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Letters ❖ Correspondance

Family medicine alert

I was relieved to read the College's full reaction to the Canadian Resident Matching Service (CaRMS) match,[1] after initial statements that the solution was more involvement in medical schools. The problem, however, is actually worse than the CaRMS statistics indicate. One in five family medicine residents will end up doing a CCFP(EM) year. It is no secret that the (EM) designation is pursued largely with the intention of forgoing family practice for full-time emergency room work. If only 24% of all medical students are choosing family medicine through CaRMS, this means about *80%* of new doctors will ultimately reject a career in traditional family medicine.

The CaRMS statistics are a wake-up call to every family physician in Canada. However much we promote the positive aspects of family practice, the fact remains that many FPs are not happy in their work—with good reason.

Relative to our specialist colleagues, the pay stinks. New graduates finish school or residency thousands of dollars in debt. I am one of them, and it will be years before I am worth more than a share of Nortel. Why sacrifice family and financial security to attend medical school only to spend another decade not much better off? When you are $80 000 in debt, money *does* talk.

Medical students lament the lack of prestige in family medicine. Here is where role modeling in medical school is important, because ample disrespect is accorded FPs in academic hospitals. However, let us be realistic. Hike the pay of every FP by 30% and their "prestige" will equal that of specialties in a hurry.

Finally, when we fulfilled our dreams by getting into medical school, did we envision ourselves filling out disability forms? Since when does advocating for our patients include backing their lawsuits over car accidents? And if we happen to delay the paperwork to actually care for patients (or heaven forbid, spend a night with our families), we are harassed with accusations of prejudice.

Family physicians make up *half* of Canadian physicians, a far more important statistic than the results of the CaRMS match. Only we are responsible for our own well-being, as well as for correcting the balance of power in our relationships with specialists, government, and the insurance industry. Be it a national pay standard, a pension plan, or primary care reform, there is not anything we should not be able to accomplish as a profession if we have the will to get over our passivity. Correct the problems facing family medicine, and the CaRMS trends will reverse quicker than we think.

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Make your views known!

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Electric shock during pregnancy

Regarding the article[1] on electric shock during pregnancy, we concur with the authors that fetal risk largely depends on the path of electric current—often involving the gravid uterus en route from mother's hand to foot in case of household appliances (given the low electricity resistance of amniotic fluid and uterine muscle). To exemplify this, the authors cited the safety of electroconvulsive therapy during pregnancy. It would be even more convincing, however, to mention use of direct-current cardioversion during various stages of gestation, when women are treated with electric energies ranging from 50 to 300 J. In such cases, the low risk of fetal adverse effects[2,3] (despite delivery of relatively high-energy electric discharge) is attributed to the energy not passing through the uterus.

Furthermore, risk of inducing ventricular fibrillation by electric shock during the fetal period when the ventricle is most vulnerable is low. According to animal experience in mammalian hearts almost a century ago,[4] a critical myocardial mass is necessary to sustain ventricular fibrillation, thereby explaining the relatively unaffected fetal rhythm during cardioversion.

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