Canada make it unwise for Canada to add this variable to an already complex health care system.

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References

1. Sloan FA, Taylor DH Jr, Conover CJ. Hospital conversions: Is the purchase price too low? In: David M. Cutler, editor. *The changing hospital industry: comparing not-for-profit and for-profit institutions*. Chicago: The University of Chicago Press; 2000.
2. Devereaux PJ, Choi PTL, Lacchetti C, Weaver B, Schünemann HJ, Haines T, et al. A systematic review and meta-analysis of studies comparing mortality rates of private for-profit and private not-for-profit hospitals. *CMAJ* 2002;166(11):1399-406. Available: www.cmaj.ca/cgi/content/full/166/11/1399
3. McClellan M, Staiger D. *Comparing hospital quality at for-profit and not-for-profit hospitals*. Cambridge (MA): National Bureau of Economic Research; 1999. Working paper no. 7324.
4. Pitterle ME, Bond CA, Raehl CL, Franke T. Hospital and pharmacy characteristics associated with mortality rates in United States hospitals. *Pharmacotherapy* 1994;14:620-30.
5. Bond CA, Raehl CL, Pitterle ME, Franke T. Health care professional staffing, hospital characteristics, and hospital mortality rates. *Pharmacotherapy* 1999;19:130-8.
6. Lanska DJ, Kryscio RJ. In-hospital mortality following carotid endarterectomy. *Neurology* 1998;51:440-7.

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The decline of family medicine as a career choice

Walter W. Rosser

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In 2001 less than 28% of medical students made family medicine their first choice for a career, continuing a steady decline from 40% in the early 1990s. Having a family doctor has been accepted as a core value in Canada, a value now threatened. The traditional 50:50 ratio between specialists and family physicians in Canada is beginning to erode. To reverse this trend, an understanding of the complex causes feeding the loss of interest by medical students in family medicine is required.

During the 20th century the role of physicians underwent many dramatic changes. At the beginning of the century physicians provided comfort and support with little more than a trusting relationship to offer the patient. Over the subsequent 100 years scientific knowledge exploded. Medicine responded by dividing into increasingly narrower subspecialties. The accelerated pace of this change in the 1950s and 1960s led to a prediction of the demise of the generalists. In Canada, and in many other developed countries, organizations supporting general practitioners began to focus on a new role that saw family doctors emphasizing the support of the person through health and illness, rather than on specific ages, organs or disease.[1] In recent years the respect for this new discipline of family medicine has waned, in part because of real changes that have affected the practice of medicine and in part because of myths.

The reality is that, as the volume of medical information increased and technology flourished, the prestige spotlight in medical schools focused on subspecialists and their research. Academic family physicians were left with the less glamorous chores of teaching interview and basic clinical skills. Teaching these clinical skills affords little opportunity to describe any of the disciplines of family medicine to students. Since family medicine is mostly community based, there is little visibility of family doctors in teaching hospitals, where the "real action" is for medical students. The result is that the unique methods used by family doctors to approach diagnosis are not well understood, both by students and by their subspecialist colleagues. The scientific basis for watchful waiting — a strategy to separate common nonspecific complaints from significant disease — is rarely discussed in medical schools.[2] Thus most medical students buy into the myth that family medicine is an amalgam of all specialties and is impossible to practise competently given the overwhelming information load. These misunderstandings lead to negative comments about family physicians and their style of work.[3] Although academic family medicine has led much of the educational innovation in medical schools, research has not evolved as rapidly in family medicine as it has in most specialties. University promotion policies that favour research over teaching leave large departments of family medicine with few full professors or associate professors.

Students hear complaints from family physicians themselves about physician shortages, excessive workloads, increased difficulty "keeping up" and declining financial re-

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wards compared with those of specialists.[4] Governments talk about reforming the primary care system and produce schemes to address the maldistribution of family doctors by forcing young family doctors into remote, rural or "underserviced" practice locations. Unfortunately, these are not myths, they are realities.

From the student's viewpoint, many plan to lead a more balanced lifestyle by working 30 or 40 hours a week rather than the traditional 50 to 70, excluding time on call. Why would anyone choose a medical career with an excessive workload, an unclearly defined role, information overload and the lowest pay? Many specialties have a clear definition of tasks and knowledge requirements and appear to provide more academic opportunities. Given this picture and the need to invest at least $75 000 to start a comprehensive family practice when the educational debt for many students is already $100 000, it is a remarkably brave and altruistic 28% of students who choose family medicine as a career. They deserve our attention and admiration.

Shattering the myths and changing the realities are possible. Family medicine is a well-defined discipline that requires a specific knowledge and skill set and that focuses on the patient–physician relationship, population health, health promotion and meeting community needs.[5–12] Family physicians define and nurture their own scope of practice on the basis of community needs and their own interests in medicine. The role of patient advocate and the interpreter of medical information to optimize each patient's quality of life provides family physicians personal enrichment. Building a trusting relationship with people through their lives will continue to make family medicine a particularly rewarding and satisfying career choice.

The information explosion problem can also be tackled. Electronic information systems and ever smaller wireless computers are becoming practical tools in the examining room. This technology will allow physicians to retrieve the latest evidence-based knowledge and tailor it to the needs and wishes of each patient. As well, the growing availability of critically appraised guidelines and information that has been systematically assessed (www.gacguidelines.ca) will address the fear of lacking sufficient knowledge to practise appropriately.[13]

International assessments of health care systems always place Canada's near the top, while the costliest system, in the United States, yields a poorer population health status. Starfield[14,15] attributes this phenomenon to the strength of primary care.[14,15] If the decline in interest in choosing family medicine as a career continues, we are on a course that flies in the face of what most countries are seeking.

Because of declining student interest in family medicine, the College of Family Physicians of Canada has organized a task force to investigate the reasons for the decline, to evaluate its effect on the supply of family physicians and to recommend changes in training programs. Its report is due in the fall of 2002. Open discussion in the Canadian health care system about the complex issues that influence medical students' career choices and concerted action to address them can avert a threat to one of the great health care systems of the world.

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References

1. Johnston WV. *Before the age of miracles*. Toronto: Fitzhenry and Whiteside; 1972.
2. Rosser WW. Approach to diagnosis by primary care clinicians and specialists: Is there a difference? *J Fam Pract* 1996:42(2):139-44.
3. Rosser WW. Courtesy requires respect among clinicians. *Ann R Coll Physicians Surg Can* 2001;35:99.
4. Rosser WW, Kasperski J. Organizing primary care for an integrated system. *Health Care Papers* 1999;1(3):5-12.
5. Royal New Zealand College of General Practice. *Defining the general practitioner*. Auckland: The College; 1995.
6. Olesen F, Dickinson J, Hjortdahl P. General practice: time for a new definition. *BMJ* 2000;320:354-7.
7. *The role of the general practitioner/family physician in health care systems: a statement from WONCA*. Singapore: World Organization of Family Doctors (WONCA); 1991. Available: www.globalfamilydoctor.com/publications/index.htm (accessed 2002 Apr 24).
8. Gay B. What are the basic principles to define general practice? Presented at inaugural meeting of the European Society of General Practice/Family Medicine; Strasbourg; 1995.
9. World Health Organization. *WHO framework statement: WHO framework for professional and administrative development of general practice/family medicine in Europe*. Copenhagen: The Organization; 1998.
10. European Academy of Teachers in General Practice. *The core competencies of the general practitioner/family physician* [draft document]. Barcelona: WONCA Region Europe; 2001.
11. Donaldson MS, Yordy KD, Lohr KN, Vanslow NA, editors. Summary. In: *Primary care. America's health in a new era*. Washington: National Academy Press; 1996. p. 6.
12. College of Family Physicians of Canada. *The four principles of family medicine*. Toronto: The College; 1999.
13. Rosser W, Davis D, Gilbart E. Assessing guidelines for use in family practice. *J Fam Pract* 2001;50(11):969-73.
14. Starfield B. Is primary care essential? *Lancet* 1994;344:1129-33.
15. Starfield B. Equity in health [editorial]. *CMAJ* 2000;162(3):346. Available: www.cmaj.ca/cgi/content/full/162/3/346

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