Second thoughts on third-year training

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All across Canada, leaders in family medicine are trying to encourage family physicians to offer all the medical services the public needs. They are encouraging family physicians to maintain well-rounded practices and to provide a full scope of services within practice groups. At the same time, Canadian universities are offering family medicine graduates an ever-increasing range of third-year training programs. These programs are much sought after by residents since many intend to limit their scope of practice early on. Should the College of Family Physicians of Canada (CFPC) and university departments of family medicine be focusing their efforts on developing specific advanced skills or on turning out general practitioners with a range of skills?

Third-year training programs build on the basic training that all family medicine residents receive. The 2 compulsory years of residency provide all graduates with the skills they need to practise family medicine and with the basics in most of the fields offered in third-year training. Young physicians just starting out can gradually hone their skills in specific areas through continuing medical education (CME), which generally consists of short programs that are often more theory than practice. There are, however, dense, structured programs offered part time that lead to official certificates in specific fields, such as sports medicine. These courses are paid for entirely by participants.

"Third-year training programs" and "advanced training programs" involve full-time study with clinical rotations and formal course work. These programs are generally taken directly after residency and are administered by university departments of family medicine. Depending on the field, they deliver either very structured curriculums, which are similar across Canada, or curriculums customized to the needs of individual students. The programs require a 3- to 12-month commitment, and students earn a salary. These programs are accredited by the CFPC and lead to a certificate of competency from the university delivering the program.

A hugely popular formula

In 1982, the CFPC recognized the third-year training program in emergency medicine with its own accreditation criteria, examination, and certification (personal communication from Rainsberry P, CFPC Director of Education, 2003). A program in care of the elderly followed shortly thereafter, but this time there was no national examination. More recently, a program in palliative care was accredited jointly by the CFPC and the Royal College of Physicians and Surgeons. Talks are currently under way for an accredited program in anesthesia. Throughout the years, many universities have developed programs based on regional needs and local expertise.

According to the most recent survey conducted by the CFPC's Section of Residents,[1] there are approximately 20 distinct programs. Some are available in all parts of the country; others are offered by a handful of universities (eg, aboriginal health care and psychotherapy). Variations in the names of these programs reflect variations in perspective, such as obstetrics, low-risk obstetrics, advanced maternity care, and maternal and infant care. Understandably, in 2002, the CFPC decided to regroup all of these courses under the title "Advanced Skills Programs in Family Medicine."[2] The CFPC stipulated that, to be accredited, a program had to be offered under the sponsorship of a university department of family medicine, even when taught by a combination of family physicians and specialists.

Despite the range of courses offered, a lack of stable funding limits access to third-year residency positions. In 2000, the CFPC reported that "at least 40% of residents completing their 2-year program

in family medicine were interested in additional training, but the number of third-year positions available could accommodate only 10% of them."[3] It was recommended that four times as many positions be made available, a recommendation echoed by residents.[4]

Effect of third-year training programs on the profession

In my view, the proliferation of third-year training programs has both positive and negative consequences. Acknowledging the expertise of family physicians and their contribution to the development of medical knowledge is probably due, at least in part, to the creation of structured programs in very specific fields of practice, such as palliative care. Our society values the services that family physicians provide to underserviced populations (eg, drug addicts). In certain fields where family medicine and the specialties overlap, family medicine graduates entering the work force with additional credentials help to give family medicine credibility (eg, in emergency medicine and obstetrics).

Sometimes these programs provide sophisticated expertise to family physicians who provide comprehensive care to very specific populations. Often these physicians are part of multidisciplinary teams with specialists and other health care professionals, and there is a research component. Teams like these are found in urban areas where large concentrations of people make it possible and appropriate to target services. Third-year training in drug addiction, HIV and AIDS, and women's health are three such areas. These family physicians have such unique skills that they become sought-after CME trainers. They might even create new specialties that could eventually be recognized by the Royal College.

Residents find that this intensive form of training enables them to achieve rapidly a level of expertise that their older colleagues took years to acquire through practice. Training in rural medicine is an excellent example of this. This program has the unique feature of combining advanced skills and maintaining the scope of practice. In other areas, graduates of the third-year training programs often help their colleagues manage more complex cases, such as those seen in mental health and care of the elderly. These graduates are also relied on to help organize services regionally and to develop research in their fields of interest.

The development of third-year training programs has met a need for care; it has also helped to give family physicians credibility in several growing fields of practice. In offering these programs, university departments of family medicine have fulfilled their mission with respect to the development of knowledge. This proliferation, however, could have other, less positive consequences for the future of family medicine as a discipline.

My first concern is the message we are sending to graduates in the regular stream. We live in a world that measures people by academic degrees and expertise. Regular graduates might think, therefore, that they are worth less if they have done a residency "only" in family medicine. Graduates with the best academic record have the best access to advanced training, which is generally very specific, while their colleagues, who graduate after 2 years, have to take on a diversified practice, which is an additional challenge. With all of the other challenges to family medicine, can we afford to be sending out this mixed message?

My second concern is that, in their current form and taking into account practice context, most of these programs turn out physicians geared toward practising in a single field. Can we knowingly endorse this when there is such an urgent need for family physicians who are able and ready to offer a range of services with a group of colleagues? Obviously, this does not apply to programs providing advanced training in rural medicine.

My last concern is that development of advanced training programs will lead to development of new specialties that could speed the exodus of family physicians out of more fields of practice and lead to the loss of our holistic view of patients.

Promoting family medicine with breadth and depth

The emergence and proliferation of third-year training programs is part of a natural trend. And

yet, this trend could do a great disservice to family medicine by undermining the credibility of "generalist" graduates and promoting further compartmentalization of tasks.

To reduce this risk, I recommend:

- that the main form of "advanced training" offered by any university be "a broad and diverse practice of family medicine" with value added to the 2 current years and universal access to this training;
- that the criteria for accreditation of more specialized advanced training programs include the maintenance of a large scope of practice until completion of training, ie, ongoing care to an undifferentiated patient population;
- that advanced training programs be supervised primarily by family physicians and that they model and promote the identity and skills of family physicians; and
- that the universities and the CFPC reflect together on the paradoxical effect that the proliferation of advanced training is having and redirect their efforts accordingly.

The proliferation of advanced training does not augur well for our discipline. I suggest that we explore, instead, the possibility of a 3-year residency for all residents, combining broad-based practice and the development of specific skills based on individual interests. In the medium term, this strategy would more adequately serve our patients and the development of excellence in the discipline of family medicine.

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