

Correspondance

Yes, being sued can be painful and perhaps even destructive. But it would be far worse, for individual patients and for society, if we failed to use the commission of an error as an impetus to be frank about our mistakes and as an opportunity to improve patient safety.

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1. Hébert PC, Levin AV, Robertson G. Bioethics for clinicians: 23. Disclosure of medical error. *CMAJ* 2001;164(4):509-13.

Take a lesson from the drug companies

The authors who recently reviewed the barriers that inhibit the implementation of hypertension management guidelines in Canada¹ neglected to mention what might be one of the most important factors: the powerful influence of pharmaceutical manufacturers' marketing campaigns on physician practice patterns.² The freebie phenomenon was addressed in a news item in the same issue of *CMAJ* in which the review appeared.³ Flip through the pages of that particular issue and you will come across 5 glossy advertisements promoting angiotensin-converting-enzyme inhibitors or AT₁ receptor blockers in the treatment of hypertension. Clinical practice guidelines are reflected only in footnotes in tiny print stating that the drugs being advertised are indicated when treatment with diuretics or β -blockers is ineffective or not appropriate.

If the groups that create clinical practice guidelines are wondering how to influence physicians' practices more effectively across the country, perhaps they should take a lesson from the drug companies: give out lots of free samples and promotional items, host elaborate events at which physicians are told about the excellent safety and tolerability profiles of the recommended drugs and place glossy 2-page ads in each issue of *CMAJ*. Apparently, it works.

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2. Wazana A. Physicians and the pharmaceutical industry: Is a gift ever just a gift? *JAMA* 2000; 283(3):373-80.
3. Sibbald B. Doctors asked to take pledge to shun drug company freebies. *CMAJ* 2001;164(4):531.

Choosing family medicine

As a third-year medical student trying to choose a specialty, I was interested in your recent article on the residency match.¹ I am attracted to family medicine's breadth and its emphasis on the total care of the patient. I recognize the value of continuity of care: by knowing your patients, you can see their medical problems in context. In other words, you can treat the patient, not just the disease.

However, to a person in his 20s, the concept of continuity of care can seem stifling: "For the good of your patients, you must never leave!" What if you are a family physician who ends up in an underserved community and after a few years you are miserable? If you pack up and leave, you betray your patients. Furthermore, the energy (and money) you invested in your practice may be lost.

Sadly, most family physicians must become business managers as well as

doctors: they must buy their equipment, hire staff, recruit patients, struggle with office expenses and hope that their practice stays afloat. Sometimes it seems much more attractive to work as an internist in a hospital because the office, the equipment and even the patients may be provided. Thus, you are free to practise medicine instead of trying to run a business. You are also surrounded by colleagues with whom you can discuss cases, socialize and engage in research projects.

On one hand, being a family doctor who provides total care seems exciting. On the other hand, I am scared that in doing so I will be trapped forever in some isolated community, cut off from the world of research and buried under a mountain of office expenses and paperwork.

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Reference

1. Sullivan P. Family medicine loses lustre as students "vote with feet" in 2001 residency match. *CMAJ* 2001;164(8):1194.

I was surprised your article on the 2001 residency match¹ did not mention the introduction of the 2-year family medicine residency, albeit almost 10 years ago, as a factor in the declining popularity of family medicine among medical students.

I graduated from Dalhousie in 2000 and am currently a first-year resident in anesthesia. During medical school I considered a career in family medicine and enjoyed my rotations in it during clerkship. I would love to have had a chance to practise it for a few years before ultimately deciding whether to specialize further. However, my decision to apply only to anesthesia was based, among other reasons, on the belief that it would not be worth losing 1 to 2 years of training (which is the cost of doing a 2-year family medicine residency and later beginning in another specialty program and having to repeat PGY-1 or PGY-2 or both). This and