

Crossing boundaries

Family physicians' struggles to protect their private lives

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ABSTRACT

OBJECTIVE To explore the tensions between professional and personal boundaries and how they affect the work and private lives of family physicians.

DESIGN Qualitative case study using semistructured interviews.

SETTING Province of New Brunswick.

PARTICIPANTS Forty-eight family physicians from across the province.

METHODS A collective case-study approach was developed, with 24 cases of 2 individuals per case. Cases were selected based on sex, location (urban or rural), language (French or English), and number of years since medical school graduation (<10 years, 10 to 20 years, or >20 years). Physicians were interviewed in either French or English. Participants were recruited using the College of Physicians and Surgeons of New Brunswick's physician directory. Based on the rates of response and participation, some cases were overrepresented, while others were not completed. All interviews were audiotaped, transcribed verbatim, and analyzed thematically using a categorical aggregation approach. A coding scheme for the thematic analysis was developed by the research team before the interviews were transcribed.

MAIN FINDINGS Almost all of the family physicians interviewed discussed how their profession negatively affected their personal lives. Many struggled with issues such as heavy workloads, the adverse effects of their profession on their family lives, and the trespassing of patients onto their personal lives in small towns and rural communities. Some physicians had developed strategies to balance their personal lives with their professional demands; however, this often meant reducing work hours or terminating certain shifts, such as those in the emergency department or after-hours clinics.

CONCLUSION Family physicians struggle to keep their profession from intruding too much into their private lives. These struggles are important to acknowledge and address in order to avoid physician burnout and premature retirement from clinical practice.

EDITOR'S KEY POINTS

- Most physicians struggle to find a balance between personal and professional lives. Participants in this study indicated that extensive paperwork, on-call hours, and shifts in emergency departments and after-hours clinics made finding this balance difficult, as did patients in rural or small-town communities who did not respect physicians' private lives.
- The infringement of work life onto personal life can result in physicians refusing to work in the high-need environments that contribute to these boundary issues and can even lead to burnout or premature retirement, all of which would negatively affect the provision of primary care.
- Lifestyle issues related to family practice might be a reason fewer medical students are opting for this specialty; therefore, in light of the shortage of family physicians in Canada, medical schools, residency programs, and health care systems must develop policies and curricula geared toward positive strategies to overcome boundary-related problems that might arise.



Fast Facts from the National Physician Survey on balancing personal and professional commitments are available at www.cfp.ca. Go to the full text of this article on-line, then click on **CFPlus** in the menu at the top right-hand side of the page.

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Où fixer les limites?

Les médecins de famille s'efforcent de protéger leur vie privée

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RÉSUMÉ

OBJECTIF Examiner les tensions entre les milites de la vie personnelle et professionnelle, et la façon dont elles affectent le travail et la vie privée des médecins de famille.

TYPE D'ÉTUDE Étude de cas qualitative à l'aide d'entrevues semi-structurées.

CONTEXTE Province du Nouveau-Brunswick.

PARTICIPANTS Quarante-huit médecins de famille d'un peu partout dans la province.

MÉTHODES On a utilisé une approche d'étude de cas regroupés, avec 24 cas comprenant chacun 2 sujets. Ces cas étaient choisis en fonction du sexe, du lieu de pratique (urbain ou rural), de la langue (anglais ou français) et du nombre d'années depuis l'obtention du diplôme (< 10 ans, 10 à 20 ans ou > 20 ans). Les entrevues étaient en anglais ou en français. Les participants ont été recrutés à l'aide de l'annuaire des médecins du Nouveau-Brunswick. D'après les taux de réponse et de participation, certains cas étaient sur-représentés tandis que d'autres n'ont pas été complétés. Toutes les entrevues ont été enregistrées sur bande audio, transcrites mot à mot et analysées de façon thématique par une méthode d'agrégation catégorique. L'équipe de recherche a mise au point un système de codage pour l'analyse thématique avant la transcription des entrevues.

PRINCIPALES OBSERVATIONS Presque tous les médecins de famille interviewés ont décrit comment leur profession affectait négativement leur vie privée. Plusieurs étaient aux prises avec des problèmes tels qu'une lourde charge de travail, les effets néfastes de la profession sur la vie de famille, et l'intrusion de patients dans leur vie privée dans les petites villes et les collectivités rurales. Certains médecins avaient mis au point des stratégies pour équilibrer exigences professionnelles et vie de famille; mais cela conduisait souvent à réduire les heures de travail ou mettre fin à certains quarts de garde, par exemple les gardes à l'urgence et les heures supplémentaires en clinique.

CONCLUSION Les médecins de famille s'efforcent d'éviter que leur profession empiète trop sur leur vie privée. Il importe de reconnaître ces efforts et de rechercher des solutions afin d'éviter l'épuisement professionnel des médecins et leur retraite prématurée de la pratique.

POINTS DE REPÈRE DU RÉDACTEUR

- La plupart des médecins cherchent un équilibre entre vie privée et profession. Les participants à cette étude ont indiqué que l'omniprésente pape-rasserie, les gardes sur appel, les quarts de garde à l'urgence et les heures supplémentaires en clinique mettaient cet équilibre en péril, tout comme certains patients dans les régions rurales ou les petites collectivités qui ne respectent pas la vie privée des médecins.
- L'empiètement du temps de travail sur la vie privée peut amener les médecins à refuser de travailler dans les milieux très exigeants qui favorisent de tels dépassements de limites et peut même entraîner un épuisement professionnel ou une retraite prématurée, ce qui affecteraient négativement la dispensation des soins primaires.
- La question du rapport entre le mode de vie et la pratique familiale pourrait être une raison pour laquelle moins d'étudiants en médecine choisissent ce type de pratique; compte tenu de la pénurie de médecins de famille au Canada, les facultés de médecine, les programmes de résidence et les systèmes de santé doivent élaborer des politiques et des programmes axés sur des stratégies positives pour contrer les problèmes liés aux éventuels conflits de cette nature.

*Le texte intégral est accessible en anglais à www.cfp.ca.

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There is scant literature on boundary issues in the private and the professional lives of family physicians. What literature exists tends to focus on harassment, abuse, and violence in the family physician's workplace.¹⁻⁵ However, there are other boundary issues besides abuse that need to be addressed. Physicians seek to find a balance between community activism, work, and their personal responsibilities.^{6,7} A 1993 article in *Canadian Family Physician* defined *boundary issues* as the "expected and accepted psychological and social distance between practitioners and patients."⁸ Most of the literature on boundary issues is in the form of commentaries and is not empirically based.⁸⁻¹¹ An article published in 2000 examined the experiences of American general internal medicine physicians with patients' boundary transgressions.¹² The most bothersome nonabusive or nonsexual transgression for physicians was being addressed on a first-name basis instead of by the professional title "Doctor." Almost twice as many women as men reported this occurrence and being annoyed by it (72% versus 47%). Other reports of boundary violations included patients giving physicians inappropriate gifts, trying to socialize with their physicians privately, or showing inappropriate affection.¹²

The overall focus of this qualitative study was to examine how the increasing number of female physicians affects the day-to-day work environment of family physicians in New Brunswick. However, upon analyzing the data, boundary issues for both male and female family physicians emerged as an important theme. In this paper, therefore, we examine the daily struggles with boundary issues experienced by family physicians practising in a variety of settings.

METHODS

New Brunswick has a population of approximately 760 000 people, half of whom live in rural areas and one-third of whom are French-speaking. According to the 2007 National Physician Survey data,¹³ the average age of family physicians in New Brunswick was 47 years, with male physicians being older than female physicians (mean age 50 years versus 43 years). Sixty-three percent of New Brunswick family physicians were male and 50% practised in rural areas or small towns. Forty-four percent of physicians spoke French with their patients (although many of these physicians also spoke English with other patients), 42% worked in solo practices, 34% worked in group practices, and 22% worked in inter-professional practices. Twenty-eight percent of physicians wanted to decrease their practice hours, while 19% wanted to increase their practice hours. Two-thirds (67%) reported satisfaction with the balance between their personal and professional lives. On average, family physicians reported working 50 hours per week, but

when on-call hours were added the average work week total was closer to 86 hours.¹³

A qualitative case-study methodology was used to explore the "bounded system" through in-depth interviews.¹⁴ Time and place are the prevailing characteristics of a bounded system; in this case, the work environment of family physicians was the parameter studied.¹⁴ We used collective cases to examine the system by creating several distinct groups of family physicians based on demographic characteristics that shape workplace experiences. The characteristics we selected were as follows: primary language (French or English), sex, location of practice (urban or rural), and years since graduation from medical school (<10 years, 10 to 20 years, or >20 years). For example, one case would be "female/young/urban/French," while another would be "male/older/rural/English." Based on these characteristics, 24 distinct cases were created with 2 participants per case, for a total of 48 participants required. Participants were not asked to provide social demographic information in order to protect their identities as much as possible. Ethics approval was granted by review committees of Dalhousie University and the Université de Moncton.

The College of Physicians and Surgeons of New Brunswick's physician directory provided basic potential participant information, such as year of graduation, location of practice, and contact information. We used a purposive sampling strategy, sending letters of invitation explaining the study to potential participants in 8 separate mailings to ensure that we would target the physicians who fit the case-study criteria. A reply card was included with the invitation letter along with a self-addressed, stamped envelope and a fax number. All information was sent in both French and English, and potential participants were given the option to select their preferred language for the interviews. Physicians were offered an honorarium of \$120 to cover their overhead costs during the study should they choose to participate.

Research team

The multidisciplinary, bilingual research team consisted of 3 coinvestigators (a sociologist, a family physician, and a professor of philosophy and ethics) and 3 research assistants trained in qualitative methods. On the consent form before the interview, participants were given the option to be audiotaped—all but 2 participants agreed. For these cases the research assistants took detailed notes and did audiotaped recaps after the interviews were completed. Most of the interviews took place in participants' homes or offices.

Analysis

All audiotaped interviews were transcribed verbatim and analyzed thematically using a categorical aggregation approach. In this type of analysis "the researcher seeks a collection of instances from the data, hoping

that issue-relevant meanings will emerge.”¹⁴ Each member of the team read and analyzed 2 transcripts, making notes to help generate initial codes. At a preliminary team meeting, comparisons were made within and among transcripts, further contributing to the development of thematic categories. Related themes were then compared and collapsed into major categories. Most codes were easily agreed upon; however, in cases where there was disagreement, team discussion led to consensus about the importance of codes. After developing the initial coding scheme, some minor revisions and additional codes were discussed by the research team through telephone and e-mail correspondence. A second team meeting took place in order to finalize the coding scheme. A bilingual research assistant used the English coding scheme to analyze the French transcripts. Dependability and confirmability of the data were assessed by sending a summary of the analysis back to the interviewees for review.¹³ None of the participants sent back any comments.

FINDINGS

The response rate to the mailing was 35%, achieving the target of 48 participants required. Of the 24 cases, 15 were complete (2 participants per case); 6 cases comprised only 1 participant, 5 of whom were male; and 3 cases had more than 2 participants, all of whom were female. One case—“female/older/rural/French”—had no participants. We elected to interview all 48 participants instead of reducing the number of interviews, even if that meant overrepresentation in some cases. Of the 48 participants, 29 were female and 19 were male. The distribution of characteristics among the study participants is presented in **Table 1**.

For the purposes of this paper, all French quotes were translated into English. In order to protect the identities of the research participants as much as possible, we restricted identification to sex only, unless the context of the quote required further demographic information.

Overwork

More than three-quarters of participants discussed the encroachment of their work lives onto their personal lives. Physicians complained of frequently being required to bring work home and field calls at home related to patient care in order to keep their offices running. Workload was deemed very heavy, to the point of intrusion upon family life. As one male physician said,

[Practising family medicine] places a lot of demands on your time. There’s the day to day, which is the office, and that’s not so bad, that doesn’t bother me at all, I even enjoy it The paperwork is a problem You know, I don’t exercise as much as I’d like to, I don’t vacation as much as I’d like to, I

don’t spend as much time with my family as I’d like to and so on and so on. (Interview 18)

A young, salaried, female physician said,

Sometimes I feel like work is never over, because I have a set number of hours that I am supposed to be working, but there’s always emergencies and unpredictable things coming up. Almost every week I’m working some free overtime. (Interview 31)

Another male physician, whose spouse was also a family physician, said, “Between the [two of us] we are on call 1 in 3 or 1 in 4. And that has a definite impact on family life. After 22 years, you get a little sick of it.” (Interview 33)

Very busy work schedules and the difficulty of obtaining backup coverage led to difficult situations for some. One female, rural physician described the extreme difficulty of changing an on-call shift when faced with a personal crisis: “I called 7 physicians to take my call night and couldn’t get one. You feel pretty lonely I am better now, but 100 hours a week was nothing at one point.” (Interview 5)

Overlap

More than half of family physicians complained about the tremendous effect their profession has had on their family lives. One female physician described an example of the intersection between family and work responsibilities as follows: “I’m in the middle of cooking supper, and I’m trying to talk to some physician on the phone, and the kids are all demanding ... I had a call [from a colleague] one day and he said, ‘I thought it was a day care.’” (Interview 1)

Other physicians have made difficult choices in order to raise families and manage busy work schedules concurrently. One physician assigned partial blame for her divorce to the incompatibility of the demands of the profession. As a single parent, the physician also felt that in order to provide her child with solid schooling, the child had to be placed in a boarding school. The physician made this difficult choice after deciding that practice demands did not allow the child to receive the level of attention needed from a parent for a proper education.

Table 1. Distribution of participant characteristics: N = 48.

CHARACTERISTICS	N (%)*
Sex	
• Female	29 (60)
• Male	19 (40)
Location	
• Urban	27 (56)
• Rural	21 (44)
Language	
• French	25 (52)
• English	23 (48)
Years in practice	
• < 10 years	18 (38)
• 10–20 years	18 (38)
• > 20 years	12 (25)

*Not all values add up to 100% owing to rounding.

Another physician with grown children expressed regret about the effect the profession had on his personal life as a parent. This physician described the time period from the birth of his first child to the adult stages of all his children as follows:

The whole period is a blur. I just did not really have enough time to spend with the family, you know, and I wish I had done it differently [As an emergency department] doc you are always working nights, evenings, weekend days, the weekends are when the kids are out of school and so we kind of suffered that way. (Interview 15)

A young physician felt that when on call, it was impossible to organize or attend social events. She said, "Yes it definitely does affect my personal life." (Interview 31) Another female physician summed it up as follows: "You come home from work most days tired and drained, and sometimes very overwhelmed by what you've shared that day. And it has a huge impact on the family." (Interview 25)

Overstep

Rural and small-town family physicians often have difficulty separating the personal from the professional because their patients readily cross the private boundaries of physicians' lives. When these physicians go shopping or participate in community activities, they inevitably meet patients. Participants described patients showing up at their homes for consultations and advice and, in some instances, patients have been known to call physicians' family members to gain after-hours access to the physicians. One male physician said,

[O]ne of the problems when you've been around the city 20 years and you go out [is that] you are constantly talking to people that you know. That can be a nuisance after a while because ultimately medical issues come up when you're in the store looking for groceries and someone comes up and says "Hey, by the way" (Interview 41)

In another example, a female physician discussed how work intrusions negatively affected her family life. In this example, it forced a physician couple to leave their small-town practice:

We had difficulty putting limits on our practice. Everyone in the world knew us, they knew our parents. They would call my parent's house: "We would like to make an appointment" They would call my secretary at home. It was really complicated. (Interview 3)

Another physician couple had planned to practise in a rural area, but decided against it after a rotation in the

small community. She said, "We only had 1 night out of 3 free, and it was very difficult. Everybody knew our moves, like if you went to the grocery store they'd be watching you." (Interview 28)

An older, male physician said that although he still had patients approaching him outside the office in the community, it had become less bothersome because he had learned how to deal with it:

[W]hen I was first here, it would bother me a lot more when people would approach me at a restaurant, at the mall, or in the parking lot and ask me stuff. And it bothers me a lot less now. I think I just handle it a lot better; I'm not convinced that it happens any less now; it probably happens more actually. (Interview 11)

Finding balance

Of the 48 participants, 12 discussed various strategies they had implemented to balance their professional and personal lives. Finding balance invariably leads to working fewer hours or refusing to do shifts in the emergency department (ED) or after-hours clinics. One physician couple with a small child decided that one of them would temporarily terminate employment in order to stay home and care for the child. Another female physician said,

I still could work more, if I want to, but I'm making a choice, and my husband and I are actually making choices that we want to spend more time with each other and more time doing things that are fun in exploring other things. (Interview 6)

One female physician decided to make changes after working in these nonoffice settings became too disruptive to her family; however, some of her colleagues did not appreciate this personal choice:

[I]t was very disruptive to my family life trying to coordinate shifts and then schedule offices and so on. I stopped the after-hours clinic because it was just too difficult. It was just too much When I opted out of emerg, I was told by male and female physicians, who were at that time still doing emerg and family practice, that I was abandoning ship When I look back now it was the best thing I could have done and I should have done it years before I did it. (Interview 24)

DISCUSSION

Most family physicians who participated in this study struggled to achieve and maintain a satisfactory balance between professional and private responsibilities. More women and younger physicians indicated that they tried

to balance their professional and personal lives, while older physicians expressed regret for having allowed their work to impose on their personal lives, particularly because they missed many of the pivotal moments of parenthood. In a proactive manner, however, many young physicians have taken action to avoid “missing out” by limiting their involvement with EDs or after-hours clinics, recognizing how those types of work can infringe on their family lives. Paperwork and “extras,” such as on-call shifts, ED involvement, and after-hours clinics—in addition to the regular practice hours—are hugely demanding. Moreover, on top of professional demands, some rural physicians feel that they are unable to “take their white coats off” in the community because patients do not respect professional boundaries.

Although the literature is not robust in this area, the available research seems to indicate that when physicians are unable to find a satisfactory balance between their professional and family lives, they “burn out” and leave the profession—many medical students, in fact, decide not to enter it at all. A study in the United States has demonstrated that lifestyle issues have a significant effect on a medical student’s choice of specialty ($P < .001$).¹⁵ Family practice was classified in the same study as having an “uncontrollable lifestyle” and had dropped in preference—in 1996 it was the choice of 73% of medical graduates compared with 47% in 2002, for both male and female medical students.^{15,16} In Canada, the percentage of medical undergraduates selecting family medicine as their first-choice specialty dropped from 44% in 1992 to 28% in 2005.¹⁷ Although there is no specific evidence indicating a causal relationship between the “uncontrollable lifestyle” of family medicine and the decreasing numbers of medical students opting for family practice, it is reasonable to assume that quality-of-life factors and lifestyle issues might play a role.

It is possible that our self-selected study sample was biased—physicians who struggle with professional boundaries were probably more likely to participate in this study. Nevertheless, the participants represent an important group among family physicians. In light of both our findings and the fact that there is already an existing deficit of family physicians in Canada, any risk of burnout and premature retirement, reduction in working hours, or refusal to work in certain settings will have a considerable influence on the delivery of primary care.¹⁷ Although this study examined the experiences of family physicians in New Brunswick, we believe that the study results can be generalized to other communities in Canada, especially the small towns and rural areas of all provinces.


For family physicians, the balance between professional and family responsibility is important. The old-school model of the male physician with a “stay-at-home wife” who manages all domestic affairs is outdated and does not reflect the current makeup and values of the

family physician labour force.¹⁸ Recruitment and training of young physicians should take this new reality into consideration.

Implications

Medical schools, residency programs, professional advocacy agencies, and health care systems might want to develop curricula and policies that deal with professional and personal boundaries so that family physicians are equipped with the knowledge and tools to cope with any problems that might arise. We believe that this is not a frivolous issue, particularly owing to the professional repercussions (fewer physicians in rural areas, after-hours clinics, EDs, etc).

Conclusion

Many family physicians believe that their professional responsibilities infringe on their personal lives. Family physicians in small communities and rural areas in particular have great difficulty stepping out of their professional roles because community members often approach them after hours, instead of respecting their privacy as individuals. Many family physicians in New Brunswick struggle to maintain professional and personal boundaries. One of the strategies uncovered in this study for dealing with this issue of a skewed work-life balance was to work fewer hours or refuse to work in demanding settings, such as EDs or rural areas. The consequences of coping strategies like these will be dire for the continued provision of primary care in this country. 

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Contributors

Dr Miedema was the principal investigator for this study and contributed to all parts of the project, from conception to the final manuscript. **Dr Fortin** was a coinvestigator. **Ms Easley** and **Mr Hamilton** contributed to the study design, data collection and analysis, and writing the manuscript. **Dr Tatemichi** was a coinvestigator and contributed to the study design and to writing up the results.

Competing interests

None declared

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