

so that he or she also has a summary of the patient's medications at discharge.

Ann Davidson

Pharmacist
Peace Arch Hospital
White Rock, BC

REFERENCE

1. Forster AJ. Can you prevent adverse drug events after hospital discharge? *CMAJ* 2006;174(7):921-2.

DOI:10.1503/cmaj.060801

Novel technique for critical care training

Capital Health provides care for 2 million Albertans across 9800 km². Many critically ill patients require transfer to Edmonton. Long distances, climatic factors and resource pressures complicate how we stabilize and transport patients and then triage them at the receiving hospital. A major communication aid is the critical care line, a 24-h service with teleconference capabilities and contact numbers for both transferring and receiving staff.

Given the importance of optimal communication, we have incorporated simulated calls from the critical care line into the education of trainees in critical care medicine. Senior trainees are paged during a normal workday by the line. A facilitator assumes the role of a physician in a distant town. Relevant staff members are notified of this exercise and asked to act as they normally would. For example, emergency physicians and internists are notified that they may be brought into the call if the trainee decides, for instance, to bring the patient through the emergency department for further workup or if no bed is currently available in the intensive care unit. All calls are recorded to aid debriefing.

These simulated calls allow us to ascertain how well trainees obtain focused histories, offer practical advice appropriate to the skill set of the referring physician and deal with complex ethical issues (e.g., deciding what to do if a family wants to override a patient's wishes about medical intervention or deciding how aggressively to treat a ter-

minally ill patient with whom no discussions have occurred about end-of-life care). We can test not only factual knowledge but also how that knowledge is applied in practice.

The Royal College of Physicians and Surgeons of Canada has decreed that physicians must be not just medical experts but also communicators, collaborators and managers.¹ Our novel, simple and cost-free addition to training helps to address these laudable goals. The technique has been very well received, and we hope others may consider using it.

Peter Brindley

Medical Lead for Patient
Simulation
Capital Health
Edmonton, Alta.

REFERENCE

1. Royal College of Physicians and Surgeons of Canada. The CanMEDS roles framework. Ottawa: The College; 2005. Available: rcpsc.medical.org/canmeds/index.php (accessed 21 Nov 2006).

DOI:10.1503/cmaj.1060159

Training Canada's future clinician-teachers and researchers

Although Mark Baerlocher's review of data from the 2004 CFPC/CMA/RCPC National Physician Survey¹ suggests that medical students have a greater desire to engage in teaching or research than physicians currently in practice, it fails to address the key issue revealed by the data: a noticeable disparity between student intention and physician action. Do current students have a genuine commitment to teaching and research or are they simply being optimistic about their future career?

In the survey, residents in family medicine programs were not asked whether research training was included in their residency program, let alone whether they perceived such training to be necessary. Residents in specialty programs fared somewhat better: they were asked to evaluate the necessity

and quality of their research training. However, none of the residents were asked about the pedagogical content of their programs.

If we wish students to retain an interest in teaching and research we must foster it early in their training programs.² Knowing the current status of pedagogy and research training in residency is the first step to ensuring a future supply of clinician-teachers and scientists.

Andrew J. Perrin

MD/PhD Program
University of Toronto
Toronto, Ont.

REFERENCES

1. Baerlocher MO. Canada's future physicians: clinicians, researchers or teachers? *CMAJ* 2006;174(11):1549.
2. Pillai D. Quelling research excellence in residency programs [letter]. *CMAJ* 2002;167(3):236.

DOI:10.1503/cmaj.1060142

[Dr. Baerlocher responds:]

In his interesting letter, Andrew Perrin makes a good point: intention may not translate into action when it comes to participating in research during one's medical practice. If this is true, it may be due in part to a lack of research training, but other factors may also play a role, such as the negative impact of research on income or a lack of time. One solution that has been proposed is the creation of research chairs, which provide protected research time.

I fully agree with Perrin that we must foster student interest in teaching and research early in medical training programs. All residency training programs, including family medicine, should include a compulsory research project. After all, every physician will need to evaluate research at some point and personally performing some research is a great way to learn how to critically evaluate the work of others.

Mark O. Baerlocher

Radiology Residency Training
Program
University of Toronto
Toronto, Ont.

DOI:10.1503/cmaj.1060143