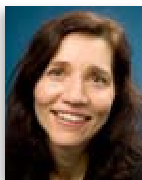

Editorial

Talk of the town

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Taking community seriously not only gives us the companionship we need, it also relieves us of the notion that we are indispensable.

Robert McAfee Brown

After my family medicine residency, I worked for a year at a university student health service. One day, a student came in with an abscess on his arm. A few days later, another student came in with the same complaint. Then a third. I began to wonder if there was some connection. After some investigation, I discovered that they all lived in the same house. I brought everyone who lived in the house into the clinic and I swabbed their noses. Two of the housemates were nasal carriers of *Staphylococcus aureus.* A few tubes of mupirocin later, the outbreak was over. As a member of the university community, I was able to see a pattern of illness in these students and act to prevent further infections.

One of the principles of family medicine is that family medicine is a community-based discipline. Being part of a community allows family physicians to identify local needs and access appropriate resources.[1] To mobilize these resources one must know what is available locally and further afield—or at least understand where to find this information.

Roster of resources

Is it our responsibility as family physicians to keep a roster of available resources? In their study (**page 1008**) of family physicians' perspectives on dementia care, Yaffe et al found that physicians felt much of this care lay within the realm of support services offered outside of their offices, including government-run, community-based health and social service centres. The physicians had little knowledge of these services. More important, they did not perceive an obligation to maintain accurate or current information on community resources.

Others argue differently. In his January 2007 President's Message, Dr Tom Bailey confirmed that family physicians should be able to mobilize resources to meet patient needs.[2] Understanding the local community and available resources is central to achieving this goal.

A 2004 qualitative study examined a group of community-responsive physicians who had a very different perspective on patient resources than the physicians in the study by Yaffe and colleagues.[3] Oandasan et al looked at how primary care physicians responded to the needs of their communities. The physicians studied collaborated with other health care providers to offer a broader range of resources to their patients. They were also advocates for their patients' access to health and social services. In short, they were familiar with the resources in their communities and used them to help their patients.

Challenges

If we should be aware of community resources, what challenges do we face? With the plethora of options available in some large communities, determining which program or service is most appropriate can be confusing. For those in smaller or remote communities, simply finding accessible resources can be difficult and time-consuming. In Jiwa and colleagues' literature review of aboriginal community-based alcohol and substance abuse programs (**page 1000**), there were few local programs in aboriginal communities. Physicians had to resort to distant residential treatment centres for their patients.

Physicians in Oandasan and colleagues' study faced 2 key challenges to acting as collaborators with other health professionals or as advocates for their patients[3]: a lack of funding for these activities and a dysfunctional health system. Participants commented that inadequate funding restricted opportunities to collaborate with other providers, effectively limiting patient access to resources. Lack of integration in the health care system between health care professionals and community resources left physicians feeling frustrated and powerless.

So, it comes down again to time and money. It takes time for a family practice to maintain accurate information on community resources—and that takes money. In the traditional fee-for-service model, there is no provision for remuneration of this task; newer funding models are more promising.

Appropriate funding at the individual practice level only addresses one part of the problem. Unless there is serious work at the community level and beyond to integrate health care services, physicians might continue to be unaware of many useful community resources—and patients in turn might suffer.

Cet article se trouve aussi en français à la **page 963.**

References

1. College of Family Physicians of Canada. *Four principles of family medicine.* Mississauga, ON: College of Family Physicians of Canada; 2006. Available from: **www.cfpc.ca/English/cfpc/about%20us/principles/default.asp?s=1**. Accessed 2008 Jun 3.
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