Survey of Third-Year Postgraduate Training Positions in Family Medicine

NICK BUSING, MD, CCFP

SUMMARY

In a survey of 16 program directors of residency training in family medicine, respondents were asked about numbers and types of third-year positions they offer. As Canadian educational programs move toward implementing or expanding 2-year prelicensure requirements, many directors are exploring the need to add even more positions for adequate training in primary care. Respondents offered suggestions on tailoring strategies in view of the educational, political, and economic climate.

RÉSUMÉ

Dans une enquête effectuée auprès des 16 directeurs de programmes de médecine familiale, on a questionné les répondants sur le nombre et les divers types de postes de résidence de troisième année qu'ils offraient. Puisque les programmes éducatifs canadiens s'orientent vers l'implantation ou l'expansion de programmes de deux ans avant l'obtention du permis d'exercice, de nombreux directeurs explorent la nécessité d'ajouter des postes supplémentaires pour satisfaire les exigences d'une formation adéquate en médecine de première ligne. Les répondants ont offert des suggestions sur les stratégies organisationnelles qui tiennent compte du climat éducatif, économique et politique.

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IN 1984, THE CANADIAN MEDICAL Association Task Force on Education for the Provision of Primary Care Services recommended that "sufficient extra residency training positions be funded to allow some family physicians to develop areas of special competence."[1] In the same report, the Task Force examined the length of training for family physicians and stated that, "given the professional goals we have assumed for the family physician, we cannot defend the disparity of training efforts expended on the generalist and the specialist. Either the generalist is under-trained or the specialist is over-trained."

At present, family medicine programs are 2 years long. In the next few years all provinces will require a minimum of 2 years of prelicensure training for all postgraduates, be they generalists or specialists. It is recognized that family medicine training is the preferred prelicensure route to general practice. These programs are currently expanding and trying to meet the increasing requests of medical students for admission.

However, the core curriculum in family medicine is exceedingly full. Program directors receive constant requests from specialists arguing for inclusion of their particular subject areas in the basic 2-year program. All of the programs are built around core family medicine training (at least 8 months). Beyond this family medicine training, curricula have many variations. For example, some programs provide specific surgical rotations, while others do not. Some programs have 3 months of obstetrical training and others less. Only some programs have geriatric rotations.

It is increasingly difficult to design a 2-year program that meets all the demands. These demands arise not only from our specialist colleagues, but also from the accreditation and licensing authorities. As well, residents are demanding more and more flexibility to shape their programs to meet their individual interests and needs.

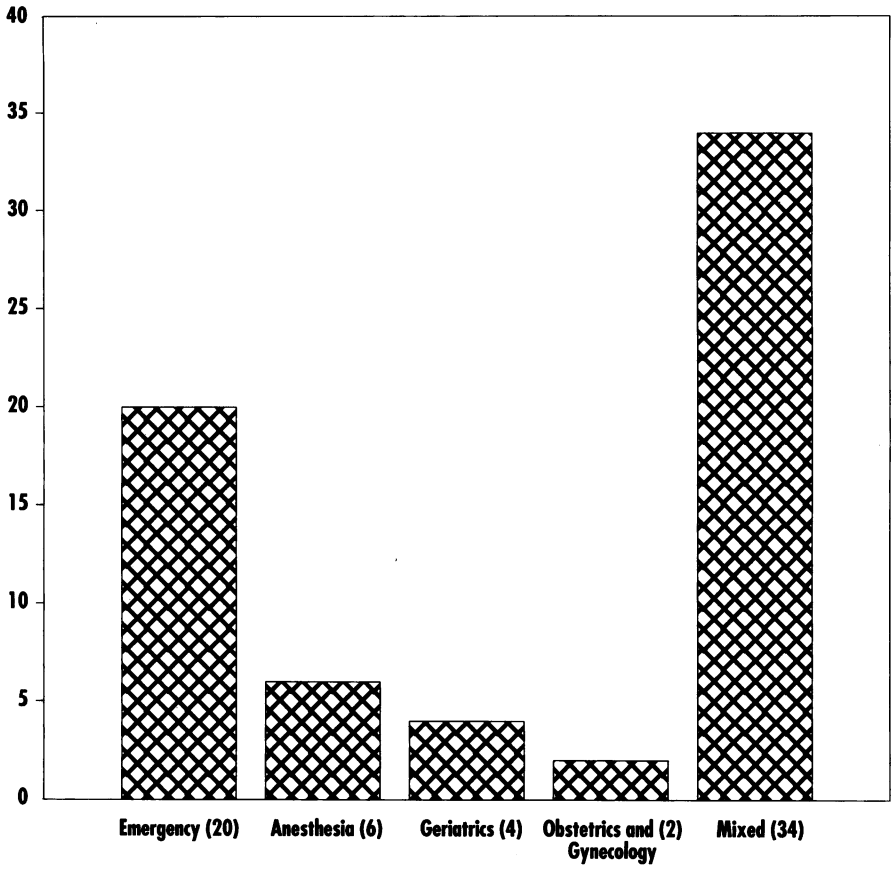
In this environment, family medicine educators are concerned that a 2-year program is not long enough. Currently, program directors are working within the constraints of a 2-year program and arguing for selective third-year positions (R3) in addition. These positions can be used to provide additional skills for rural and remote practice, to train teachers and researchers, and to achieve special competence in emerging disciplines.

Unfortunately, few studies in the Canadian literature analyze the length of train-

Dr Busing, *a Fellow of the College, is Assistant Professor and Director of Postgraduate Education in the Department of Family Medicine, University of Ottawa, Ont.*

Figure 1. **POSITIONS AVAILABLE IN SPECIALIST DISCIPLINES**

Mixed – positions were used for single-discipline training, but the exact number was unspecified in responses, or positions were used for mixed training.



ing required for family physicians to meet the community need. In 1984, Drs Curry and Woodward undertook a survey of Canadian primary care physicians for the CMA Task Force on Education for the Provision of Primary Care Services.[2] In their survey, graduates from family medicine programs, rotating internships, and mixed internships were surveyed. They were asked to describe their programs and to comment on changes they would have made to their programs. Most of the respondents (62%) would choose the same training route, if they had the opportunity to do it again. However, among the respondents who said they would change their programs if they were to repeat their education, 20% would change to a 3-year family medicine program.

In a survey by Ferentz and colleagues, 50% of recent graduates surveyed who practise in rural areas in the United States favored longer training than the basic 3-year family medicine residency currently offered in the United States.[3]

In order to respond to the proposals that there be more R3 positions available in family medicine, it is essential to begin with an analysis of the current situation. A database of current R3 positions is necessary. Attempts to describe the need for R3 positions in the future precisely are required; only then can rational training programs be undertaken.

In the fall of 1989, I undertook a cross-Canada survey of all family medicine residency training programs to determine the current number of and perceived need for R3 positions in family medicine. In October of that year, I mailed a questionnaire to all program directors and followed up with a reminder and a repeat questionnaire to non-responders several months later.

RESULTS

The survey included eight questions and could be completed in less than 0.5 hours. All 16 of the program directors (100%) responded to my questionnaire.

Third-year positions available

Program directors were asked whether they had any R3 positions in their family medicine programs. Six programs (38%) had no R3 positions. Three programs (19%) had R3 positions in emergency medicine only. The remaining seven programs (43%) had positions available in a variety of disciplines or in mixed training. Of the seven, three universities had positions available in anesthesia. Four programs had positions for geriatric training. Two programs had positions for a third year in obstetrics and gynecology. In all, eight programs had emergency medicine training positions.

In four programs, R3 positions could be individually tailored for rural practice, emerging disciplines (eg, palliative care), specialty substitution skills (eg, surgery), and academic family medicine. *Figure 1* shows the number of positions available in specific disciplines. Unfortunately, in many instances the respondents indicated that they had positions available in a number of disciplines but did not indicate how many in each one. These numbers are included in the "mixed" category.

Positions lost

The program directors were asked whether they had lost any third-year positions in recent years. One program indicated that such a position had been lost.

Positions from other university departments

Some speciality departments had made positions available for training of family medicine residents. Nine program directors reported that they might have positions available to them. In five programs a total of eight positions were available for anesthesia training. Ten positions were available in programs for training in an individually designed third-year program. These positions were available on a case-by-case request. In addition, family medicine program directors can occasionally obtain an extra position for third-year training from the university pool of positions that would go unfilled.

Defining the need

Program directors were asked to speculate about the need for R3 positions and to estimate the numbers needed. Thirteen programs identified a definite need for R3 positions. Most respondents suggested positions were needed for training to provide additional skills for rural and remote practice. Training in obstetrics, anesthesia, and geriatrics was specifically mentioned in some replies.

Regarding the numbers of R3 positions needed, five program directors did not give an estimate. The program directors from the Ontario Departments of Family Medicine suggested that at least 40% of second-year residents should have access to R3 positions. Other program directors' estimates of the numbers required ranged from 18% to 80% of the graduating classes of second-year residents.

Educational, political, and economic climate

Program directors were asked to describe the educational, political, and economic climate in which requests are being made for R3 positions. Some directors responded that universities and government are receptive to requests for positions when a specific need is identified or when the additional training is for graduates going into rural practice. Most respondents, however, believed the climate was generally poor for seeking additional positions. Some directors believed that, with the expansion of 2-year training programs, there would be little likelihood of getting additional R3 positions.

How to demonstrate the need

The program directors were asked for suggestions that would better demonstrate the need for R3 positions when speaking to university colleagues and governments. A range of opinions was offered. Some suggested that all graduates entering a rural or remote practice should have a third year of training. It was suggested that, the better trained a family physician is, the more cost effective he or she is to the system. It was

pointed out that keeping a resident in training for an additional year will provide a significant savings to the government, because a salary for a third-year resident is far less than the average family physician bills in 1 year of practice.

A number of directors suggested that any requests for R3 positions should be tailored to the obvious needs, such as for general practitioner anesthetists. It was also suggested that a survey of second-year residents could help to define the need for additional training more clearly.

DISCUSSION

The nine programs in which the program directors gave a specific estimate of the numbers of R3 positions required were analyzed. When compared with the current second-year resident population in these nine schools, the program directors, on average, suggested that 46% of the graduating class should have training opportunities in R3 positions. Extrapolating this percentage across the country, that creates a need for 256 R3 positions when compared with the current second-year residency population of 640. This study identified 66 R3 family medicine positions currently available in the country, clearly inadequate when compared with the need described in this survey.

Currently the fewest R3 positions are in eastern Canada and in the far west. The respondents from these areas suggested that financial constraints and the political climate had a lot to do with the lack of additional training positions.

Quebec has enlarged its complement of second-year positions dramatically. The rest of the provinces in Canada are moving toward a 2-year prelicensure requirement and the accompanying expansion of family medicine residency training positions at this level. The program directors appear to be concerned that there is resistance to adding even more positions for a third year of training. However, the program directors have also identified a clear need for these positions, and some have pointed out that 2 years of training is a minimum and that optimally all family medicine trainees should have a 3-year program. In the United States, the American Board of Family Practice requires 3 years of training for eligibility to write the examinations; the Royal College of General Practitioners in the United Kingdom requires 4 years; and the Royal Australian College requires 5 years.

Recognizing that a 3-year program is likely not yet achievable, there should be a hard push to gain more R3 positions based on very specific and identified needs. These needs include general practitioner anesthetists, specialty substitution skills for physicians going into rural areas, more teachers in family medicine, and more expertise in the emerging disciplines, such as palliative care, occupational health, and geriatrics.

Community-based training programs began during 1991 in Thunder Bay and Sudbury, Ont. Graduates will need additional skills to branch out into smaller remote communities where there is less speciality backup.

CONCLUSION

Dialogue should be broadened with manpower planners but is equally important with Royal College specialists. Our job as family physicians is to provide high-quality primary care to the people we serve. This requires appropriately trained physicians, whose needs could be different depending on the location and type of practice.

This survey described the current R3 residency population in family medicine and demonstrated that program directors believe there is a real need for additional training positions for many family medicine residency graduates. Respondents suggested some strategies for obtaining more positions. ■

Requests for reprints to: *Dr Nick Busing, Family Medicine Centre, 210 Melrose Ave, Ottawa, ON K1Y 4K7*

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