

Reply to letter to the Editor of T. Deutsch et al.: Efforts to maintain rural motivation should be encouraged and documented

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Implementing courses and electives to improve the attraction of primary care and rural practice, such as those presented by Deutsch and colleagues [1], can contribute to limiting the negative effects of traditional hospital-based and specialty-heavy medical curricula. Such efforts do exist in many countries. As the authors point out, reports on their effectiveness are not limited to English-language literature [2]. These programmes are important: their implementation and effects should indeed be documented as well as possible to encourage others to adopt similar curricular changes.

It is plausible that establishing general practice chairs in every medical school, as called for by the authors, will contribute to these efforts. Academic general practice chairs are likely to enhance the prestige of general practice and provide role models for medical students. Developing research programmes focused on questions relevant to general practice would make the intellectual challenges of general medicine more visible, improving the attraction of the field for medical graduates. Improving the evidence base available to general practitioners for some of the specific difficulties they face could also lead to decreased work frustration, further improving recruitment and retention. Should rich countries – such as Switzerland and Germany – lead the way, this could simultaneously decrease the need for foreign medical graduates and improve the prestige of general practice in poorer countries as well [3].

As the authors point out, however, actually documenting such effects is difficult and the literature on curricular interventions to improve medical graduates' interest in primary care and rural practice is weak. One possible cause could be the very point made by the authors, that “career choice is a multifactorial process with many factors beyond the medical school's sphere of influence.” There are two elements here: like other attempts to induce behaviour changes [4], curricular changes to improve interest in primary care and rural practice can require multi-component interventions, and their results will play out in complex systems [5]. Rather than considering students' regional background as a source of bias, then, it may be more realistic to consider it as a component of either the intervention (if such recruit-

ment was intentional) or of its context (if it was not). In any case, strengthening the evidence base on which to build effective curricular changes for primary care and rural practice could require greater integration of such elements into the description of studies and interpretation of results [6].

Another possible cause for the weakness of this literature is the difficulty in interpreting data on mere intention to engage in primary care. Although data on actual recruitment and retention in primary care and rural practice should become the gold standard in this field, the timeline within which researchers are encouraged to publish their results can remain an obstacle as such approaches require lengthy follow-up. Inasmuch as such publication incentives encourage the preservation of traditional curricula as the default, they represent yet another manner in which the structure of medical schools is contributing – albeit indirectly – to maintaining curricula that may be turning students away from primary care and rural practice.

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