Career in family medicine

We read Dr Lerner's article "Wanting family medicine without primary care" in the February issue of *Canadian Family Physician* with great interest, and we applaud Dr Lerner for bringing this topic forward for open discussion.[1] His article digs at the heart of an uncomfortable conversation that we have been having at the College of Family Physicians of Canada (CFPC) for quite some time, but are now poised to move beyond. How do we support family physicians who provide comprehensive, continuing care while ensuring that we remain the professional home for those with special interests or focused practices?

To be clear and unequivocal from the CFPC's perspective, there is no family medicine as a discipline without primary care. Dr Lerner suggests that we have 2 choices: embrace focused practices *or* embrace generalism. This is unnecessarily divisive and misses a critical perspective. The practice of family medicine is not a zero-sum game but rather nuanced based on context. Our paradigm of practice, while important, is secondary to our responsibility in meeting the health care needs of Canadians, whatever that looks like. Take for example the development of our Certificate of Added Competence in enhanced surgical skills. What we have learned from our rural colleagues is that general surgical and obstetric services are linchpins that keep rural hospitals open and able to offer care close to home. Family physicians with enhanced surgical skills are a key part of this solution in some regions. Our support of comprehensive, continuing care should be reinforced, but it might look different across communities depending on the composition of health care teams.

As an organization, we have embraced Certificates of Added Competence and their role in providing an enhanced scope of practice within the broader concept of a Patient's Medical Home. In addition, these practitioners contribute greatly to family medicine in the form of teaching and research capacity. Family physicians with enhanced skills have a diversity of practice patterns and are not all in focused practices. Those in focused practices concern themselves with, and are committed to the aims of, comprehensive primary care. Family physicians, regardless of practice pattern, embrace a common approach and philosophy of practice. We take pride in this professional identity and it unites us. These are some of the messages of the new CFPC Family Medicine Professional Profile,[2] a position statement developed with broad input and wide support including the CFPC's Section of Communities of Practice in Family Medicine (CPFM). Drs Charbonneau and Lemire elaborate further in their articles that also appear in the same February issue of *Canadian Family Physician*.[3,4]

The CFPC Section of Family Physicians with Special Interests or Focused Practices, now called the *Communities of Practice in Family Medicine*, evolved out of a need to find a practice home for family physicians with diverse practice interests to network, collaborate, and conduct scholarly activity. It was a time when debate over generalism versus specialization within the College was quite polarized. The section was deliberate in trying to bridge that philosophical gap, and the past 10 years has seen progress with physicians in focused practice supporting family doctors who provide comprehensive care. Most members of the CPFM are generalists with a special interest. It is under this premise that the CPFM helped create documents such as *Best Advice. Communities of Practice in the Patient's Medical Home*.[5] This document highlights how physicians with special interests can truly fill health care gaps and augment the group-based comprehensiveness that we see evolving in family health teams, family health networks, and many other group practices across the country. There has been a deliberate process at CPFM meetings to engage colleagues providing comprehensive and rural care in moving activities and initiatives forward—from creating an opioid strategy to developing surgical skills to support primary care obstetrics in rural communities.

For those medical students who are trying to decide their career paths, we agree that the CFPC should provide a clear description about what they can expect from a training program and a career in family medicine. Here it goes … Family medicine is a good choice if you are interested in and committed to the front lines of care; if you want to contribute to the health of a community; if you are dedicated to the primacy of the physician-patient relationship; if you accept the challenge of being a good generalist; and if you are enthusiastic about the dynamic and responsive ways that these skills can be used (sometimes this means a focused practice). If you know now that you are drawn to a very specific dimension of care, and that is exclusively what you want to do, then you are better to choose a specialty targeted at this interest. No hard feelings.

—Nancy Fowler MD CCFP FCFP,
CFPC Executive Director, Academic Family Medicine
—Frank Martino MD CCFP(EM) FCFP,
CFPC Section Chair, Communities of Practice in Family Medicine

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—*Victor Ng MSc MD CCFP(EM) MHPE, CFPC Physician Advisor*
—*Jeff Sisler MD MClSc CCFP FCFP, CFPC Executive Director, Professional Development and Practice Support*
—*Roy Wyman MD CCFP FCFP, CFPC Director, Certificates of Added Competence*

Competing interests
Drs Fowler, Ng, Sisler, and **Wyman** are paid employees of the College of Family Physicians of Canada.

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Purdue's influence continues

I am disappointed that *Canadian Family Physician* continues to publish pro-opioid articles by authors who have declared conflicts of interest with opioid manufacturers.[1,2] For the debates regarding the new opioid guidelines in the February issue, I think it is telling that the only authors for the yes side of the debate both have conflicts of interest with opioid manufacturers.[2]

—*Dan W. Hunt MD CCFP*
Winnipeg, Man

Competing interests
Dr Hunt receives funding from Manitoba Health for providing clinical care to patients with chronic pain and opioid use disorders.

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2. Gallagher R, Hatcher L. Will the new opioid guidelines harm more people than they help? Yes [Debates]. *Can Fam Physician* 2018;64:101-2 (Eng), 105-7 (Fr).

Author's honoraria from opioid seller

I am disturbed that *Canadian Family Physician* published the article "New category of opioid-related death" by Dr Gallagher in the February issue.[1] I do not know Dr Gallagher, but an article touting the benefits of treating noncancer pain with opioids in the elderly by someone who has received honoraria from Purdue Pharma, a big seller of opioids, strikes me as not too far from the key opinion leader articles that encouraged the opioid crisis in the first place. At the very least we should be aware of the size of the honoraria before deciding on the value of the piece.

—*Gordon Ferguson MD CCFP*
Sturgeon Falls, Ont

Competing interests
None declared

Reference
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Taking unnecessary aim at MAID

In the article "New category of opioid-related death" in the February issue of *Canadian Family Physician*, I appreciate Dr Gallagher's concern for the inadequate treatment of pain in our elderly patients, and I concur that the judicious use of opioid therapy can make a world of difference to patients suffering from chronic degenerative diseases, such as osteoarthritis and spinal stenosis.[1] However, I take issue with her insinuation that medical assistance in dying (MAID) will become a de facto alternative to proper pain management.

Multiple studies have shown that most patients who seek MAID do so not because of unrelieved symptoms, such as chronic pain, but because of more existential suffering, such as loss of autonomy and an inability to enjoy life.[2,3] This is borne out by my clinical experience as a MAID provider, and many of my colleagues anecdotally report this as well. A substantial number of patients I assess have already been receiving exemplary palliative care and symptom management, and in those few situations where unrelieved pain is the primary driver of a patient's MAID request, it is most often the case that they have already tried multiple therapeutic strategies, including various opioid analgesics, to help ameliorate their suffering, without adequate success.

Untreated and undertreated pain in the elderly is a real and worrisome phenomenon, but it should not be conflated with unfounded fears and prejudices about MAID.

—*Edward S. Weiss MD CCFP*
Toronto, Ont

Competing interests
Dr Weiss is a member of the Physicians Advisory Council for Dying with Dignity Canada and of the Canadian Association of MAID Assessors and Providers. He does not have any financial conflicts of interest.

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Cannabis view

I thank Dr Ladouceur for providing a balanced view on the benefits of cannabis in his February editorial.[1] While I have not collected statistics, it is my impression that increasing numbers of daily cannabis users are presenting to my emergency medicine practice with cannabis-induced hyperemesis. Many of these patients use cannabis for anxiety management, and usually this has not been initiated by a physician. My suspicion is that this is a dose-related condition, and one that will emerge increasingly as cannabis use spreads.

As a medical community, it might behoove us to exercise some vigilance in assessing the risks and benefits of cannabis prescribing, so that we do not repeat the detrimental situation that arose with the liberalizing of narcotic prescribing in the 1990s and 2000s.

—*Jean Marc Benoit MD CCFP(EM)*
Hamilton, Ont

Competing interests
None declared

Reference
1. Ladouceur R. The cannabis paradox. *Can Fam Physician* 2018;64:86 (Eng), 87 (Fr).