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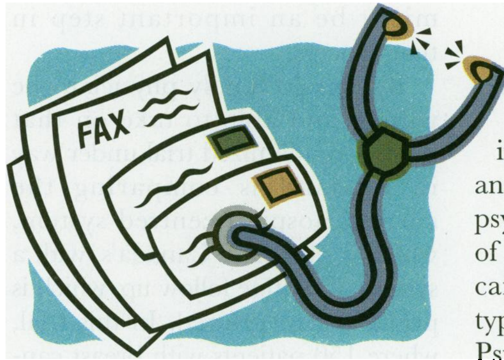

Residents learning psychotherapy

I found Dr Swanson's article[1] on psychotherapy very interesting. As a second-year family medicine resident, I couldn't agree more that we need better and more innovative methods to learn the art of psychotherapy in the 2 short years of residency. The traditional 1- or 2-month block rotations in psychiatry do not optimize the trainee's exposure to the various psychiatric problems that family physicians encounter.

To maximize my learning experience in psychotherapy and psychiatry, I have set up a yearlong longitudinal elective with the approval of my program director. I spend up to half a day a week seeing patients for up to 1-hour sessions in the family practice unit, either weekly or biweekly. A staff psychiatrist from my hospital has agreed to be my supervisor. We meet weekly for an hour to discuss the cases and plan future management.

Patients are referred to me from the Departments of Psychiatry or Family Medicine. My supervisor is ultimately responsible for the patients and therefore bills the patients I see and discuss with him. He is also available to the patients when I am away on teaching practices. I have found this method to be extremely useful and exciting, and I do hope that it will help me to provide effective psychotherapeutic care to my future patients.

I wonder whether this method of instruction would be appealing to other family practice units. The advantages are many. It allows residents to develop therapeutic relationships over time. Trainees can explore and manage many important processes and dynamics and can also learn different types of psychotherapy under the guidance of their supervisors. The case load can be varied easily to reflect the types of problems seen in practice. Psychopharmacology can also be learned because there is adequate follow up for patients prescribed psychotropic medications. Videotaped interviews, if used, will allow for further review and learning; direct supervision in time is unnecessary.

A potential pitfall that could preclude this form of training is reticence on the part of trainees to undertake such training. The perceived need for these skills while in residency is low because we are struggling to master managing "organic" or "real disease" processes. However, if our future practices will have patients with emotional disorders, it behooves us to be competent mental health care providers as well. Also, finding a suitable supervisor could be difficult in some settings. However, all teaching centres have a Department of Psychiatry with several staff psychiatrists. Supervisors could also be GP psychotherapists, psychologists, or social workers if psychiatrists are unavailable.

With the increasing burden on psychiatrists, many are referring patients back to family physicians for ongoing psychiatric or psychotherapeutic care. Family medicine residency programs should consider this approach to equip us to deal with the many patients with

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psychosocial or psychiatric disorders that we will encounter.

— *Peter Selby, MB, BS*
Toronto

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Family physicians caring for cancer patients

Dr Dworkind and colleagues[1] ask whether urban family physicians are willing to take on the task of continuous care of cancer patients, and if they are, whether they feel knowledgeable enough to meet the challenge. This question arises out of concern for the growing separation between family physicians and their patients with cancer; a phenomenon that the authors rightly suggest is a problem in Great Britain as well as in Canada.

The reasons for this separation are complex,[2] with both family physicians and oncologists contributing to the problem.[3] However, there is good reason to suppose that both continuity of care and quality of life might be enhanced if care of cancer patients were primary care–centred rather than hospital-centred. For this reason, recognition of the importance of community care of oncology is gaining momentum.[4,5]

Breast cancer is one oncologic problem that might be particularly amenable to community care, especially during the follow-up period. Patients with breast cancer have a good prognosis with long disease-free intervals during which the skills necessary for follow up are within the reach of family physicians. Furthermore, women with breast cancer would benefit from having their lives return to normal as quickly as possible. Follow up by family physicians might be an important step in that process.

But would family physicians be willing and able to take on that role? A randomized trial under way in England is comparing the current hospital-centred system, which is similar to Canada's, with a system of routine follow up, which is primary care–centred. In this trial, where 150 patients with breast cancer in remission were randomized to receive follow-up care from their own GP, only two GPs refused to provide the care – refused for administrative reasons, not because they felt unable to provide the care. This supports the suggestion by Dworkind et al[1] that family physicians might be willing to take on the role for their own patients.

Another question is whether patients would be willing to have their family physicians take on that role. In this trial, 67% of eligible patients accepted randomization despite being told repeatedly, before the study began, that it was important to come to hospital for their follow-up visits. This suggests that they had sufficient confidence to have their routine breast cancer care provided by their family physicians.

The most important question, however, is whether quality of care or quality of life are affected by this devolution of follow-up care to the community. It is this question that the trial is designed to evaluate.

— *Eva Grunfeld, MD, CCFP*
Oxford, United Kingdom

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Is a third year necessary?

I applaud Lloyd et al[1] for embarking on a study designed to assess the needs of a community. Assessing need is an arduous task. Coupled with this are the problems described by Moore[2] of quantifying work patterns of physicians and assessing quality of care.

The purpose of this study was to assess the needs of the community for the proposed third-year residency positions in family medicine. I challenge the validity and usefulness of this paper on the basis of the authors' choice of data and the lack of evidence that there is a need for a third year in family medicine training.

This study is based on the perception of need by district health council (DHC) executive directors and chief executive officers (CEOs) of hospitals. The authors have acknowledged this at the beginning of their discussion; however, the only conclusion that can be drawn from this survey is that DHC executive directors and CEOs of hospitals, when given a