Resident Doctors of Canada

# A Resident-Informed Path Forward for Canada's Primary Care Crisis

POSITION PAPER

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# Family Medicine Matters

The practice of Family Medicine in Canada faces profound, widely acknowledged challenges. These are not only felt by practicing physicians, but also by the resident doctors preparing to join the profession. At Resident Doctors of Canada (RDoC), our mission is to champion the healthiest ways for residents to learn and work. Guided by our board-approved strategic plan, we address national issues affecting the quality of postgraduate medical education and advocate for system-level change rooted in the lived experiences of all residents.

Within that context, for over 50 years, RDoC has served as the national independent voice of all family medicine residents (outside of Quebec). During this time, we have collaborated with the College of Family Physicians of Canada (CFPC) to ensure the best possible medical education experience for Family Medicine residents.

This collaboration is particularly critical at a time when Family Medicine in Canada is facing profound and widely acknowledged challenges - challenges that are being felt acutely by residents as they prepare to enter practice.

In 2024, RDoC convened a national Family Medicine Team to capture resident perspectives on the current state of Family Medicine training and practice. This group reflected the breadth of Family Medicine training across Canada, including urban, rural, and remote settings; Indigenous and Black communities; Enhanced Skills programs; the Medical Officer Training program; and representation from the CFPC Section of Residents. Through a professionally facilitated process, residents identified key pressures within the training environment, expressed concerns about entering a profession under strain, and articulated opportunities for meaningful system-level improvement. They also outlined what they saw as opportunities for RDoC to engage and help the situation.

RDoC has since made the following commitments:

- Participate on the joint CFPC and Canadian Medical Association (CMA) Focus on Family Medicine Task Force with a commitment to:
    - Voice concerns of Family Medicine residents;
    - Elevate Family Medicine as a specialty;
    - Advocate for policies that support residents in their transition to practice;
    - Contribute to working groups aimed at improving practice conditions and reducing administrative burden.
- Increase collaboration with the CFPC through existing and potential committee opportunities;
- Develop opportunities for residents to share the story of their training experiences;
- Widely disseminate and move forward recommendations outlined in RDoC's *Determinants of Resident Health* research project;

- Address and respond to anti-Indigenous and anti-Black racism in all specialties, with a specific focus on Family Medicine;
- Collaborate with Provincial Housestaff Organizations (PHOs) (regional professional associations of resident doctors), Postgraduate Medical Education (PGME) offices, and the larger medical education community to develop and implement actionable responses to the occupational health and safety risk of excessive fatigue in all specialties, with special attention to the unique challenges faced in Family Medicine;
- Establish a Family Medicine–specific award to recognize and elevate the contributions and leadership of residents in the specialty;
- Develop supporting tools for PHO contract negotiations with employers, with a focus on adapting contracts to the specific needs of Family Medicine residents.

This position paper was also identified as an outcome by the Team to support advocacy efforts. Its purpose is to outline a rationale for optimizing Family Medicine training so that future family physicians are well prepared, supported, and empowered to meet the evolving health care needs of Canadians, both in the context of the current crisis and throughout their careers.

## Executive Summary

Canada's primary care system is in a deepening access crisis, with an estimated 5.8 million Canadians lacking a family physician as of 2026. This growing gap has led to increased reliance on emergency departments for routine and chronic care, contributing to system inefficiencies and physician burnout. At the same time, the existing workforce is shrinking, with two-thirds of family physicians expected to reduce hours or retire within five years.

Crucially, this crisis is not solely a workforce supply issue. While efforts such as expanding residency positions and recruiting internationally trained physicians are underway, they have proven insufficient. Structural challenges—such as unsustainable working conditions, misaligned compensation models, administrative burden, and lack of work-life balance—discourage both entry into Family Medicine and long-term participation in comprehensive primary care. If training continues to rely on unsustainable workload, the system will continue to produce physicians who rationally avoid the very practice models it seeks to expand.

Resident doctors and medical students represent the future of the family medicine workforce. Their career decisions should be understood not as a lack of interest in comprehensive care, but as a signal about the conditions into which they are being asked to graduate.  Increasing reliance on alternative career paths such as hospital-based or focused practice reflects, in part, the gap between residents' commitment to patient care and the systemic realities of practice models that can leave comprehensive family physicians undersupported, overburdened, and financially vulnerable.

Medical education plays a pivotal role in shaping these outcomes. Misalignment between training environments and real-world practice, exposure to unsustainable workloads, and the influence of the hidden curriculum all contribute to declining interest in longitudinal primary care. Issues such as racism, excessive

fatigue, and lack of supportive learning environments further impact resident wellbeing and career decision-making.

Addressing the primary care crisis requires coordinated action across the training and early-career continuum. Residency programs can better prepare residents for practice, but they cannot solve compensation, administrative burden, practice infrastructure, racism, or unsafe workloads alone. These recommendations therefore require shared accountability across medical education, health system planning, compensation reform, accreditation, and resident advocacy. Key strategies include aligning training with sustainable practice models, improving compensation and reducing administrative burden, supporting work-life balance, addressing systemic inequities, and strengthening professional culture around Family Medicine.

Family Medicine requires and should remain at two years of residency training. This paper does not argue that Family Medicine residents need longer training to become competent comprehensive family physicians. Rather, it argues that training and transition-to-practice must better prepare, support, and protect residents within the current two-year structure as health systems address the practice conditions that make comprehensive care difficult to sustain. Supporting resident wellbeing and aligning system structures with their needs will not only enhance physician satisfaction but is critical to rebuilding a sustainable primary care workforce and improving access to care for Canadians.

RDoC recommends the following actions:

1. **Measure and act on drivers of practice choice, including administrative burden, compensation, team-based supports, alignment with personal and professional priorities (e.g. financial stability, work-life balance)**

2. **Align training environments with sustainable real-world practice models**

3. **Improve access to sustainable compensation and practice-support models at entry to practice and throughout a physician's career**

4. **Reduce administrative and operational barriers to comprehensive care by funding shared infrastructure, compensating non-clinical work, and supporting team-based practice options**

5. **Operationalize and establish fatigue risk management as a foundational standard across the residency training and practice continuum**

6. **Dismantle the hidden curriculum and reform professional culture**

7. **Advance equity and anti-racism in training and practice**

## Recommendations

Canada continues to face a primary care access crisis with 17% of Canadians without a family doctor. However, this measure alone obscures the workforce dynamics driving and maintaining the shortage. Two-thirds of currently practising family physicians are expected to retire or reduce practice hours within the next five years (Myran et al., 2025, p.383) and Family Medicine residency positions have increasingly gone unfilled over the past decade (Myran et al., 2025), and many newly practising physicians are choosing hospital-based or focused practice rather than longitudinal primary care (CIHI, 2024b; Myran et al., 2025, p.384). Addressing access therefore requires attention not only to patient needs, but also to the conditions shaping physician career decisions.

Addressing Canada's primary care crisis requires action across the medical education and early-career transition continuum. Increasing residency seats alone will not produce more primary care physicians providing longitudinal comprehensive care unless the structural factors influencing practice career choices are addressed. These recommendations require coordinated action across medical education, health system planning, compensation reform, accreditation, and resident advocacy as no single organization can resolve these barriers alone.

RDoC recommends the following actions and the organizations responsible in parentheses:

**1. Measure and act on drivers of practice choice, including administrative burden, compensation, team-based supports, alignment with personal and professional priorities (e.g. financial stability, work-life balance)**

- As part of the CFPC's DARE-FM work, regularly collect and publicly report national data on resident and early-career physicians' intended and actual scope of practice, including factors influencing practice decisions over time. (CFPC)
- Incorporate resident and early-career physician input into provincial workforce planning and payment model design. (Provincial and territorial governments, Provincial and territorial medical associations)
- Align early-career practice supports (e.g., mentorship, transition-to-practice programs, and clinic integration supports) with resident-identified preferences, including team-based practice with more manageable administrative workloads. (Provincial and territorial governments, Provincial and territorial medical associations)

**2. Align training environments with sustainable real-world practice models**

- Require postgraduate programs to provide structured exposure to sustainable comprehensive practice models, including team-based clinics and shared-care environments with acknowledgement of sites already successfully doing so. (CFPC, FM programs)
- Expand longitudinal and rural training opportunities for medical students and residents, including continuity clinics and community-embedded rotations. (CFPC, Undergraduate Medical Education and FM programs)

- Ensure residents receive explicit preparation for practice operations, including billing, administrative processes, and team-based care management. (CFPC, FM programs)

**3. Improve access to sustainable compensation and practice-support models at entry to practice and throughout a physician's career**

- Increase availability of alternative and blended payment models in all provinces. (Provincial governments, provincial medical associations)
- Prioritize early-career physicians for positions within team-based primary care organizations. (Provincial and territorial governments, regional health authorities)
- Provide transition-to-practice incentives for physicians who establish, join or take over from transitioning colleagues longitudinal comprehensive practices, particularly in underserved communities. (Provincial and territorial governments, provincial and territorial health associations)

**4. Reduce administrative and operational barriers to comprehensive care by funding shared infrastructure, compensating non-clinical work, and supporting team-based practice options**

- Fund shared administrative supports (e.g., centralized staffing, billing support, and documentation assistance) for community-based primary care practices. (Provincial and territorial governments, regional health authorities)
- Compensate physicians for non-clinical work essential to longitudinal care, including care coordination, patient communication, and documentation. (Provincial and territorial governments, regional health authorities)
- Support adoption of practice infrastructure that reduces administrative workload, including team-based staffing and appropriate clinical technologies. (Provincial and territorial governments, regional health authorities)

**5. Operationalize and establish fatigue risk management as a foundational standard across the residency training and practice continuum**

- Recognize fatigue as a critical occupational health, safety, and patient-safety issue that demands protections and must be addressed throughout a physician's career to prevent burnout and early departure from the workforce. (CFPC, Royal College, institutions offering Postgraduate Medical Education, employers of resident doctors)
- Implement specialty-specific scheduling protections, duty-hour limits, and mandated post-call relief. (CFPC, Royal College, institutions offering Postgraduate Medical Education, employers of resident doctors)
- Provide national guidance and tools to programs on how to implement FRM, including mandatory FRM training for faculty and supervisors, FRM principles for program evaluation, and clearly defined FRM responsibilities for hospitals, PGME offices, and supervising physicians. (RDoC in partnership



with CFPC and Royal College)

- Ensure sustainable workload management is taught as a core professional competency for autonomous practice.
- Utilize non-punitive data systems to monitor the structural contributors to resident fatigue. (Institutions in collaboration with Provincial Housestaff Organizations)
- Require transparent, standardized work-hour logging across all rotations and sites, as well as protocols for when violations occur. (Institutions in collaboration with Provincial Housestaff Organizations)
- Ensure residents can decline unsafe work due to fatigue without academic or professional penalty. (Institutions)
- Enforce FRM accountability through accreditation, Provincial Housestaff Organization-PGME policy collaboration, and institutional accountability mechanisms. (Institutions, Provincial Housestaff Organizations)

**6. Dismantle the hidden curriculum and reform professional culture**

- Further incorporate respect for Family Medicine and team-based care into accreditation standards and faculty development. (CFPC, Royal College)
- Support initiatives that promote positive professional identity formation in Family Medicine, including mentorship and recognition programs. (CFPC, Provincial Family Physicians Colleges and Associations)

**7. Advance equity and anti-racism in training and practice**

- Implement anti-racism policies and reporting processes within training institutions and practice environments. (Institutions with support from relevant organizations)
- Support recruitment, retention, and advancement of physicians from equity-deserving communities and in rural, inner city and Indigenous communities. (Institutions with support from relevant organizations)
- Expand culturally safe and community-responsive primary care training opportunities, particularly in underserved and Indigenous communities. (Institutions, FM programs)
- Support accessible learning environments, recognizing accommodations as a legitimate component of equitable training. (Institutions, FM programs, CFPC)

Residents sit at the intersection of medical education and workforce planning. Their career decisions reflect what the system makes possible. Improving the sustainability of training and early practice will not only support residents, it will directly improve access to comprehensive primary care for Canadians. The rest of



this position paper details the training and practice situation from the resident lens and refers back to these recommendations to address the noted challenges.

## Canada's Primary Care Crisis: Not Simply a Workforce Supply Issue

Canada's primary health care system is facing a crisis of access driven by an insufficient supply of family doctors and unsustainable working conditions for those currently delivering care. As resident doctors and medical students prepare to enter this system, many are understandably concerned about how these realities will shape their professional lives, and whether it will be possible to provide high-quality, comprehensive care without personal harm or burnout.

RDoC's vision is for healthy residents to be fulfilled physicians. Achieving this vision requires that residents are able to look toward their future careers with optimism, confidence, and a sense of sustainability. This document outlines why intentional support for resident doctors and medical students pursuing Family Medicine, through training and early career transition, is essential to addressing the primary care crisis both now and in the years ahead.

In 2019, **4.5 million Canadians** did not have access to a family doctor (Duong & Vogel, 2023). By 2023, that number surged to **5.4 million Canadians**, approximately 17% of the total adult population (Canadian Institute for Health Information [CIHI], 2024a; Statistics Canada, 2025). As of 2026, that number has risen to an estimated **5.8 million** Canadians living without access to a family physician (Canadian Medical Association [CMA], 2026). The decline in primary care access has been stark and, in less than a ten year span, Canada's need for primary care access has dramatically expanded.

Consequently, Canadians have been left increasingly reliant on the Emergency Room (ER) as they attempt to seek alternative routes to primary care. This ER dependence costs the system more money and patients more time, and is not the most effective use of limited health human resources. Patients without a primary care provider turn to the ER not only for common acute issues, but also for essential care, including prescription refills (CIHI, 2024c) and the ongoing management of chronic conditions, such as diabetes (Zhang, 2024). For physicians attempting to meet the demands of a consistently overwhelmed ER, the price is burnout (Li et al., 2023).

Further, the crisis is expected to intensify. Even the current limited workforce is not sustainable, with research indicating that "two-thirds of family physicians who provide most of the primary care in Canada are expected to reduce practice hours, or retire within the next five years" (Myran et al., 2025, p.383).

**However, this crisis cannot be solved through workforce supply alone.** As the Canadian Medical Association (CMA) has noted, "focusing on recruiting more health care workers without addressing other systemic challenges will probably result in more burnout without notable gains in the system's performance." (2024, p.8)

Addressing this crisis requires intervention well before physicians reach independent practice, beginning instead in undergraduate and postgraduate medical education. **The current shortage is the predictable result of policies, perceptions, training environments and practice expectations that discourage physicians from both entering Family Medicine training and sustaining comprehensive primary care practices over time.**



RDoC recommends targeted action early in the medical education continuum to support resident doctors and medical students pursuing Family Medicine. By strengthening training environments and aligning expectations with sustainable models of care, medical education can help cultivate a new generation of family physicians who are equipped and willing to provide longitudinal primary care to their communities without sacrificing their health, wellbeing, or professional fulfillment.

## Considerations

Family Medicine resident doctors in Canada are highly motivated to enter practice and contribute to addressing the crisis in access to care. At the same time, they are calling for changes to the profession that reflect modern clinical, professional, and personal realities; changes that would enable them to thrive and sustain careers in longitudinal primary care.

RDoC represents the more than 2,700 residents in Family Medicine and Enhanced Skills programs in Canada outside of Quebec. To inform this work, RDoC convened a diverse and representative group of Family Medicine residents to articulate their aspirations for the profession and their concerns about its current trajectory. This position paper is a direct product of that resident advocacy and has been reviewed and validated by the contributing team.

Across training contexts, residents consistently expressed concern about their ability, individually and collectively, to resolve the crisis in access to care within existing system structures. The recommendations outlined in this paper are intended to address those concerns by strengthening the attractiveness and sustainability of longitudinal primary care practice, thereby supporting both resident wellbeing and the long-term capacity of Canada's primary care system.

### Adding more physicians

By 2031, Canada is expected to face a shortage of approximately 20,000 family physicians (CMA, n.d.). While bringing in internationally trained physicians and expanding Family Medicine residency seats may help alleviate this gap to some degree, relying solely on these measures is too limited an approach (Grudniewicz et al., 2023; Kiran, 2022) and has yet to yield sufficient results. Ultimately, the severity of this predicted shortage will largely depend on how responsive healthcare policy is to the needs and concerns of Family Medicine residents, Canada's future family doctors.

Canadian Family Medicine residency training seats doubled over the span of 2006 to 2023 (Myran et al., 2025, p.383). Despite this great expansion, from 2015 onward, a growing number of these seats have been left unfilled following the first and second rounds of the CaRMS match. In 2023, for example, following the first and second round of the CaRMS match, 16.5% and 6.1% of family medicine seats were left unfilled. By contrast, in 2010, much earlier in Canada's efforts to expand Family Medicine seats, 14.4% and 5.6% of seats were left unfilled following the first and second round of the CaRMS match (Myran et al., 2025, p.383). This demonstrates that **while Canada has been increasingly equipped to train more family doctors, medical students' interest in the specialty has not kept pace and needs to be addressed.** Expanding seats without addressing the conditions that currently make comprehensive practice unattractive risks producing more unmatched positions rather than more comprehensive family physicians.



Again, as noted by the CMA, simply increasing the number of residency positions will not resolve the primary care crisis. Each year in Canada, approximately 1,730 Family Medicine residents complete their two-year residency training and become full practicing physicians with a range of practice options available to them. These physicians represent a critical resource within the health care system as they are uniquely positioned to expand access to primary care. However, whether these doctors choose, or feel they have the choice to go into longitudinal primary care, is not guaranteed.

In recent years new-in-practice physicians have increasingly opted to work in hospitals and focused practice (CIHI, 2024b; Myran et al., 2025, p.384). This is not to say that these physicians are not interested in providing primary care (Mitra et al., 2021, p.805-806), but rather that there are serious challenges, limitations, and responsibilities that may deter them from choosing to enter practice as a longitudinal primary care provider. As one recent Family Medicine residency graduate put it, the issue is not lack of commitment to comprehensive care, but the conditions under which that care is currently expected to be delivered:

> *"We're not asking for less responsibility. We're asking for a system in which comprehensive Family Medicine remains viable, and in which doing it well doesn't require sacrificing our health, our financial stability, or our lives outside of medicine."*
>
> - Dr. Nicholas Preobrazenski, Family Medicine Physician

It is RDoC's position that Family Medicine physicians must retain the autonomy to practice in ways that align with their skills, interests, and circumstances. At the same time, meaningful improvements are required to ensure that longitudinal family practice is a viable, attractive, and sustainable option for those who wish to pursue it.

As trainees and new physicians opt for other specialties or to practice outside of longitudinal primary care, it becomes increasingly important to meaningfully engage Family Medicine residents in efforts to address Canada's family doctor shortage.

**Without addressing systemic challenges both within the training environment and the broader health care system, expanding the workforce risks perpetuating the very conditions that drive burnout and attrition.**

**Responding to the family doctor shortage in Canada requires meaningfully listening to the voices of those who have chosen to pursue Family Medicine as a specialty and thoughtfully responding to the core factors that shape their decision-making on how they want to deliver care after finishing training and in the years that follow.**

## Practice Models Shape Career Choices and the Primary Care Workforce

The shortage of physicians providing comprehensive primary care is not simply a recruitment issue; it is shaped by the structural features of practice that influence career choices from training through early independent practice. By exploring three key tensions, specifically work-life balance, financial stability, and the alignment of training with practice realities, the following section demonstrates how current practice

structures predictably steer many physicians away from comprehensive longitudinal primary care and underscores the need for systemic change. (*See Recommendation 1*)

## Practice Decisions Are Shaped by Structural Realities

Medical students and resident doctors enter residency and practice with personal and professional priorities. While these priorities may differ by individual and can evolve over time, they weigh heavily on practice decisions. This can be limiting in the context of primary care as current structural realities, namely business ownership expectations, compensation models, and administrative burden, can often be in conflict with leading personal and professional priorities. Primary care, as it currently operates, may fail to align with doctors' value for financial stability, work–life balance (Grudniewicz et al., 2023), and time with family (Kabir et al., 2022). (*See Recommendation 4*)

Practice decisions are therefore not simply reflections of personal preference. They are rational responses to the incentives, risks, and constraints embedded within the health system. These systems need to be responsive to the priorities, autonomy and well-being of residents transitioning into practice if they expect to successfully recruit them into longitudinal primary care in the long-term.

## Priorities in Conflict: Work-Life Balance

While doctors' practice decisions are driven by a unique set of factors and values, there are shared points of tension inherent in the current design of the primary care system. As mentioned above, many doctors may weigh a value for time with family in their practice decision.

This priority can be challenging to meet in the context of primary care as family doctors running a practice are responsible for a full panel of patients. As such, taking any time off comes with the burden of also having to arrange locum coverage. This may not only be challenging to organize (Grudniewicz et al., 2023); it can also be accompanied by frustration and resentment from patients (Kabir et al., 2022).

For doctors specifically interested in both starting their career and starting a family, the challenge of taking time off, especially parental leave or caring for aging parents, can be an immediate deterrent in the practice option of primary care (Kabir et al., 2022). As such, physicians seeking to prioritize time with family may decide against opening and managing a practice as a primary care physician. Understandably, they may instead pursue alternative career options, such as focused practice or locum positions, that offer greater flexibility and freedom (Kabir et al., 2022). Work-life balance should therefore not be dismissed as a generational preference or lack of commitment, but rather recognized as a workforce sustainability issue.

Provincial governments, regional health authorities and other organizations structuring primary care should align support for new-in-practice physicians to ensure that there are fewer barriers to achieving their preferred work-life balance when selecting how they want to practice such as reliable locum coverage and accessible parental leave.



## Priorities in Conflict: Financial Stability

For Family Medicine residents transitioning to practice, the option of becoming a primary care provider may be in conflict with the priority of financial stability. (*See Recommendation 3*)

Under the fee-for-service compensation model prevalent in most provinces (The College of Family Physicians of Canada [CFPC], 2023, p.2), family doctors effectively become small business owners (Grudniewicz et al., 2023) unless they entrust clinic management to third parties, which can have concerning risks for physician autonomy. Consequently, these doctors are not only responsible for patient care but also for acquiring a space to practice (Mitra et al., 2021) and the long-term obligations of managing billing, completing administrative tasks, and hiring staff (Grudniewicz et al., 2023). Much of this work, particularly the administrative component, is often uncompensated (Storseth et al., 2025).

Residents transitioning to independent practice are asked to assume substantial financial and managerial risk. Many are assuming this financial risk while also carrying significant educational debt (Grudniewicz et al., 2023). According to the Association of Faculties of Medicine of Canada (AFMC) Graduation Questionnaire, graduating medical students have a median debt of $90,000 (2024). It is therefore unsurprising that many physicians, especially those who prioritize financial stability, choose practice pathways that minimize financial burden.

Family Medicine is the lowest paid specialty in Canada (CFPC, n.d.). Yet, it often comes with a greater overhead cost burden than other specialties as many family doctors own and operate their own practice (CFPC, 2023). Recognizing the salary limitations and overhead cost demands of going into practice, it is understandable that many Family-Medicine trained physicians may instead pursue alternative career options such as locum positions or focused practice. These career paths offer physicians the opportunity to work under compensation models other than fee-for-service (Mitra et al., 2021), without the additional overhead costs and uncompensated administrative burden of running a traditional primary care practice (Li et al., 2023).

The increasing uptake of locum work and focused practice should not be interpreted as diminished commitment to comprehensive care. Rather, it reflects rational adaptation to practice environments that place disproportionate strain on individual physicians.

These challenges, however, could be addressed by reducing structural constraints and offering alternative or blended compensation models, including models that appropriately remunerate administrative and non-clinical work. The National Circle for Indigenous Medical Education's Calls to Action for Indigenous Physician Wellness and Joy in Work emphasize equitable pay models that allow physicians to spend adequate time with patients and reduce structural contributors to burnout. The Calls further advocate for Indigenous-led, interdisciplinary, team-based models of care, underscoring that sustainable primary care must be designed to support physician wellness alongside patient access (The National Consortium for Indigenous Medical Education [NICME], n.d.).

Adopting changes such as offering alternative or blended compensation models is part of a workforce planning strategy, not solely a payment method. Changes being introduced in British Columbia, Nova Scotia



and Ontario show promise in this regard. This would better align with training structures with which residents are familiar and ease their transition into longitudinal family care.

### Creating Learning Environments Worth Replicating in Practice

To encourage medical students and resident doctors to pursue careers in longitudinal primary care, learning environments must be intentionally designed to align with their aspirations and values. Addressing the hidden curriculum, eliminating racism, mitigating unsafe levels of fatigue, and expanding high-quality longitudinal training experiences that model sustainable, team-based primary care practice would significantly strengthen interest in this essential career path. (*See Recommendation 2*)

> ***"Other challenges, such as strenuous call schedules, administrative burdens, and under-resourced work situations, can all be managed when you have a supportive learning environment.*** *Creating a supportive environment where residents feel safe and valued is crucial for their well-being and success." (RDoC, 2025)*

## Addressing the Hidden Curriculum

The hidden curriculum remains one of the most powerful forces shaping how learners perceive Family Medicine. RDoC welcomes the work of the Focus on Family Medicine Task Force, led by Dr. Karen Schultz at Queen's University, in confronting the impact of the hidden curriculum on practice choice and professional identity. Persistent negative messaging, including portrayals of Family Medicine as less prestigious, lacking academic opportunity, or a "backup plan" (Hamza et al., 2021, p.251), continues to shape how learners perceive the discipline. (*See Recommendation 6*)

These perceptions matter. They form at a pivotal moment when medical students are exploring career options and determining where they believe they will be respected, supported, and valued.

As a specialty, Family Medicine can be immensely fulfilling and positively impactful. Practicing family physicians have the unique opportunity to care for and support patients over their full life course. Yet, this reality is often overshadowed by negative narratives and comments that distort students' perceptions of the specialty. Consequently, the meaningful contributions family physicians make through primary care are often overlooked (Jin, 2025). Residents from other specialties would do well to do off-service rotations in Family Medicine to better understand the breadth of expertise of their colleagues and its intersection with their own work.

Research demonstrates that the hidden curriculum does more than subtly influence opinion. It can also cause harm. Moravac et al. (2024) describe how implicit messaging about what constitutes an "ideal" or "proper" family physician can undermine trainees who cannot or choose not to conform to narrow expectations. For some, internalizing these ideals contributed to burnout, alienation, and, in some cases, departure from comprehensive Family Medicine altogether. Therefore, it is not enough to challenge negative narratives from outside the specialty; Family Medicine must also internally legitimize and embrace the diversity of career pathways available to Family Medicine-trained physicians.

**The hidden curriculum is not incidental. It shapes recruitment, influences retention, and reinforces structural pressures that are already driving physicians away from longitudinal comprehensive care.**

Accreditation standards at both undergraduate and postgraduate levels should be strengthened to require active identification and mitigation of hidden curriculum effects, including explicit accountability for how Family Medicine is portrayed, supported, and valued across learning environments.

Addressing the hidden curriculum cannot be left to isolated initiatives. All members of the Canadian Medical Forum, building on the work of the Focus on Family Medicine Task Force, should undertake coordinated, locally tailored strategies to dismantle disparaging narratives and foster cultures of respect for Family Medicine.

If Canada is to rebuild a sustainable primary care workforce, it must confront not only payment models and workload expectations, but also the cultural signals sent to learners about what, and who, is valued within medicine. Failing to do so will continue to erode interest in Family Medicine and undermine efforts to strengthen comprehensive primary care across the country.

## Recognizing the Role of Residency Training

### Ensuring Alignment Between Training Models and Practice Realities

Through residency training, doctors develop interests, expectations, and assurance around the practice options available to them. For this reason, it is extremely important that residency training and independent practice are aligned and that training provides residents with a realistic perception of what they can expect as a primary care provider.

Yet, ensuring such alignment remains a problem. Moravac et al. (2024), for example, detail how many residents are trained in team-based environments under payment models other than fee-for-service. However, when transitioning from training to practice, these same physicians often find that there are significantly fewer options to work under this type of practice model. In such cases, misalignment is not only present in the shift from team-based to individual practice, but also in the very different demands that accompany practicing under a fee-for-service compensation model.

This misalignment has consequences: When residency models demonstrate sustainable, team-based longitudinal care but graduates cannot access those structures in independent practice, it undermines both recruitment into and retention within comprehensive primary care.

Residents' transition to practice can be further challenged by a lack of exposure to the administrative requirements of providing primary care. While certainly important to training, residency can place too much focus on the clinical components of Family Medicine, limiting residents' exposure to and preparedness for the administrative practice demands (Moravac et al., 2024).

This can be done within the existing two-year training program. Residency is one phase of a physician's lifelong learning, and residents consistently demonstrate the ability to achieve the core competencies of Family Medicine within the current timeframe, succeed in their examinations, and deliver safe, competent

care. The duration of training should remain stable and must not be extended in response to incremental additions or changes in curricular content, which are an expected and ongoing feature of medical education.

When expectations formed during training do not match the realities encountered in practice, confidence in the sustainability of longitudinal care is undermined at the point of transition to independent practice. Preparing residents for these realities is important, but preparation alone is insufficient if the underlying workload remains unreasonable.

## Creating more longitudinal and rural training opportunities

Residency training strongly shapes how physicians understand both the rewards and the sustainability of comprehensive practice. To encourage graduates to provide longitudinal primary care, training must not only develop clinical competence but also expose residents to sustainable models of care. This must be accompanied by efforts to reduce the administrative burden placed on physicians in practice.

As noted by the Society of Rural Physicians of Canada and others, rural training environments offer a particularly important opportunity to align training with sustainable practice. Exposure to rural rotations and rural preceptors has been shown to influence both specialty choice and scope of practice (Moravac et al., 2024). Residents in these settings experience continuity of care across multiple contexts; clinic, hospital, and emergency department; while also developing broader competencies in obstetrics, inpatient medicine, geriatrics, palliative care, and Indigenous health. These experiences demonstrate how continuity and scope can coexist within a meaningful and professionally fulfilling practice.

## Improving resident and physician wellbeing is a central part of the fix

Supporting provider wellbeing is not in opposition to high quality patient care and system performance, it is central to it as a key component of the quintuple aim of healthcare (Nundy et al. 2022).

As evidenced by RDoC recent *Determinants of Resident Health* research, both racism and excessive fatigue play a critical role in the health of resident doctors which in turn contributes to shaping their career choices. Addressing these concerns for Family Medicine residents interested in longitudinal care would help solve the crisis.

## Eliminating racism from training

As one resident shared with RDoC, *"the constant microaggressions, implicit biases, and outright racism I have encountered have been psychologically draining. This lack of belonging and validation has taken a serious toll on my mental health"* (RDoC, 2025).

Despite stated commitments across the medical education system, including the Canadian Medical Forum's joint statement on Truth and Reconciliation and anti-racism in Canadian health care, to which RDoC is a signatory, racism remains a persistent and significant concern for many resident doctors.

Addressing racism within medical training environments is increasingly urgent. (*See Recommendation 7*) As highlighted at the Canadian Resident Matching Service Forum in 2025, Canada's resident population continues to diversify. Indigenous Physicians Association of Canada has likewise reported the highest number

of Indigenous residents in training to date. These residents must not be expected to endure racism during training, both for their own wellbeing and for the wellbeing of the communities they will serve. Evidence consistently demonstrates (CMA 2025) that physicians from equity-deserving communities often provide care to, and improve outcomes for, populations that have historically faced barriers to access.

In both training and practice, the National Circle for Indigenous Medical Education Calls to Action for Indigenous Physician Wellness and Joy in Work emphasize the importance of program models in which Indigenous physicians work alongside one another rather than in isolation. Supporting Indigenous-led, community-centred, and team-based models of care is critical to ensuring that the next generation of Indigenous physicians is able to practise safely, sustainably, and in ways that meaningfully support their communities over the long term (NCIME, 2025).

## Supporting Sustainable Training Environments

The medical education community has had a significant shift in discourse and policies surrounding Fatigue Risk Management (FRM) over the past decade to reduce the risks posed by excessive fatigue for residents and their patients. Still, much work remains to be done to mitigate risks of fatigue on patient and resident safety (Preobrazenski, 2025) and to ensure it is not a barrier to longitudinal practice. (*See Recommendation 5*)

If residency training environments are to support graduates in continuing to practise within those settings after completion of training, they must not routinely expose learners to unsafe or unsustainable levels of fatigue. This is a systemic issue that requires shared accountability among training institutions, governing colleges, and employers. In the absence of adequate structural protections, residents are often left to manage fatigue individually during training, and once they gain greater autonomy in practice, many choose to work differently as a means of self-preservation.

As called for in RDoC's *Determinants of Resident Health* research, "provide residents enough time and flexibility to be able to sleep, eat, exercise, and take care of their basic needs. Provide them the same basic rights that would be expected for other employees such as breaks, limits to work hours, emotional safety at work." (RDoC, 2025)

Those entering medical education understand that they must sacrifice a lot to become care providers. However, excessive fatigue caused by that education puts them and their patients at risk.

In one study, "some participants [articulated] that residency taught them how they did not want to practice. While many preceptors were described as admirable for their devotion to their practices, their personal and professional sacrifices demonstrated a lifestyle contrary to what learners were willing to take on in their future careers. Messaging in residency about achieving work-life balance were frequently juxtaposed with examples of very long work hours in learning settings" (Moravac et al., 2024).

But it's not only the immediate impacts of these shifts which present a danger to the sustainability of longitudinal care. "Expecting residents to prioritize work at the expense of their personal lives, with little to no time for self-care, family, and outside interests. This can contribute to burnout and feelings of resentment." (RDoC, 2025) Residents will look for practice opportunities that do not resemble their training if that training continuously puts them through unsafe working conditions.

**If training continues to rely on unsustainable workload, the system will continue to produce physicians who rationally avoid the very practice models it seeks to expand.**

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