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 review[1] 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 muct 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

https://doi.org/10.1017/S1481803500005984 Published online by Cambridge University Press

agreement, and any money lost in this way did not rightly belong to the emergency group in the first case.

The AFA will be particularly attractive to ED groups that already act cohesively and where the premium over FFS is considered worthwhile. It is least attractive to sites where individuals traditionally function as autonomous practitioners and wish to stay that way. It is certainly not for everybody, but gives Ontario physicians a choice they previously did not have. It is not perfect, but 65 EDs thought it was better than the status quo. If they are at any time disappointed in the terms or effect of the AFA they can withdraw with 90 days notice. It is very hard to ascribe a hidden government agenda for this program; the motive appears obvious: to stabilize physician staffing in order to improve public service and keep EDs out of the headlines. That is a motive we can all support.

Jonathan Dreyer, MD, CM
Chair
Howard Ovens, MD
Vice-Chair
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Past-Chair
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[The author responds:]

Caution and judgement must be exercised whenever a body of power offers something. In the matter of alternate funding plans, it is ludicrous to say our government does not have a hidden agenda. The agenda is to control costs; at whose expense is hidden.

Dreyer and colleagues state that alternate funding plans (AFPs) are intended to exceed the current FFS pool, but I ask: When was the last time a government lined up to give doctors a raise and does this take into account the large clawbacks that some EDs on AFP have seen?

AFPs are based on numbers seen (CTAS data), and if physicians are less than diligent in the administrative task of "shadow billing," it will appear that our productivity has fallen, and this will translate into more cutbacks. Dreyer and colleagues suggest there are neither standards nor external monitoring of individual or group productivity, yet all organizations need monitoring and managers to function, and the government will develop systems to monitor individual and group productivity — information that will not be used to give doctors raises.

Many centres with AFPs have opened "walk-in" clinics, allowing them to practise FFS for low-acuity patients and AFP for sicker patients. This drives ED numbers down and, as a result, the AFP pool shrinks. In an AFP, emergency physicians will become lackeys of the government — motivated to please their employer rather than their patients.

The authors suggest that "cohesive groups" will find AFPs attractive, but I believe the converse is true: groups will be more cohesive if emergency physicians work independently. The more that individuals become aware of each other's workload, productivity and income, the more likely problems are to arise. Our system is in crisis not because of supply and demand economics (i.e., FFS), but because government has exercised too much control over the "supply side" of medicine. AFPs are just more of the same. Let's not jump on the bandwagon that promises nirvana.

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An apology to Dr. Nijssen-Jordan

The National Working Group on Triage would like to recognize Dr. Cheri Nijssen-Jordan as one of the contributing members involved in the development and publication of the Canadian Paediatric Triage and Acuity Scale (PaedCTAS) guidelines.[1] Dr Nijssen-Jordan has been a valued contributor to the development of the CTAS guidelines from the inception of the National Working Group.

We apologize for the error we made in inadvertantly excluding her from the list of members in the supplement.

Michael J. Murray, MD
Chair
National Working Group on Triage

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1. Warren D, Jarvis A, Leblanc L, and the National Triage Task Force members. Canadian Paediatric Triage and Acuity Scale: implementation guidelines for emergency departments. CJEM 2001;3 (4 Suppl):S1-27.

https://doi.org/10.1017/S1481803500005984 Published online by Cambridge University Press