



workload, without considering the intensity of the visit. The number of patient visits per physician may give a good estimate of income, but it is a poor estimate of workload.

The second problem is in attributing the workload of emergency department visits. The authors do not include emergency physicians in the definition of a generalist physician, although they include emergency department visits in their definition of ambulatory visit. Rural generalist physicians provide almost all emergency services in their communities, but the authors do not make clear the number of emergency department patients treated solely by generalists in the urban environment.

The third problem is the lack of any consideration of the specialist functions performed by rural physicians and the proportion of their workload relating to functions that would not normally be done by an urban generalist. In my community (where no physician has specialist certification) we routinely provide complete medical care for uncomplicated myocardial infarction, appendicitis, trauma and major psychiatric disease (among other conditions) and perform obstetric and gynecological procedures (including cesarean section) and anesthesia. We also perform many outpatient procedures, including biopsy and minor operations, that are seldom performed by urban GPs.

The authors' inability to appreciate the distinctiveness of rural practice is made clear by their statement that 16 000 visits to Winnipeg physicians by residents of the North would have required 4.6 physicians in the North, but only 2.8 Winnipeg physicians "because of their higher workload." The implication is that visits to urban and rural physicians are equally intense and that Winnipeg physicians could perform the same functions, seemingly more efficiently. They would not and likely could not. One might consider what proportion of those 16 000

visits ended with a specialist referral that would not have occurred had the patient seen a rural physician.

Solving the maldistribution of physicians is not simply a matter of shifting urban family physicians to a rural environment. Physicians need additional training to feel comfortable in a rural setting. Ten years ago this would have meant a rotating internship plus additional training in obstetrics, anesthesia or surgery. It now means a 2-year residency in family practice with a rural stream, plus an additional year in a specialty. Only 2 of the 7 authors of this study are physicians, and it is unclear if either of them has experience as a rural practitioner. Researchers who plan to make comparisons between urban and rural family practice should seek the participation or advice of those who know the differences.

Gordon B. Hutchinson, MD, PhD

100 Mile House, BC
Received by email

[Two of the authors respond:]

Dr. Hutchinson's criticisms betray a misunderstanding of our technique. In addition, our successful Manitoba experience in training and placing family physicians in rural practice suggests that thinking of rural medicine as a distinct discipline may be misplaced. We wish to underline 3 points.

First, we accounted for what Hutchinson calls the "intensity of the visit," as well as the specialist functions that rural GP/FPs perform, by determining the average annual number of ambulatory visits for physicians practising in different settings (e.g., urban centres, the Rural South, the North). This gave us an estimate of the number of visits a new physician might expect. Our focus on visits captures the key services delivered by generalist physicians in both urban and rural settings.

Other approaches count the number of physicians serving residents in a given area and compare physician-population ratios. Hutchinson rightly suggests that because family physicians servicing a rural area spend much of their time doing surgery, delivering babies and providing anesthesia, a ratio-based approach tends to overestimate physician contact with residents; our approach explicitly acknowledges this. Moreover, variations in the visit workload of physicians across areas seem greater than those recognized by most ratio-based methods. In Winnipeg, generalist physicians received on average 22% more visits per physician than those in the Rural South; the differential was much greater for northern physicians. Typical adjustments of target ratios for family physicians that recommend more physicians for rural than urban areas insufficiently account for these differences. The Saskatchewan Physician Resource Planning Task Force¹ recommended family physician ratios for urban and regional centres and for rural areas that recognized only an 18% difference from the highest to the lowest, less than the workload differences we have identified. Unless such ratios are adjusted, rural areas will be penalized.

Second, we included emergency physicians and their work in calculating physician deficits and surpluses. They were excluded only when we estimated the average visit workload of generalist physicians.

Third, one of our team (P.K., head of the Department of Family Medicine) has direct experience with rural medicine, having practised in a rural setting in Manitoba and the UK. In the Manitoba Family Medicine Program all residents gain experience in both urban and rural settings, and more than half of those graduating over the past 3 years now practise in rural areas of Manitoba.

We share Hutchinson's concern



that a better way of determining physician supply requirements is needed. Our approach recognizes the unique characteristics of rural practice and goes a long way toward providing a better alternative.

Noralou P. Roos, PhD

Professor and Co-director
Manitoba Centre for Health Policy
and Evaluation
Winnipeg, Man.

Peter Kirk, MB, ChB

Professor and Head
Department of Family Medicine
University of Manitoba
Winnipeg, Man.

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1. *Physician resource requirements for Saskatchewan. Phase I report.* Saskatchewan Physician Resource Planning Task Force; 1994.

A futile search

For their article "Provision of preventive care to unannounced standardized patients" (*CMAJ* 1998;158[2]:185-93), Dr. Brian Hutchison and colleagues might have found greater use of the recommendations of the Canadian Task Force on the Periodic Health Examination if these recommendations were more readily available. I was unable to find them on the CMA Web site or through any Internet search. I phoned Health Canada and was told that the purchase price of the 1994 recommendations is \$69.95 — but the book is currently out of print. These guidelines probably need revision and would be well suited for posting at an independent Web site.

Ronald A. Blattel, MD

Ottawa, Ont.
Received by email

[Dr. John W. Feightner responds:]

Dr. Blattel raises some important issues related to the availability of guidelines and recommendations for physicians. The Canadian Task

Force on the Periodic Health Examination shares his concerns about the importance of dissemination. In the past, apart from the publication of our 1994 *Canadian Guide to Clinical Preventive Health Care*,¹ we have disseminated most of our recommendations and background evidence through *CMAJ*. We are fortunate in that *CMAJ* has a wide readership, and this has been an important vehicle for our work. Increasingly, however, we and others have recognized the need for additional means of dissemination, in particular the electronic media. The task force is now developing its own Web site, which will provide access to its recommendations and the background evidence. Discussions are also under way to explore the feasibility of a limited run of additional copies of the 1994 publication.

Although we hope that the electronic route will enhance the availability of the task force's recommendations, dissemination is only the starting point. Regrettably, it is rarely sufficient to ensure full "uptake" of the recommendations.² Full implementation across the primary care system is much more complex and challenging. The work of Dr. Hutchison and his colleagues provides important additional information to those concerned with how best to support family physicians in their efforts to provide effective preventive health care.

John W. Feightner, MD, MSc

Chair
Canadian Task Force
on the Periodic Health Examination
Parkwood Hospital
London, Ont.
Received by email

References

1. Canadian Task Force on the Periodic Health Examination. *The Canadian guide to clinical preventive health care.* Ottawa: Health Canada; 1994.
2. Davis DA, Taylor-Vaisey A. Translating guidelines into practice. A systematic review of theoretic concepts, practical experience and research evidence in the adoption of clinical practice guidelines. *CMAJ* 1997;157(4):408-16.

Editor's note: *The Canadian Guide to Clinical Preventive Health Care* is available electronically through the Health Canada Web site (www.hc-sc.gc.ca/hppb/healthcare).

The torch is lit and burning, thank you!

The article "First the bad news . . ." (*CMAJ* 1997;157[12]:1675-6), by Drs. J. Dick MacLean and Brian J. Ward is in general a succinct and informative summary of recent news on tropical medicine. However, the authors assert that a bad-news item has been the closure of the Health Sciences Division at the International Development Research Centre (IDRC), and they claim that the Canadian International Development Agency (CIDA) "has been too slow to pick up *the torch dropped by IDRC*" (emphasis added). These statements could not be further from the truth. The IDRC did not close its Health Sciences Division any more than it closed its Social Sciences or Environmental Sciences divisions. What it did was move away from a unidisciplinary approach to development research and toward defining 6 development research themes and 15 programming units that zero in on specific issues, including health-related problems.

The Strategies and Policies for Healthy Societies theme incorporates 3 program initiatives with a strong health component. Moreover, health research is present in other programs that focus on the impact of macroeconomic policies and structural adjustment programs on health and health care in the South. Since the "closure" of the Health Sciences Division, the IDRC has spent \$12.7 million funding 50 health projects in 35 countries. Furthermore, the IDRC has been active in developing a new initiative on lung problems, which account for 25% of the total burden of disease in