Letters ❖ Correspondance

Reflections on walk-in clinics

Disappointingly, none of the articles[1-3] on walk-in clinics (WICs) in the March issue provided evidence to support or weaken the belief that managing health problems in for-profit WICs and emergency departments instead of family physicians' offices incurred higher costs per patient visit, involved more investigations per patient, or had a higher referral rate to specialists. Possibly no studies have been conducted. If this is true, it would be most remarkable in view of the health care funding problems for the last 10 years or more in Canada. One would think that at least one provincial government would have investigated this controversial issue that is considered one of many factors contributing to escalating health care costs.

Most family practice groups[2] continue to provide full-service primary care 24 hours a day, 7 days a week, but a sizable portion (42%[2]) do not. It appears that an increasing number of family practices offer telephone accessibility on weekdays 10 AM to noon and 1:30 PM to 4:30 PM and are closed one to two afternoons a week (with no backup outside these weekday hours); a scheduling system that allows for only a few extra patients to be seen each day; reluctance to work past the scheduled closing time; office practice restricted to patients who fall into a narrow healthy age spectrum; reluctance to cover evenings, nights, and weekends; and a failure to have backup coverage 24 hours a day, 7 days a week.

These practice patterns, which are characteristic of many Canadian family physicians, appear to have been directly responsible for the evolution and rapid expansion of WICs and the overuse of emergency departments. Thus it seems reasonable that family physicians should feel somewhat reluctant to criticize what they perceive as shortcomings of WICs.

At one time, patients used three important parameters to determine their choice of physician: availability, affability, and ability (prioritized in that order). While there is no reason to believe that the second and third qualities have diminished among today's practising family physicians, many family physicians have become less available. Limited availability combined with the declining comprehensiveness of primary care[4] compromises family medicine and might kill it. If current trends are not soon reversed, the journal name *Canadian Family Physician* might eventually become "Primary Care" to reflect its readers more accurately. (Cynics might be tempted to add "Physician Oriented.")

If the values of family medicine are to be preserved, then certainly the most appealing solution[3] to eliminate the inadequacies of WICs and family practice groups is for government to mandate that all access points to primary care (including WICs) provide full-service primary care 24 hours a day, 7 days a week.

In his well written editorial, Dr Rainer Borkenhagen[1] presents some insightful and sound philosophical observations on the value of time, lifestyles, and life goals and how these parameters are affecting primary care practice. Some of the aspirations of today's physicians do not dovetail with traditional family medicine, especially with continuity of care. The very future of traditional family medicine is being challenged by these new and evolving parameters.

In the same editorial, Dr Borkenhagen implies that all primary care is universally undervalued in Canada. That statement ignores factual and anecdotal evidence that many primary care providers (ie, family physicians, WIC physicians, hospitalists, and emergency physicians) in some provinces are receiving appropriate or possibly even excessive remuneration.

When Dr Borkenhagen sees regulating patient mobility as a solution, presumably he is referring to patient rostering.

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Contact us by e-mail at
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(905) 629-0893 or by mail to
Canadian Family Physician
College of Family Physicians of Canada
2630 Skymark Ave
Mississauga, ON L4W 5A4

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Mississauga, ON L4W 5A4

His next proposal is to resist regulating physician mobility. Consequently, the prospects of recruiting family physicians to rural areas grow dimmer all the time. I hope governments will soon realize that increasing student numbers is futile when fewer and fewer medical students (28% in 2001)[5] are choosing family medicine as their first choice for a residency program.

In recent years an increasing number of graduates of family medicine programs have decided not to practise as traditional family physicians. Of those who do, an inadequate number are willing to live and practise outside large urban centres with medical schools. Instead of resolving the rural family physician shortage, the problem escalates. The answer to this scenario is not clear, but if lifestyle goals prompt medical students to reject family medicine and prompt new family medicine graduates to reject practising as traditional family physicians, especially in rural areas, what options do governments have?

—Ross McElroy, MD, CCFP *(retired)*
Tavistock, Ont
by e-mail

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Residents as teachers: time for formal training

In the February 2002 issue of *Canadian Family Physician*, Dr Gutkin[1] addresses some of the misconceptions students have about family physicians. He refers to the new opportunities that "might" exist in family medicine for students interested in teaching as part of their careers.

In fact residents already have this opportunity to teach during their postgraduate training in family medicine. Residents play an influential role in educating medical students.[2-5] They not only model the professionalism and skills demanded by their specialties, they also are enthusiastic and understand the developmental stage of medical students or junior team members.[2] Family medicine residents (FMRs) have a unique opportunity to teach their juniors while modeling the four principles of family medicine.[5]

At most, if not all, medical schools, FMRs teach medical students and junior residents both on and off service. At the University of Toronto in Ontario, on-service teaching and

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mentoring opportunities for FMRs have been recognized as minimal; hence efforts are under way at the teaching units to increase FMR-student contact. Dr Gutkin also states that "the number of medical graduates selecting family medicine for their careers has been decreasing"; therefore mentoring will become increasingly important in overcoming declining interest. To further explore the role of FMRs, a resident project has just been completed through the Department of Family and Community Medicine at the University of Toronto, characterizing residents' teaching experiences and perceived needs and interests around teaching.[6]

This study was initiated when Royal College of Physicians and Surgeons of Canada (RCPSC) residents were given an opportunity to take teaching skills workshops at the University of Toronto.[7] This opportunity was stimulated by an RCPSC requirement that residents be allowed to learn how to teach.[8] A number of studies and pilot projects have looked at the benefit and use of workshops that employ the principles of adult learning in teaching residents to teach, but only a few have included FMRs. A submission was prepared for the Canadian Cancer Society/Educating Future Physicians for Ontario Project on teaching communication skills, detailing a successful experience teaching residents, including FMRs, to teach.[9] Overall, the results have been encouraging both in evaluations of the workshops and feedback provided by medical students assessing their "own" residents.[2-5,9]

Currently the College of Family Physicians of Canada does not have a statement on FMRs as teachers. We recommend that the College consider revising the standards of accreditation and include a requirement that programs offer opportunities for FMRs to develop their teaching skills. As more and more FMRs choose to do additional years of training as clinical fellows, their roles as senior residents and teachers will likely increase. Upon graduation, residents choosing to become faculty will continue to teach in ambulatory clinics and teaching practices in underserviced and rural areas. We should be providing the essential teaching skills in the form of training workshops to FMRs in all postgraduate programs in Canada, to meet current and future career needs.

—Bindu Kumar, MD
Second-year resident in family medicine
The Scarborough Hospital
Department of Family and Community Medicine
University of Toronto, Toronto, Ont
—Helen Batty, MD, CCFP, FCFP
Toronto, Ont
—Risa Freeman, MD, CCFP, FCFP
Toronto, Ont
—Anita Rachlis, MD
Toronto, Ont
—Wayne Weston, MD, CCFP, FCFP
London, Ont
by e-mail

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