Response

Dr Steben is correct in that the photograph of the patient with pathologic phimosis has concurrent balanitis xerotica obliterans (BXO) or lichen sclerosis et atrophicus. In the pediatric age group there is an association between the two. This does not represent a "diagnostic error," however. Although the BXO might respond to high-potency topical steroids, it has been our experience, and that of others, that the scarred phimotic ring rarely does.[1] Balanitis xerotica obliterans might require treatment with topical steroids for a time after circumcision, but in most cases removing the pathologic foreskin will resolve the problem. The risk of cancer of the penis with BXO is not pertinent to the pediatric age group, as the condition is reversed by timely circumcision with or without topical steroid application. The biggest risk in children is the development of meatal stenosis secondary to BXO, which might require meatotomy.

—Michael P. Leonard MD FRCSC FAAP
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by e-mail

Reference

1. Webster TM, Leonard MP. Topical steroid therapy for phimosis. *Can J Urol* 2002;9(2):1492-5.

We cannot market the unsaleable

The Commentary article by Ivers and Abdel-Galil[1] about improving marketing of family medicine is a praiseworthy attempt to put a brave face on family medicine's poor reputation. Their solution, to "make a good offence, and change the perception of family medicine" is good as far as it goes, but it is a salesman's approach. Sadly, even the best marketer finds it difficult to sell a second-rate product: like North American cars, when Japanese brands are available.

Even worse, the idea of selling niche-market family medicine to those who find the main approach unattractive is avoiding the real issue. Medical students and their in-hospital preceptors are not fools. They can see the reality. Yes indeed, family medicine does include many who came into it because we love what we do and try our hardest to do it well. But it also includes many who trained in our specialty because the system would not let them do what they really wanted. Some of these accept the station in life to which the Canadian Resident Matching Service has called them, others move into niche practice close to what they wanted, while others become "bottom-dwellers," aiming to get away with the minimum work at maximum speed for maximum pay. Their patients are overrepresented among the patients seen by specialists, with inappropriate referrals, poor diagnoses, and unavailable follow-up, so biasing the perception of family medicine overall.

Sadly, when the pay and conditions for community-based, continuing, comprehensive family medicine are so much less desirable than those for many of the specialties, it is unreasonable to expect bright young people with debts and family commitments to join our ranks. Some of those who entered with high ideals feel let down when the reality sinks in.[2] Most of the discussion about earnings is misleading; even if family physicians earn 80% of specialists' gross income, their office overheads and the cost of paying back debt and feeding a family are similar, leaving specialists with a disposable income several times higher. If a gastroenterologist has an entry salary of $252 000, that is more than a full professor of family medicine can currently hope to earn. Someone must have decided that this disparity has some relationship to our value to society. How can I as a professor honestly tell undecided students that they should join our program and thereby earn much less than if they spent an extra year or two training in most other fields? And if they graduate in family medicine, they find that niche practice pays better and provides a better lifestyle. Yes, the personal rewards of family medicine work are wonderful, but I have heard

rumours that other specialties find satisfaction in their work—and their bank balance too!

Until the economic bias against family medicine and rural medicine (and other thinking, nonprocedural specialties) is reduced, it would be morally wrong to spend effort marketing to students, earning us a reputation for mendacity as well as incompetence. Instead, the College should spend effort selling the benefits of mainstream family medicine to the people who decide the funding allocation within the Canadian health care system. It is pleasing that in the same issue of *Canadian Family Physician,* Dr Gutkin, the Executive Director, makes this point.[3] Doing this might lead to students wanting to join us, especially if we increase the training and raise expectations of our graduates, so family medicine really does provide consistently high quality.

—James A. Dickinson MBBS CCFP PhD FRACGP
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by e-mail

References

1. Ivers NM, Abdel-Galil R. Marketing family medicine. Challenging misconceptions. *Can Fam Physician* 2007;53:793-4 (Eng), 796-7 (Fr).
2. Suende T. Money talks—and this resident is starting to listen. *National Rev Med* 2007 May 15, p. 39.
3. Gutkin C. The voice of family medicine. *Can Fam Physician* 2007;53(5):963 (Fr), 964 (Eng).

Response

We believe Dr Dickinson makes his point well about the financial disincentive to choosing family medicine and agree with his assertion that the best way to improve remuneration is to convey the merits of family medicine to the policy makers in charge of funding and pay structures.

We do take issue with the notion that using marketing techniques to find out which elements of the job are most appealing to medical students and advertising techniques to better communicate those strengths is "morally wrong." We believe that it will be most efficient for the profession of family medicine to spend time and money to better understand what medical students know and don't know about family medicine in order to better target the best and brightest for recruitment.

If, as Dr Dickinson suggests, medical students are frequently exposed to the less than ideal care provided by those family doctors who would rather not be in our specialty, then it becomes even more important that we make an effort to prove that good family medicine is possible. In this regard, we strongly affirm the potential value of positive role models and mentors, in addition to market research and advertising techniques.

In our opinion, there is no reason to allow recruitment to languish while waiting for government reforms to occur. Rather, a young, motivated, and invigorated influx of bright, young doctors who understood the benefits of family medicine and chose it willingly and fully informed could only strengthen the force of advocacy for the reforms Dr Dickinson desires. To be clear: we simply feel that, for a variety of reasons, many medical students discount family medicine as a career choice too early and never find out if it could be right for them. We share many of Dr Dickinson's concerns, yet stand by our recommendation that the College investigate the value of a marketing campaign to better communicate the merits of the specialty and, through improved recruitment, strengthen the profession itself.

—Noah Michael Ivers MD
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by e-mail

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