geographic component, an information component, an interdisciplinary component, and a chronologic component.

In our residency training programs, we should not consider one component of continuity of care as either the most important or the only component. We need to acknowledge that it is a multifaceted concept and can be taught and learned in many ways and settings.

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The other side of primary care: human resources

While recent articles comment favourably on the strength of primary care in the Canadian health care system, little attention has been given to the importance of financial and human resources in the departments of family medicine of Canada's 16 medical schools.[1-4] We suspect that most readers are unaware of the number of full- and part-time colleagues in our 16 departments.

In 1992 we surveyed the chairs of the 16 departments, and all responded. Full-time faculty was defined as holding formal full-time faculty appointments, at least a 60% time commitment, and method of payment and tenure or non–tenure track were not determinants. Part-time faculty was defined as holding formal faculty appointment, irrespective of funding, and a time commitment of less than 60%.

Faculty appointments are held by 2520 family physicians, and an additional 501 are clinical teachers without university appointments (*Table 1*).

Departments vary considerably in size from a low of 18 members (13 full time and five part time) to a high of 354 (108 full time and 246 part time), with an average of 173 (37 full time and 136 part time). Non–family physician faculty include a variety of disciplines, such as social workers, nurses, clinical psychologists, and emergency medicine physicians.

Department members and family physician teachers without academic appointments are involved extensively in educating medical students in community electives, required clerkship experiences, and office-based training. More than $3 million is available annually for funding community family physician supervisors with students and residents in their practices. The amount ranges from none at one school to over $600 000 at another, with an average of $186 865.

Table 1. **Appointment categories in Canadian departments of family medicine**

	GEOGRAPHIC FULL TIME	GEOGRAPHIC PART TIME	FAMILY PHYSICIAN TEACHERS WITHOUT APPOINTMENTS	TOTAL
Family physicians	509	2011	501	3021
Non–family physicians	79	161	—	240
TOTAL	588	2172	501	3261

The findings from our survey reveal the extensive contribution by most provincial governments and medical schools to supporting strong departments of family medicine in Canada.

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Thrombolytic therapy a standard practice

It is encouraging to know that thrombolytic therapy is widely available throughout northern Ontario; however, we are concerned with Dr Hutten-Czapski's assertion[1] that the use of thrombolysis followed by transfer requires a "worrisome leap of faith."

Rather than being a unique practice, thrombolytic therapy is a standard form of treatment in rural Alberta. Preliminary analysis of a questionnaire sent to all rural hospitals in Alberta showed that 83% (n = 48) of hospitals responding provided thrombolytic therapy. Of these, 48% (n = 23) electively transferred the patient after thrombolysis to referral centres.

A number of studies have suggested that thrombolytic therapy is a safe practice.[2,3] With a mean distance of 165 km from these Alberta hospitals to their referral centres, we would estimate that administering streptokinase or tissue plasminogen activator would be delayed by at least 2 hours if transfer took place before thrombolysis. As the efficacy of thrombolysis depends critically on time,[4] we believe that such a delay is unacceptable. Hospitals lacking the capability to provide continuing care for patients with acute myocardial infarction should instead be encouraged to give thrombolysis before transfer.

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