

### It's more than "just" a year

As a family physician who began practising relatively recently, I read with some concern Dr Buchman's President's Message that called for consideration of lengthening family medicine residency training to 3 years.<sup>1</sup> His arguments in support of re-opening the debate about the length and scope of family medicine residency can be broadly summarized as the following: studying family medicine has become more difficult over the decades; fewer family physicians are providing full-scope, comprehensive care; and, simply put, other jurisdictions are doing it, so why shouldn't we?

The first argument presents the logical fallacy that "different is more difficult." We can concede that family practice today is different. However, calling it *more difficult* ignores the fact that the broad nature of family practice has always challenged physicians who have made it their calling. Consider that family physicians in 1972 and 1992 did not have nearly as much access to diagnostic, therapeutic, programmatic, and allied health support as family physicians do today. In essence, it is not solely the problems that have changed. There is an armamentarium that has grown alongside; the advent of electronic medical records,<sup>2</sup> the Internet,<sup>3</sup> multidisciplinary health teams,<sup>4</sup> improved patient education, and novel teaching methods all allow today's family physicians to effectively and efficiently address the new challenges faced by our specialty.

Related to this, we must remember that there is no replacement for the practical knowledge that comes from practising in the very environment that Dr Buchman describes. Academic family medicine resident practices are often heavily skewed to specific population groups.<sup>5</sup> One questions what would be gained by a third year in such an environment instead of shouldering the full responsibility of a real-world practice. Nothing can

replace the valuable lessons I learned during my first year of practice, when it was me on the hot seat without a tether.

In his second argument, Dr Buchman correctly states that "many factors contribute" to fewer family physicians deciding to practise full-scope comprehensive care, but highlights his belief that a 2-year residency is "likely ... too short" for residents to gain the confidence and achieve the competencies required to practise family medicine today.<sup>1</sup> This could be true. However, anecdotally among my colleagues and I, there are certain procedures that today's graduating family physicians will never be interested in practising. Indeed, many residents choose family medicine for the sole reason of avoiding surgical or hospital involvement<sup>6</sup>; others select family medicine because of the flexibility associated with a broad field of practice.<sup>7</sup>

In many cases, avoidance of certain aspects of comprehensive care is more related to a lack of interest than a lack of confidence. If someone is uninterested, they are no more likely to develop these skills by pursuing learning experiences in a 3-year program than they would be after a 2-year program. Competency-based education is more likely the way to go: support those who are interested in specific areas, while ensuring all physicians (including those less interested) at least know the basics. The expectation that all family physicians will practise comprehensive care in all settings and regions of our diverse country unfortunately lies somewhere just short of fantasy. Supporting trainee interests and talents would be more effective in ensuring appropriate allocation of training opportunities and subsequent distribution of human resources.

The final argument—that other jurisdictions are lengthening their training time—can be addressed in many ways. Other jurisdictions are not Canada, for one. But closer to that, Canada's proximity to the United States (US) is concerning. As Dr Buchman rightly points out, the US has long required at least 3 years of training in an Accreditation Council for Graduate Medical Education-accredited program to qualify for board certification. At present, family physicians seeking to head south need to jump several hoops to qualify for board certification, which include either doing another year of residency in the US (or a deemed equivalent, such as an enhanced skills year), or being non-certified but "involved in family medicine" and a resident in the US for 6 months (presumably without pay) before challenging the board examination.<sup>8</sup>

These requirements are in place, obviously, to protect the domestic US market of family physicians. However, as Obamacare survived the November election, we also know the US will be hard pressed to recruit a vast amount of primary care physicians to provide service

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to the nearly 40 million Americans who will now have health insurance.<sup>9</sup> We would, essentially, be making it easier for Canadian physicians to show equivalence of training and head south, particularly before the 4-year requirement is put in place.

Finally, Dr Buchman's message also does not address the negative aspects that are associated with adding an extra year of residency training. Canadian physicians today are graduating with some of the highest debt levels ever seen.<sup>10</sup> An additional year of resident-level pay pushes these residents toward greater delay of financial independence, which delays related issues such as starting a family, settling in a practice, and so on. Further, one can't help but wonder if the addition of a third year of residency would be resented as a move to squeeze an additional "service" year out of a resident who is functioning at the level of a family physician.

We also know many medical students choose family medicine because of the length of training.<sup>11</sup> How will we reverse the shortage of family physicians if family medicine training is 5 years long (like in Australia, which remunerates residents and registrars at rates far higher than those in Canada<sup>12</sup>) and does not have the remuneration parity or respect that other specialists derive from

the same length of training? Finally, there is nothing to say that a third year would actually develop the skills that are in demand. At present, there are enhanced skills programs that those interested in further training can pursue. Is there something wrong with this system?

There are, to be sure, positives and negatives to be gained by moving to 3 years' worth of family medicine residency. After an overwhelming endorsement from the President of the College of Family Physicians of Canada, I hope this letter highlights some of the potential pitfalls. As the old saying goes, "if it ain't broke, don't fix it." The question of whether family medicine training as it stands today is "broke" should probably be debated first before we decide on a "fix."

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#### Competing interests

None declared

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## Bioidentical hormone therapy

The conclusion of the July Tools for Practice, “that there is no convincing evidence that bioidentical hormones are safer or more effective than synthetic HRT [hormone replacement therapy],”<sup>1</sup> is contradicted by a meta-analysis that concluded “physiological data and clinical outcomes demonstrate that bioidentical hormones are associated with lower risks, including the risk of breast cancer and cardiovascular disease, and are more efficacious than their synthetic and animal-derived counterparts. Until evidence to the contrary, bioidentical hormones remain the preferred method of HRT. Further randomized controlled trials are needed to delineate these differences more clearly.”<sup>2</sup> I wonder if the authors of the Tools for Practice have reviewed the papers that made up this meta-analysis.

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### Competing interests

None declared

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## Response

Thank you for your comments regarding the Tools for Practice on bioidentical hormones.<sup>1</sup> As you mentioned, there is a commonly referred to review published in *Postgraduate Medicine* that comes to very different conclusions regarding the efficacy and safety of bioidentical hormones.<sup>2</sup> We are very familiar with this review.

First, we would point out that this is not a systematic review or meta-analysis, but rather a general review of the literature.<sup>2</sup> Of the 196 references listed in this review, we found only 2 randomized controlled trials that compared progesterone to medroxyprogesterone acetate (MPA) with regard to symptoms and tolerability.<sup>3-5</sup> One of these involved only 23 women.<sup>3</sup> The other, published as 2 papers looking at different symptoms, was discussed in our Tools for Practice and demonstrated no significant benefit of progesterone compared with MPA.<sup>4,5</sup> The conclusion for harm reduction with regard to breast cancer was based largely on 1 cohort study (2 publications), which we also reviewed and found to contain a number of potential biases.<sup>6,7</sup> No studies comparing progesterone with MPA looked at clinical outcomes for cardiovascular harm reduction.

The largest trial cited in this review assessed surrogate outcomes and reported a statistically significant increase in high-density lipoprotein cholesterol with progesterone (Bonferroni  $P < .004$ ).<sup>8</sup> We know from previous data that increases in high-density lipoprotein cholesterol do not always correlate positively with improved clinical outcomes.<sup>9</sup> The other articles refer mainly to in vitro data, observational data, or data from primates. We believe that one cannot make reliable conclusions with regard to human outcomes from these data. Our opinion is that the conclusion presented in this review is in stark contrast to the evidence that is presented. Of note, while Dr Holtorf reported no conflict of interest in the writing of the paper, he is Medical Director of Holtorf Medical Group Inc, which is a centre for “hormone balance, hypothyroidism and fatigue” and is self-reported to provide physicians a “turn-key program for a successful cash-based anti-aging practice.”<sup>10</sup>

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### Competing interests

None declared

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