

Fewer students select family medicine

There is little surprise or mystery to me in this steadily worsening problem. I blame all the points raised in the editorial,¹ but I must add some other important issues.

The current postgraduate training system is doing a gigantic disservice to Canada. Students are now being forced to make medical career choices far too early in their training and are matched directly into specialty programs rather than being given an opportunity to train and practise generally before entering a specialty. This leaves the country bereft of consultants who have any generalist experience and multiplies the already considerable barriers between consultants and their generalist colleagues.

Further, the ability to change programs midstream is severely limited. First, it is very hard to get into another program with its already full complement of trainees. Second, if a student realizes that a certain field is not for him or her, there is no fallback position. A third-year orthopedics resident cannot exit the program early and go to work. He or she is utterly unlicensureable!

Compounding all of this is the immense difficulty getting reentry positions. The current attitude is essentially this: you have one certification so we will not easily let you try for another. Why is this? Why not change career paths if students so choose? Taking this attitude is a grave mistake. The brains trust is very valuable. We should not be forcing such talent into a career straitjacket.

I believe that some things can be done to address these concerns.

- Increase the ratio of postgraduate to graduate positions to 1.5 to 1. That way, reentry positions are always available.
- Reintroduce general licences. This will make a large core of generalists available, if not always working as generalists.
- Reintroduce common early training years. This allows for proper generalist training for general licensure, as well as giving trainees more opportunity to experience generalist medicine and make good career choices.
- Provide many extra certifications in family medicine. These should include common focus tracks, such as hospitalist medicine, obstetrics, and geriatrics, as well as the already established palliative care, emergency medicine, sports medicine, and anesthesia.

The point of all these recommendations is to emphasize opportunity, remove barriers to change, and increase the number of physicians actually providing generalist care. I think that one of the greatest strengths of my current training is the wealth of opportunity it has brought me. The system continues, however, to strangle such opportunity very early in training.

Family medicine is a fantastic field. Let us give opportunities to more people to experience that. Let us allow those of us already practising family medicine to further broaden our skill sets and add even greater value to the field.

—Han Friesen, MD
Calgary, Alta
by e-mail

Reference

1. MacKean P, Gutkin C. Fewer medical students selecting family medicine. Can family practice survive? [editorial]. *Can Fam Physician* 2003;49:408-9 (Eng), 415-7 (Fr).

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More critical analysis needed

As a family physician with a large geriatric practice, I was most disappointed with the lack of critical analysis regarding osteoporosis management in the April issue of *Canadian Family Physician*. The editorial¹ by Dr McKercher; the review article² by Dr Aliya Khan, "Chair of the Canadian Panel of the International Society of Clinical Densitometry and member of the Scientific Advisory Council of the Osteoporosis Society"; and the article³ by Dr Jaglal imply that family physicians are neglectful if they do not immediately start screening and treating patients for osteoporosis.

The paper by Dr Khan describes in Table 4 five “well conducted studies,” four of which provide “level I” evidence and one “level II” evidence comparing the use of bisphosphonates with a placebo. The outcome measure is reduction in relative risk of fracture. For three of the five studies, the reduction of relative risk for hip fracture was not significant. The relative risk reduction for new vertebral fractures ranged from 18% to 47% in the four studies where this was an outcome measure.

As a treating physician, reduction in relative risk does not tell me very much. It would have been much more useful to know the difference in prevalence of fractures between treated and placebo groups. The number of patients needed to treat to prevent one fracture also would have been helpful.

The second reference⁴ in Dr McKercher's editorial suggests 90% of women older than 65 should be candidates for bone mineral density testing. The predictive value of bone mineral density in terms of relative risk of fracture varies with age and has little value in younger age groups. For example, as quoted in the guidelines, a 25-year-old with a low bone mineral density (T score of -2.5) has a very low risk of fracture, as low as that of a 25-year-old with a high bone mineral density. Similarly, a 55-year-old with a low bone mineral density is at 10 times less risk than a 75-year-old with the same low bone mineral density of having a fragility fracture of the hip or vertebra.

A recent editorial⁵ in the *British Medical Journal* concluded,

Against a background of controversy over disease definition, poor predicted value of bone density measurement, and heavily advertised expensive therapies offering marginal benefit to postmenopausal women, corporate-backed promotional activities are attempting to persuade millions of healthy women worldwide that they are sick.

In contrast, on the front cover of April's *Canadian Family Physician* were the words “Osteoporosis. Silent Epidemic.” Who is correct?

Readers of *Canadian Family Physician* would have been better served if a health epidemiologist not associated with the osteoporosis industry had the opportunity to provide a critical analysis of the efficacy of screening and treatment. In an era of increasing demands for health resources and finite funding, we need to be better convinced that the recommended screening and treatment for this condition is appropriate.

—John Sehmer, MD, MSC, CCFP
Vancouver, BC
by e-mail

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2. Khan A. Advances in osteoporosis therapy. 2003 update of practical guidelines. *Can Fam Physician* 2003;49:441-7.
3. Jaglal SB, Carroll J, Hawker G, McIsaac WJ, Jaakkimainen L, Cadarette SM, Cameron C, Davis D. How are family physicians managing osteoporosis? Qualitative study of their experiences and educational needs. *Can Fam Physician* 2003;49:462-8.
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Show us the numbers

Thank you for the article¹ on osteoporosis. It does have some helpful information. However, there could be a few improvements, especially if this information is supposed to educate us. We should not forget to indicate *absolute risk reduction* in addition to relative risk reduction. As you can imagine, relative risk reduction can be extremely misleading. For example, if the incidence of a disease after a treatment drops from 2 per 1000 to 1 per 1000 that is a whopping 50% relative risk reduction! That sounds great, but the absolute risk reduction is 0.1%, meaning the treatment is pretty useless. We need to know what these numbers are, particularly if we might change our practice patterns.

It is a great drug company trick to publish only relative risk reductions. I

believe that some journals are refusing to publish articles unless the absolute risk reduction numbers are included. We should do the same. We should also include the number needed to treat (NNT) and the number needed to harm (NNH). It is impossible for me to judge the use of a drug without these numbers.

I would also like to point out that the finding of risedronate causing a 30% relative reduction in the risk of hip fracture should be brought into question because it was found through subgroup analysis, as the author points out. I think it is dangerous to make positive judgments on subgroup analyses, and I believe that your editors should be making this very clear to readers. These results can form only the basis for a new experiment. They are, otherwise, data dredging.

Finally, whenever there are studies done wherein the tested drug is tried at several different doses, I would suggest high suspicion in interpreting these results. I refer to the calcitonin tests. I think the author does hint at this problem. We should be a little more up front in explaining why these types of experiments are pets of the drug industry because the more doses tested, the greater the chance, simply by chance alone, that one of them will be shown to be “beneficial.” These results cannot be trusted.

—David Larocque, MD, CM, CCFP(EM)
Castlegar, BC
by e-mail

Reference

1. Khan A. Advances in osteoporosis therapy. 2003 update of practical guidelines. *Can Fam Physician* 2003;49:441-7.

Response

I agree with Dr Larocque that there are limitations in using relative risk alone, and absolute risk is important to consider. Relative risk reduction of greater than 25% is generally considered to be clinically significant. I refer Dr Larocque to an excellent book.¹ The authors describe why relative