Family medicine in decline?

In describing the historical demise of family medicine, Walter Rosser[1] misses an essential point: at one time there was a large pool of recent graduates in the locum pool. This provided much-needed vacation and education relief for busy family doctors. It also provided an opportunity for medical graduates to expose themselves to a variety of communities and practice styles, something lacking in their "big-city" educations. Many of them (myself included) settled in the communities they first got to know during a locum.

The locum pool has shrunk markedly in the last few decades as medical students are forced to lock into residency programs. I was in the last cohort that was allowed to return to complete a residency after being out in the "real world." Medical students are now forced to commit themselves to family medicine or specialty training at a stage when they have little experience in clinical medicine. This is a huge disincentive to choose family medicine. It also shows little respect for the experience a family doctor can bring to any specialty.

I hope the task force organized by the College of Family Physicians of Canada will take into account the locum physicians who play such an important role in rural medicine. Unfortunately, they are dispersed and mobile. They have no political voice. But, in many ways, they are the (declining) future of rural medicine.

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Reference

1. Rosser WW. The decline of family medicine as a career choice [editorial]. *CMAJ* 2002;166(11): 1419-20.

The unfortunate title of Walter Rosser's otherwise excellent commentary[1] perpetuates a negative view of family medicine as a career choice. It is far more important to recognize the opportunity that stems from the crisis in family medicine than to focus on the crisis itself. Canadians are already busy "reforming" a health care system that has been the envy of many other countries. If there is any doubt, one has only to read Barbara Starfield's commentary,[2] which emphasizes the strength of primary care in providing better population health at a lower cost. Canadian-trained family physicians are the "platinum standard" world wide. Never has there been a better time to enter family medicine. This is the real message we need to get out to our trainees.

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References

1. Rosser WW. The decline of family medicine as a career choice [editorial]. *CMAJ* 2002;166(11): 1419-20.
2. Starfield B. Equity in health [editorial]. *CMAJ* 2000;162(3):346.

The concerns that Walter Rosser[1] raises regarding the decline in the number of medical students choosing family medicine as a career are appropriate and timely. I would like to expand on some other important factors in this decline.

First, debt load has become an important factor in students' choice of career. Provincial governments seem to have abandoned the principle that higher education is a national resource to be supported heavily and have taken the hard-nosed view that those who enter a profession should pay the freight up front. Unfortunately, this has affected the socioeconomic mix of medical students and has caused a large increase in expected debt on entering practice.[2] To retire that debt as quickly as possible, students are likely to choose specialties with the highest remuneration.

Another significant factor is the elimination of the rotating internship as a route to licensure. When licensure was being re-evaluated in the 1980s and early 1990s, a third stream other than family practice or specialty certification was discussed. However, this option was not implemented. As expected, pressure was placed on medical students to make early decisions regarding career choice. An unexpected consequence was the development of major barriers to flexibility in career choice, both during and after residency training. Not very helpful are some provincial programs for re-entry into training, whose return-of-service requirements are seen as coercive.

It may not be possible to bring back the rotating internship, but what is needed is the revisiting of a third route to licensure and changes to alleviate the inflexibility that affects medical students, residents and physicians in practice.

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References

1. Rosser WW. The decline of family medicine as a career choice [editorial]. *CMAJ* 2002;166(11): 1419-20.
2. Kwong JC, Dhalla IA, Streiner DL, Baddour RE, Waddell AE, Johnson IL. Effects of rising tuition fees on medical school class composition and financial outlook. *CMAJ* 2002;166(8):1023-8.

Hip-fracture and stroke care: parallel problems in evidence

Although Gary Naglie and colleagues' study of postoperative care for geriatric patients with hip fracture[1] produced a neutral result, it may well have been underpowered, as the authors note in their interpretation. In looking for an absolute risk reduction of 17%, they may have missed a clinically important difference of 5%. Here I see a parallel with the development of evidence in favour of stroke unit care.

The benefit of stroke unit care was convincingly shown only in a meta-analysis of 19 trials.[2] The absolute benefit in reduction in mortality or dependency is about 6%, a figure similar to the absolute (nonsignificant) benefit in reduction in mortality and ambulatory

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deterioration of 5.6% seen in Naglie and colleagues' trial. Equally, among stroke patients, roving stroke units are probably less effective than geographically focused units.[3] Perhaps the physical centralization of geriatric hip-fracture patients is similarly important.

It is still unknown in definitive terms why stroke units are effective. Common sense gives us reasons but, broadly speaking, perhaps focused multidisciplinary care could improve outcomes for relatively homogeneous patient populations in a wide range of disciplines. It would be worth while to pursue a larger multicentre study of interdisciplinary hip-fracture care with sufficient power to detect small benefits. A 5% absolute benefit would be clinically important in Canada, with obvious relevance as the population ages.

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References
1. Naglie G, Tansey C, Kirkland JL, Ogilvie-Harris DJ, Detsky AS, Etchells E, et al. Interdisciplinary inpatient care for elderly people with hip fracture: a randomized controlled trial. *CMAJ* 2002;167(1):25-32.
2. Collaborative systematic review of the randomised trials of organised inpatient (stroke unit) care after stroke. Stroke Unit Trialists' Collaboration. *BMJ* 1997;314:1151-9.
3. Evans A, Harraf F, Donaldson N, Kalra L. Randomized controlled study of stroke unit care versus stroke team care in different stroke subtypes. *Stroke* 2002;33:449-55.

[Four of the authors respond:]

We thank Michael Hill for his comments and agree that our study[1] may have missed a clinically important difference because of a lack of statistical power. As we stated in our interpretation, the 95% confidence interval for the primary outcome measure (–5.6% to 17.0%) allowed for the possibility of a clinically important effect. We strongly support the need for a larger multicentre trial to study the effectiveness of interdisciplinary care for elderly people with hip fracture. However, as we stated in our paper, we recommend that the intervention be targeted to a subgroup of patients that may be more likely to benefit than the heterogeneous population included in our study.

Hill writes of the potential importance of physically centralizing geriatric hip-fracture patients, as is done with stroke patients. In our study, the intervention patients were located together in the hospital.

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Reference
1. Naglie G, Tansey C, Kirkland JL, Ogilvie-Harris DJ, Detsky AS, Etchells E, et al. Interdiscipli-

McNeil

Children's Motrin

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