Using the past to guide our future

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One faces the future with one's past.
Pearl S. Buck

As the new Curriculum Coordinator in the Department of Family Medicine at Queen's University in Kingston, Ont, I have realized more than once that some of the "new" curriculum ideas being discussed are really old ideas in modern clothing. As family physicians, we come to understand our patients in increasing complexity through caring for them over time. Along those lines, looking into the good, the bad, and the ugly of the history of family medicine in Canada, as well as the College of Family Physicians of Canada (CFPC), seemed a way to gain important insights when thinking about curriculum design. Surely there are lessons to be learned.

Past conditions

Having practised family medicine in Ontario for 24 years, I have been on the roller coaster of being a family doctor. Right now the view is great, but it was not always so. The 1990s were pretty stomach-turning: not enough family doctors; overloaded practices; poor pay, with money even being clawed back; and more than half the graduating family medicine residents, from the Ontario programs anyway, leaving for the United States. The 1940s were apparently equally nauseating if you were a GP. In his book *Strength in Study*, Woods nicely outlines the conditions that led to GPs being considered "physicians who hadn't finished their training."[1]

Despite licensing laws in Ontario in 1815 and 1819 requiring physicians to pass an examination to practise, medical quackery still abounded. In 1910 Abraham Flexner recommended, in part, that medical schools be university based and medical training take place in teaching hospitals—both were great ideas to increase the competency of physicians but had far-reaching ramifications for family medicine. In 1929 the Royal College of Physicians and Surgeons of Canada started standardizing specialist training, the result being well-trained specialists. Many specialists started working in teaching hospitals, resulting in fewer admitting privileges for GPs, and many were very busy with populations of self-referred patients who preferred treatment from these competent specialists.

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Fast forward to the 1940s. Two world wars had generated the usual wartime explosion of medical knowledge and innovation. General practitioners were practising after 1-year rotating internships, with scant training in each of the specialties, little to no training in behavioural medicine, and no training in the community. Physicians returning from the war, who might or might not have had this 1-year internship, had been exclusively practising trauma medicine. Both groups felt ill-equipped to deal with the variety of problems faced in general practice. The lucky ones joined a good group of experienced GPs and continued their learning with help from these older colleagues, but many of them were not so lucky and had nowhere to turn for continuing medical education (CME). The usual avenue for CME, through teaching rounds in hospitals, was increasingly unavailable for GPs owing to the decreased admitting privileges mentioned above. Add to this an increasing disparity in income between specialists and family physicians, due to patients going to the more fully trained specialists, and the stage was set. What followed was an exodus of bright young physicians (who had been imprinted during their Flexner-reformed specialist-driven undergraduate training) from practices where they felt ill-equipped to treat patients adequately or who found themselves in an increasingly narrow scope of practice, not to mention poorly paid, to specialty training programs.

While reading about this part of the past of general practice, I realized this was the story of my father, Maxwell Schultz. Born in Thessalon, a small town in northern Ontario, he came to Queen's University in 1940 at the age of 17 years. The usual 7-year medical degree that started right after high school had been condensed to 5.5 years owing to the need to graduate more doctors for the war. Finishing medical school just as the war ended, he completed a junior rotating internship, followed by 3 months working in Hearst, Ont, before being lured to a more secure, higher paying job ($500 a month!) as the lumber company doctor in Kapuskasing, Ont—which was not always an easy job to get to (**Figure 1**). After a year, believing there were gaps in his training, he did a self-styled senior rotating internship in London, Ont, with extra training in obstetrics and anesthesia. From there my father went to Port Arthur, Ont, where he worked on call every day for 4 years in a very busy practice with a lot of obstetrics. When the opportunity to train in a new anesthesia program in Vancouver, BC, came along, with the promise of expertise in one area, more regulated hours, and better pay, he took it—another GP gone.

Figure 1. Crossing Kapuskasing Lake: *From the memoirs of Dr Maxwell Schultz.*

In this milieu the College of General Practitioners of Canada started in July 1954. *Nostrum in studiis robur* (in study lies our strength) is a fitting motto for a college whose overarching mandate was "to do all things necessary to maintain a high standard in general practice" and pull general practice from the brink of demise. The first decade of the College was devoted largely to gaining acceptance as a college, defining what makes family medicine unique (**Box 1**[2]) (the result of which was a heavily debated name change to the College of Family Physicians of Canada), and improving (and requiring) CME for members of the College. Postgraduate training and undergraduate training efforts followed closely behind, with the establishment of educational objectives for, and development of, training programs, accreditation of these programs, and development of a state-of-the-art Certification examination.

Research, although always recognized as an important part of defining family medicine as a discipline, was slower to get off the ground. In the past 20 years, however, there has been a steady growth of research capacity with more family physicians having research backgrounds, increased funding for family medicine research, increased involvement by family physicians in granting agencies, and networks of researchers bringing together previously isolated silos of research activity.

Box 1. Principles of family medicine

- Disease is frequently seen at an earlier stage than it presents to other physicians.
- Awareness of community resources is essential for management.
- Management is often related more to prognosis than to diagnosis.
- Time is a diagnostic and management tool. Continuity of care is of considerable importance.
- Illness is frequently undifferentiated when it presents.
- Understanding illness behaviour is crucial to teaching and understanding patients.
- Illness is seen in the context of family life.
- A regional assessment is often sufficient.
- Illness might present with "signals" or "tickets."
- Family physicians deal with a great deal of uncertainty in both assessment and management.
- Psychosocial factors are an integral part of each problem.
- Family doctors require an acute awareness of community epidemiology.
- Relief of distress is a prime concern.
- The family physician is the doctor of first contact.
- The family doctor must frequently manage both chronic and multisystem disease.
- Records must be succinct but should be useful.
- The onus of lifestyle change is on family physicians, who must encourage patients to take responsibility for their health.
- A minor complaint might present an opportunity to approach a more serious health problem.
- Much of the family physician's work depends on his personal relationship with the patient.
- Sometimes patients display symptoms that are most common to one illness, when they actually have a different illness.
- It is necessary to make a decision on all new patients. The family doctor cannot say, "I'm sorry, I can't help you."
- Referrals are frequent and involve a variety of consultants.
- The family doctor sees a high prevalence of chronic, emotional, and transient illness.
- Pattern recognition is an important skill.

Reproduced from Hennen BKE.[2]

What has been learned

From this journey through the past, what lessons have I learned?

Lesson 1. For our medical students, role modeling or imprinting is important. Flexner's influence lives on though! Medical students are still primarily being trained by specialists. Based on the medical students who come to our clinics, they still do not seem to have an understanding of what family medicine is all about.

Our system needs good family doctors and good specialists working together to serve patients' needs. Medical students deserve to be exposed to both family doctors and specialists equally, from early on in their training, to understand and sort out the career that best suits their temperaments.

Lesson 2. Residents need adequate training, both in what they learn and in how to learn, to ensure competence. Without attaining this competence, taking lesson from the 1940s, it is likely that they will either end up in restricted practices or, lacking the opportunity that previously existed to go into specialty programs, leave practice. The application to third-year programs in family medicine is at an all-time high—what does this mean? Certainly the knowledge explosion continues. Is 2 years too short? How relevant is some of the training residents get? Questions about curriculum and evaluation development must centre on how to maximize the relevance of training, how to gauge the time needed to attain competence, and how to measure whether competence has been achieved. The College's push toward competency-based education is crucial.

Lesson 3. Once physicians are out in practice, CME is paramount to maintaining competence and preventing narrowing of practice. Although this has always intellectually seemed obvious to me, reading about the conditions that predated the College has vividly demonstrated how erosive too little CME can be on clinical competence. The College's mandate that members participate in lifelong learning makes so much more sense now.

Lesson 4. Money talks. For many, if not most, money symbolizes value placed on a service. Outcomes from the 1940s and 1990s tell me that a large disparity in income between specialists and family physicians will result in a shortage of family doctors: People will not choose family medicine as a career, or if they already have, many will leave for greener pastures.

Lesson 5. Research and dissemination of knowledge is an important currency in the advancement of a discipline. At a recent North American Primary Care Research Group meeting, I heard the following: "If it isn't measured and written down it didn't happen." Family medicine is unique, and research in family medicine has something to offer that cannot be done anywhere else.

Lesson 6. I am proud to be a family doctor. Reading Hennen's list of attributes of a family doctor (**Box 1**[2]) reinforces the reasons I like family medicine.

Conclusion

I recently presented these ideas at grand rounds. The audience's favourite quotes about family medicine were among the following: "General practice is the study and treatment of the skin and its contents." "Family doctors are well qualified, skilful doctors [*sic*] who will look at me as an individual rather than as a collection of parts."[1] Good exposure to family medicine during undergraduate training, deliberately defined, competency-based family medicine residency programs, relevant and adequate CME, and high-quality research to move our discipline forward will ensure this continues to be so. That about sums it up!

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Competing interests
None declared

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