

dard, its reliability and validity must be demonstrated.

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The trainee in difficulty

To the editor:

I congratulate Robert McGraw and Sarita Verma on their excellent review¹ of "The trainee in difficulty" in the July 2001 issue of *CJEM*. The editorial comments by Tim Allen were also timely and helpful.² Several key suggestions have been made that will help us all in our efforts to make the teaching environment in our emergency departments as effective as it can be.

Medical school enrollment is expanding nationally. Emergency medicine is increasingly becoming a core element of many medical school curricula. Our EDs are taking on a greater role as the setting where medical students gain their exposure to clinical medicine. We therefore clearly have an expanding role in not only teaching but in identifying the student in difficulty. Our role is one of both identification and, at times, remediation of students when they fail to meet the standards set.

The ED has several features that make it a setting particularly well suited to teaching and evaluation. I am very concerned though that with the national

trend to overcrowding, delays in patient care and resource availability that is often less than ideal, the conditions for optimal teaching are eroding. We must continue to apply pressure wherever and whenever we can to develop solutions when our departments are blocked and understaffed. We must do this as patient advocates and as educators.

With respect to identifying students in difficulty, feedback loops and early reporting of students whose performance falls short of what we expect are key requirements in our role. A further way in which we can improve our vigilance and consistency is the suggestion that students be encouraged to ask for feedback at an appropriate time at the end of each clinical shift. This critical step can become an expectation whenever staff physicians work with medical students. If shift evaluation forms are used, students can provide these at the same time. This can be an ideal time for assessment and feedback while the events of the shift remain fresh in the minds of both students and staff.

Thank you again to the authors of these articles. Their insights can be helpful to us all and can improve the way we evaluate medical students. Their suggestions can improve our contribution as teachers and will help us to develop a unique approach to medical undergraduate education in which we can all take pride.

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Alternate funding plans

To the editor:

Dr. Marshall is right that physicians should exercise caution and good judgement when assessing new payment plans.¹ However, the problems he ascribes to the Ontario Alternate Funding Agreement (AFA) are misleading. We would like to clarify several points:

The Ontario plan pays a lump annual sum, based on volume (other factors to modify workload are being developed), to emergency groups that sign on. This lump sum replaces fee-for-service (FFS) billings and is intended to exceed the amounts achieved through FFS, although the premium varies. There are no clauses requiring groups to divide this sum into a "salary," and each group is free to create its own distribution scheme. Thus, incentives for productivity, differentials based on training, experience, or for unsocial shifts are all a matter of discretion to the group members. This includes voting rights definitions within the group.

There are neither standards nor external monitoring of individual or group productivity.

There is no evidence from the 65 Ontario emergency departments (EDs) that have taken the AFA that productivity has been adversely affected.

FFS provides no funds for overhead. Under the AFA an individual physician's overhead is lowered as she or he does not need to submit FFS billings, while the group costs for shadow billing are at least partly offset by the AFA.

The AFA covers all non-scheduled visits to the ED. The plan was set up with the conversion of all FFS billings from the ED into the AFA pool, including the billings for patients seen by physicians other than the emergency physician on duty. It is up to the group to identify these funds and distribute them accordingly. Thus, any clawback for fees submitted by local family physicians indicates the lack of a local