

## Family Medicine in Switzerland: Training Experiences in Medical School and Residency

Barbara Buddeberg-Fischer, MD; Martina Stamm, lic. phil.; Franz Marty, MD

**Background and Objectives:** *A shift away from family medicine to medical specialties is noticed in many of the competition-based health care systems in Western countries. Our study's objective was to learn about career development of young physicians in German-speaking countries, with a particular focus on Switzerland. Methods:* We performed a qualitative assessment of data on physicians' training experiences in family medicine during medical school and residency. Data were obtained through a focus group interview with 12 participants, six of whom were family medicine residents, and data were analyzed by content analysis. **Results:** *The results indicate that family medicine is not well established in medical school curricula, that family physicians are often discriminated against by specialists with regard to their professional competence, that there are no structured residency programs and a lack of information about residency posts in family medicine as well as family practices to be taken over, and that the competition-based health care system does not foster a gatekeeper model and favors financially the specialists' work to the detriment of that of family physicians. Conclusions:* Suggestions for improvement of the situation of family medicine include providing well-trained family physicians as educators in medical schools, early training courses in family practices in medical school for all students, well-structured residency programs, support by the Swiss Society of Family Medicine in planning to open a family practice, financial incentives for family physicians, and implementation of gatekeeper models.

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In the last decade, a marked shift away from family medicine to other medical specialties has taken place in the health care systems of most Western countries, especially in those with competition-based health care systems (CBHCS). In 2006, of all practicing physicians in Switzerland ( $n=28,812$ ), only 13.6% were family physicians, and of all newly qualified physicians in 2006, only 13.4% specialized in family medicine.<sup>1</sup>

In Germany, the percentage of family physicians has also declined, and only half of the physicians who qualified as family physicians in the last years opened private practices.<sup>2</sup> In the United States, there has also been a marked decline in the number of medical school graduates going into family medicine.<sup>3</sup> In Great Britain, as reported in the British Medical Association cohort study,<sup>4</sup> one third of a cohort of physicians were working as family physicians 10 years after graduation. In

Norway, where one quarter of all currently practicing physicians are family physicians,<sup>5</sup> the percentage of newly certified family physicians has been stable in the last few years. Overall, the shortage of physicians providing basic health care in countries with CBHCS is not only being noticed in rural regions but is also starting to be a problem in metropolitan areas.

Reasons for the waning interest in family medicine are reported in several studies.<sup>3,6</sup> Economic incentives are one factor driving students' choice of careers<sup>7</sup> as the reimbursement gap between generalists and specialists is steadily widening in the CBHCS of Western countries.<sup>8</sup> Besides the economic reasons, the incompatibility of family medicine with the young physicians' lifestyle expectations,<sup>7,9,10</sup> or its failure to provide sufficient intellectual stimulation to sustain their interest are explanations frequently given by young physicians for a lack of interest in family medicine.<sup>6</sup>

We have been conducting a prospective study on career development of young physicians in German-speaking countries since 2001.<sup>11-13</sup> A cohort of 522 subjects has been followed up from graduation through

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From the Department of Psychosocial Medicine, Zurich University Hospital (Prof. Buddeberg-Fischer and Ms Stamm) and Swiss Society of Family Medicine (Dr Marty), Zurich, Switzerland.

to residency. As part of this study, the Swiss Federal Office of Public Health wanted to gain insight about the factors that prevent or support young physicians from specializing in family medicine. The results provide a basis for developing health policy strategies to improve the attractiveness of family medicine.

The aims of the present study were to investigate (1) the young doctors' experiences in family medicine training during medical school and residency, (2) the residents' view of significant aspects of family medicine in the CBHCS, and (3) the physicians' suggestions about how to make family medicine more attractive.

## Methods

### *Study Design and Study Sample*

The present study is part of an ongoing prospective survey of a cohort of graduates in the three medical schools in German-speaking Switzerland, beginning in 2001 (T1).<sup>11</sup> Subjects were reevaluated after 2 years in 2003 (T2)<sup>12</sup> and after 4 years in 2005 (T3).<sup>13</sup> In the third assessment, 522 fourth-year residents participated.

A subsample of the 522 residents study group were asked to participate in a focus group interview. The selection criteria to be invited to the focus group interview were the following: pursuing a career in family medicine (n=42) or pursuing a hospital career in internal medicine (n=48). From the addressed subsample, six physicians aiming for family medicine and six aiming for internal medicine agreed to participate in the focus group discussion (seven females, five males). The study was approved by the university's Research Committee on Ethical Issues.

### *Instruments*

A semi-structured interview guideline was developed. Three topics (domains) were formulated: (1) experiences in family medicine training in medical school, (2) experiences in family medicine residency, and (3) significant aspects of family medicine. The interview guide included questions about suggestions for improvement in each domain.

### *Procedure*

The focus group interview took place at the Department of Psychosocial Medicine, Zurich University Hospital, in April 2006. The first author moderated the discussion, the second author observed and took notes, the third author, a family physician himself, added some statements based on his own experience. The discussion lasted 3 hours and was tape-recorded.

### *Analysis of the Interview Material*

The material was analyzed according to the method of qualitative content analyses described by Mayring.<sup>14</sup> The recorded material was transcribed by the second author. The assignment of the statements to the three

domains of the interview guideline was made independently by the three authors and a further senior researcher in a first step and adapted after a joint discussion in a second step. The material of each domain was assigned to inductively established categories, and the number of categories was reduced by summarizing categories with similar content step by step. This procedure was partly carried out in a workshop for researchers in qualitative methods headed by an expert in qualitative research<sup>15</sup> and completed by the first and second authors.

## Results

In the following sections, the responses of the focus group participants are described according to the three domains. At the beginning of each section, the background of the addressed issue describing the situation in Switzerland is outlined.

### *Experiences in Family Medicine Training in Medical School*

**Situation in Switzerland.** It is only in the last 10 years that lectures given by family physicians have been integrated in medical school curricula in Switzerland. These lectures aim to give the students insight into what patients and illnesses are most common in primary care practice. At some universities, a one-to-one tutorship between a family physician teacher and a student has been established. This kind of teaching takes place in the private practice of the tutor.

**Focus Group Data.** The one-to-one tutorship was mentioned as an especially motivating experience, while the family physicians' lectures were often rated as less professional compared to those given by other specialists. When specialists and family physicians were supposed to present a topic together, what happened was that the specialist took most of the time, leaving the last 10 minutes for the family physician to report his/her view of the medical problem.

**Suggestions for Improvement.** Suggestions for including family medicine in medical school include having a higher percentage of lectures addressing family medicine issues and for more well-trained family physician teachers to be integrated in the university staff. It was also suggested that all residents, not only those who want to specialize in family medicine, should pass an internship in a family medicine facility.

### *Experiences in Family Medicine Residency*

**Situation in Switzerland.** Postgraduate training in Switzerland and the other German-speaking countries, Germany and Austria, is organized differently than in the Anglo-Saxon and Scandinavian countries. In the latter, graduate students apply for a residency as

a whole. In the United States and Canada, there are even residency matching programs. The residents have guaranteed rotations to different posts of their aspired-to specialty, family medicine included. In Switzerland, as well as in the other German-speaking countries, on the other hand, medical school graduates have to apply for each post of their residency separately.

Thus, to specialize in family medicine, residents have to pass a 1-year inpatient post in internal medicine, a 1-year inpatient or outpatient post in internal medicine or family medicine, and another 3 years in optional specialties. Up to 3 years of the total residency can be attended in an approved training family practice. Quite often, family medicine residents do not get the aspired-to resident post in a certain specialty because the heads of departments prefer to employ residents of their own specialty.

**Focus Group Data.** The material obtained in the second domain revealed three content categories: (1) planning the residency posts, (2) experience of being exploited or discriminated against as a family medicine resident, (3) experiences as resident in a family medicine facility.

Pertinent to the first category, family medicine residents have to organize the different posts themselves. It is difficult to get jobs in the same geographical area, ie, they often have to move. Another problem arises in that the timing of the assistantships is difficult, ie, they have vacancies in between with no salary. Planning for starting one's own practice is difficult. Since there is no administration office for practice vacancies, it is often not known which practice is to be taken over.

In relation to the second category, family medicine residents reported that they not only had difficulties getting a residency post in the optional specialties (eg, dermatology, gynecology and obstetrics, rheumatology) but also reported that they were not treated as other residents on those posts, as they were not permitted to attend medical conferences or to participate in special courses such as those on ultrasonic methods. Further, the residents witnessed negative statements from hospital doctors about family physicians, or family medicine residents were assessed by clinicians to be less qualified than residents in other specialties.

In the third category of answers, participants reported experiences as a resident in a family physician's practice. Those doctors who had attended such a post appreciated it very much and were encouraged for their own family practice later on. However, they claimed that the salary was one quarter below the salary of a resident working in a hospital.

**Suggestions for Improvement.** To improve the professional prestige of family medicine and to overcome the shortage of family physicians, it was suggested that

residents of all medical specialties should be obliged to work in a family practice for at least 6 months. Further, a central office should pass information to the family medicine residents about which family practices are to be taken over at what time.

#### *Significant Aspects of Family Medicine*

**Situation in Switzerland.** Switzerland has a CBHCS. All employed people have a basic obligatory health insurance that covers a wide range of diagnostic and treatment procedures. The doctor bills the patient for the treatment, and the insurance companies refund the money to the patient. Each patient can choose the doctor, ie, patients can either visit a family physician first or can directly ask for a consultation with a specialist. In the last decade, there is a trend to go directly to the specialist for each complaint, with the consequence that minor and everyday clinical problems bypass primary care for "first-contact services."

**Focus Group Data.** The positive aspects of family medicine identified were the variety of the work, the possibility of seeing the patient as a biopsychosocial subject and not only in terms of diseased organs, the opportunity to follow a patient through the whole lifespan, and establishing a longstanding and profound doctor-patient relationship. A positive work-life balance and being one's own boss were further positive aspects. On the other hand, some claimed that the variety of diseases seen in family medicine practice is decreasing because many patients don't have a family physician and instead, directly visit a specialist. Most negative statements addressed the low professional and social prestige and the low income of family physicians.

**Suggestions for Improvement.** Participants recommend higher salaries for family physicians, allowing patients access to specialists only by a family physician (gatekeeper model), centralized emergency units, and promotion of group practices in which family physicians and other specialists work together.

#### **Discussion**

The present study is part of the first prospective cohort study on career determinants of young physicians in German-speaking countries. Limitations of the study are the small number of interview participants. However, their statements are in accordance with quantitatively assessed data of our cohort study.<sup>16,17</sup>

Below, we discuss the study results in light of what has already been planned and in progress for improving the situation of family physicians in Switzerland and comment on what still has to be done. The situation of family medicine in Switzerland is also compared to that in other countries.

### *Family Medicine as an Academic Subject at Medical School*

Compared to Canada, the United States, Scandinavia, and The Netherlands,<sup>18-23</sup> family medicine is not well established as an academic subject in medical schools in Switzerland. As of 2005, only one out of five medical schools has a chair for family medicine; at two other universities such a chair is to be established in 2007. In addition, one-to-one tutorships between a student and a family physician teacher have been established in most of the Swiss medical schools' curricula.<sup>24,25</sup>

### *Family Medicine Residency*

Several factors have a negative influence on Swiss medical school graduates' decision not to choose family medicine for residency training and specialty qualification. First, there is the low social and professional prestige combined with the prospect of relatively low income in the future. Second, there are no structured residency programs, as known in Anglo-Saxon and Scandinavian countries.<sup>26</sup> Third, there is a lack of positive family physician role models.<sup>27</sup> Instead, family medicine trainees are confronted with derogatory statements by hospital doctors about family physicians not being competent or having missed a diagnosis. All these factors together contribute to the fact that only 128 new qualification certificates were given to family physicians in Switzerland in 2006.<sup>1</sup> About 160 family physicians per year would have to open a new practice to maintain the current population's primary health care.<sup>28,29</sup>

According to the Swiss family medicine residency curriculum,<sup>30</sup> up to 3 years of the total residency could be achieved in an approved training family medicine practice. Due to problems of financing training posts in private family practices, however, most parts of the residency are attended in inpatient and less frequently in outpatient settings in hospitals, rather than in family medicine posts. To date, residency posts in training practices have been reimbursed at a lower rate than those in hospitals, and the salary is only three quarters of the regular resident salary. Further, the family physician teacher has to pay half of the salary of the resident, so both parties (the family physician and the resident) suffer financial penalties.

Health politicians have recognized that there is need for action to remedy these concerns. The governments of some cantons in Switzerland have started to support the residency training in family practices financially (the public health departments pay three quarters, the family physician one quarter of the assistant's salary), paying the family practice resident the same salary as the public hospital resident.

### *Significant Aspects of Family Medicine and the Health Care System*

The significance of family medicine is different in various countries. In Great Britain, The Netherlands, and the Scandinavian countries, for example, family physicians play a central role in the health care system, treating the majority of ailments and caring for more than 90% of health care problems presenting to their practice.<sup>31,32</sup> They function as gatekeepers for other medical specialists and hospital admissions. By contrast, in Germany, along with Switzerland, France, Belgium, and the United States, there is no gatekeeping system.<sup>32</sup> In these countries, there is also no patient list system, and patients may elect to consult any family physician or specialist at their own discretion. There is the risk that a family physician is only seen for minor medical problems or in emergency situations at off-hours. The free choice of first doctor to contact can lead to patients "shopping around" for care and to over-consumption of medical care and consequent increases in health care expenditure.

The participants in our study, as well as reports from other studies, indicate that a variety of other problems also decrease interest in family medicine. These include lack of intellectual challenge,<sup>6</sup> increasing administrative and time-consuming efforts, and the uncertain development of health politics.<sup>33,34</sup>

### **Conclusions**

Suggestions for improvement of the situation for family medicine in Switzerland include the following four interventions. First, well-trained family physician educators and early contact with work in family practices by obligatory family medicine courses in medical school should be available to all medical students. Second, there is need for well-structured residency programs (organization of the residency posts by a central institution). Third, the Swiss Medical Association or the Swiss Society for Family Medicine should distribute information to the residents about the region and dates in which a family practice could be taken over. And fourth, there is need for better financial incentives for family physicians.

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*Corresponding Author:* Address correspondence to Prof. Buddeberg-Fischer, Zurich University Hospital, Department of Psychosocial Medicine, Haldenbachstrasse 18, CH-8091 Zurich, Switzerland. 0041-44-255 51 27. Fax: 0041-44-255 43 84. barbara.buddeberg@usz.ch.

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