examination (OSCE) to test physical examination skills and problem-solving ability. The examination section on Quebecitude is not unique to the licensing of family physicians and will be an examination requirement for the licensing of specialists in Quebec as well.

Becoming certified. Until 1990, graduates from family medicine programs became eligible to sit the certification examination only on the recommendation of their unit or program directors. This recommendation was made only if the candidate had demonstrated family medicine mastery and not just basic skills. This was determined late in

the 2-year family medicine residency year. This new application of the Certificate of Canadian Family Physicians' (CCFP) examination for licensing purposes could create problems for the process of certification, because licensure could require a lower level of achievement in the same College examination than certification.

Thus, for licensing purposes, as recommended in the Kendall report,[16] while the candidate can become eligible to sit, and even pass, the certification examination, in rare cases the candidate might fail to be certified. This comes at a time when the overall validity of the certification examination itself is still under question.[17,18] To further compound the examination process, the licensure issue would not seem to guarantee more qualified graduates.

This examination process, however, can be both a setback and an advantage. While the Cox report[19] recommended an examination for terminal evaluation on completion of the residency, this was to be a single national certification examination. The addition of a province specific examination section (covering provincial legislation and legal rights and responsibilities of patients and physicians, and the resources of and differences between the provincial health care systems) might well be overdue. Whether a multiple-choice examination will, however, ensure that the graduate has a good grasp of these issues is debatable.

Testing knowledge of the province. Previously, the McGill family medicine residency programs undertook to teach residents about the variety of resources available to them, as well as exposing them to many of the ethical, legal, and social responsibilities of a family physician. Emphasis on these areas could have been ensured through in-training evaluations, the program accreditation process of the College of Family Physicians of Canada and the Professional Corporation of Physicians, rather than by a licensing examination. Which method would have been more effective is now an academic question, as Quebec, and soon other provinces, introduce examinations on this subject. But an opportunity for a national standard of evaluation has been lost, and a potential impediment to portability between provinces has been raised, especially while Quebec and only one or two other provinces implement this expensive province-specific examination.

Examining clinical skills. The OSCEs are practical modules designed to examine physical examination and practice management skills. These are thought to be lacking in the College examination. Their introduction into the examination in 1990 as a pilot project could lead to incorporation nationally.

Implications. While it is hard to divine the intent of the planners, Quebec's new licensing regulations may be an attempt to put family medicine on the same footing as other specialties, by statutorily requiring a licensing examination. The use of the certification examination of the College of Family Physicians of Canada for licensure in Quebec is an unusual and potentially positive precedent. Quebec candidates from the other specialties have to pass an examination that is separate from the the relevant Royal College examination in order to practise their specialty. Paradoxically, in the case of family medicine, this CCFP examination could preserve national portability of family practice qualifications.

The local Quebecitude component is something of a test case; other provinces may institute similar province-specific examinations for licensure, focusing on the specific features of their particular jurisdictions. Until this happens, however, the OSCE and Quebecitude examinations could be a deterrent for those who might want to move or stay in Quebec.

Although out-of-province graduates will not require this examination for licensure in their home province, and family medicine residents have vociferously protested its implementation,[18] most, for practical reasons, wrote it last year. The examination was held on the same weekend as the national certification examination, and thus required no extra time. Many residents also anticipated doing locums in Quebec for a few months on graduating, and they needed the OSCE and Quebecitude examination as a basic requirement for licensure.

It should be remembered that McGill medical school graduates, as well as associated experienced physicians, are likely to be more proficient in English, and therefore more easily able to migrate to other provinces. The recent political events in Quebec, starting with the passing of Bill 178 and more recently the Meech Lake confusion, has resulted in a large exodus of McGill graduates. Francophone universities have not been affected in the same way. This new alteration in market forces puts McGill University at a relative disadvantage. Recruitment of residents to the family medicine program, at least in the short term, has seemed more difficult, especially because we have double the number of positions to fill.

New examination requirements impede faculty recruitment

The examination could dramatically reduce McGill's capacity to recruit faculty from elsewhere. Portability of experienced and high-level faculty has always been something of a problem in Quebec because of Bill 101 language requirements applicable to physicians and perceptions of the general political climate. Until 1989, the Licensiate Medical Council of Canada (LMCC) ensured transportability of Canadian graduates. Now, new arrivals in Quebec will not be automatically licensable, no matter what their experience. This state of

affairs could impede recruitment of faculty from other provinces, resulting in faculty inbreeding and stagnation.

Reduction of moonlighting

Family practice residents and specialty residents can now only obtain their licenses to practise upon graduation. This has had two effects. First, there has been a shortage of physicians in ambulance and emergency services in Quebec. Each Quebec ambulance has a physician on the team. In the past, many Quebec residents moonlighted for these services. Now that they are not licensed, their absence is being felt. Second, the moonlighting experience could have been an important maturing tool for family medicine residents. In any case, it was their first experience in independent practice. Many graduates have commented that it is a real pity to have lost this valuable self-testing or stepping-stone to independent practice. New residents are none the wiser, as this is no longer an option for them.

A restricted licence option could have been considered to allow residents to enrich their training, even earn some money, while at the same time provide essential services. For the first time during 1990, residents with heavy financial debts have had no method of supplementing their income, and this has increased tensions in an already demanding residency. One resident who is eligible for licensure in Ontario moonlights on weekends in Ottawa. This, of course, is a temporary option that will not be available when Ontario moves to a 2-year requirement for licensure.

Changing family medicine resident profile

Canadian Internship Match (CIMS) requires all medical students to have made their choices by December of their fourth year of study, before they have completed all their undergraduate rotations. At this stage, many students have not yet been exposed to family medicine as a career option. Choices made earlier might be inappropriate and might prematurely lock unsuitable residents into either family medicine or the traditional specialties. This could foreclose options because all the restricted residency slots would be full. The rotating internship, on the other hand, offered some flexibility to students who had not yet made up their minds about the choice of specialty versus family medicine.

In an unpublished 1986 survey, we found that only 39% of student respondents indicated that they had applied for admission to rotating internship or specialty programs in addition to applying for admission to family medicine. This figure rose, however, to 58% in 1988.[20] This could indicate that initially during expansion, a less committed student was applying for admission to family medicine. Unfortunately, these students might have more difficulty in family medicine and require more intensive teaching and remedial work. In addition, the increased size of the program results in more problems in the resident group. A by-product of this phenomenon has been increasing faculty expertise in resident remediation and counseling. This is a mixed blessing.

Other consequences of increases in family medicine residents

Rapid expansion has caused a number of problems, including recruitment of new faculty, faculty development, resident recruitment, resident morale and well-being, space requirements, overworked support staff, funding difficulties, and innovative methods of providing patient care.

The expanding family medicine units needed many more support staff to keep them running efficiently and smoothly. Adding new teams, not only with faculty and residents, but also with nurses and secretaries, was essential and required not only funds but space as well. The innovative ways in which the department dealt with these issues is beyond the scope of this article. At McGill, solutions included new satellite units attached to established parent units, new independent units in separate locales, expanded home units, and restricting the expansion of one unit.

Doubling the number of residents while maintaining the teaching model meant having to significantly increase the number of faculty. Because the expansion was not phased in, each unit had to hire a large number of teachers in a relatively short period of time. Many of the faculty hired were recent graduates requiring intensive orientation and faculty development. For many years, the department of family medicine had considered the idea of setting up a faculty development committee to address the teaching needs of its faculty, and the expansion provided the impetus to establish this committee. We can now say that we have developed expertise in faculty development and have sponsored workshops nationally and internationally.

Faculty development did not address the problems of inexperienced physicians, perhaps prematurely functioning as faculty, or of inbreeding. The department will need to evaluate the impact of these problems in the near future.

The teaching program depends on a critical number of patients for resident training and experience. Understandably, some units found it difficult to rapidly double their referral base. Besides, having to double the number of residents and the number of patients in the unit turned the unit, as one senior faculty member put it, "into a zoo." Innovative time allocations were implemented to deal with this, including evening clinics, alternative private office experiences, and the use of second-year residents as teaching assistants, thereby reducing their own clinics but continuing and complementing their training.

Resident morale in our unit hit an all-time low during the transition. Increased service requirements, inexperienced faculty, overextended managers, and delays in developing practical

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solutions did little to alleviate the stress. During this time, recruiting candidates for the following year was difficult, but this difficulty was only temporary. To solve the problems, hospital staff in all units worked together in a spirit of unprecedented co-operation. Our hospital established a Resident Well-Being and Recruitment Committee. By 1989, most of the dissatisfaction had diminished, and residents appeared to be more content.

Conclusion

The Canadian Medical Association (CMA) Task Force on Education for the Primary Services[21] and the CMA Invitational Family Practice Training Committee[19] recommended a single national standard of training for the family physician. Expanded family medicine programs in other provinces and 2-year requirements for licensure are direct results of these reports, the Kendall report,[16] which preceded and the Archambault Commission[1] and the Rochon Report[2] in Quebec.[1,2]

Quebec is not the only province that has implemented the 2-year requirement for licensure; Alberta did so with legislation in 1976, and all other provinces plan to follow shortly. The whole country is moving toward this 2-year licensure requirement by 1993. Nevertheless, Quebec alone has mandated training under the aegis of family medicine as the exclusive route to general practice. There is concern nationally that "the CFPC's training programs should not be the only route to general practice."[22] The Quebec experience, therefore, will not be repeated in other provinces planning to expand, and the transition could be less dramatic outside of Quebec.

At this stage it is impossible to fully evaluate the consequences of the expanded program. In some units, where resources were relatively small before expansion, the expansion has provided more space and more dollars. In others, where space and financial support was adequate, the expansion support was relatively less, and the dislocation greater. There is considerable concern that the overall size (more than an optimal 20 residents) could lead to a loss of intimacy and a sense of cohesion and common mission that characterized the halcyon days when the pioneers established their units in the early 1970s, which consisted of 12 to 20 residents. Further evaluation is clearly necessary.

For those family medicine units expecting to undergo some of the changes this article has described, it is hoped that most of the opportunities and impacts can be anticipated and planned for as a result of our experience of the transition. ■

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