Erosion of comprehensive care and professionalism

As a retired GP-FP, the first observation that concerned me in Dr Freeman and colleagues' article on defining comprehensive practice in the October issue was the response rate of only 42.5%.[1] Why such a low percentage? Surely responsible Canadian FPs should be concerned about the future delivery of effective primary health care in Canada and thus should feel obligated to participate in a fact-finding study about its scope and comprehensiveness. Possibly many FPs have read Dr Barbara Starfield's book *Primary Care*.[2] Many years ago I had the privilege of talking with her at a family medicine conference in Toronto, Ont. She reiterated her observation that all countries with the highest-quality health care had high-quality comprehensive primary care. Family physicians, governments, and all Canadians should feel obligated to see that Canadian primary care is timely, high-quality, and comprehensive.

Many of my retired FP colleagues are concerned that there has been an increasing erosion of FP availability and provision of comprehensive care, and an unwillingness to accept a cross section of the population as patients. Fifty years ago there were 3 important criteria to be a successful FP: availability, availability, and availability. In recent years my impression is that patients have expressed a desire for a more realistic 3 most important criteria: availability, affability, and ability, in descending order. However, listening to Canadians one would assume that current FPs have never displayed more affability or more ability along with more unavailability. There are simple remedies to this problem that include having backup colleagues.

One can still play a very important role in primary health care while having an office-only practice. Unfortunately there seems to be a trend of too many FPs opting for a narrow field of practice (a field that might not deserve focus), thus reducing the number of FPs providing comprehensive care. I am not referring to emergency medicine physicians or hospitalists. Family physicians who wish to offer focused care should only be permitted to do so after 5 years of comprehensive care. They should then be obliged to also continue to provide comprehensive care to their core patients.

We retired GP-FPs do not expect new FPs to work the hours many of us did in the 1960s and early 1970s (24 hours a day, 7 days a week, 365 days a year—this was totally sadistic) or to provide the wide spectrum of comprehensive care we offered. But a recent report states that only 44% of Ontario patients with urgent issues are able to see their GP-FP within 48 hours.[3] An FP not being able to see patients with urgent issues within 48 hours implies that that FP does not practise high-quality primary care. It is all about organization! It is very simple to estimate the number of extra requests for each day of the week and then save space in the schedule for these inevitable requests. Be prepared to shorten the lunch hour. Have the receptionist answer the phone starting at 8 AM.

Availability. Availability is a challenging issue to assess. The poor availability of some FPs can be contrasted with many other FPs who have changed their booking habits so that all urgent cases are seen within 48 hours and the remainder are seen within an impressive 5 to 7 days.

Some primary care issues might be easily solved with an increased sense of responsibility among offending FPs. At the same time some GP-FPs might be overly focused on responsibility, to the detriment of their health. Assessing health care needs and appropriate physician practices has never been easy!

Many GP-FPs, male and female, seem to focus on not working more than 15 to 20 hours a week to maintain a lifestyle! It does not seem appropriate for Canadians to share the financial cost of their medical education. Perhaps those who wish to practise outside of Canada or work only 15 to 20 hours a week should pay the real cost of their education (presumably considerably higher than current medical tuition fees). Those willing to work 35 to 40 hours a week in Canada, with 6 weeks of holidays and 2 weeks of refresher courses a year, could pay greatly reduced medical student fees with the obligation to practise as FPs in underserviced areas (like Woodstock, Ont, which is hardly remote) for 5 years. Those physicians who derive very high incomes, along with other Canadians who make more than $200 000 a year, would be taxed at higher rates to pay for medical education and other essential services in a functioning democracy.

Professionalism. That more than 55% of family medicine graduates of Western University in London, Ont, failed to respond to Dr Freeman and colleagues' survey suggests a lack of responsibility or even an erosion of professionalism. Why? Several academic members of the University of Western Ontario Faculty of Medicine Class of 1966 believed there has been an increasing erosion of professionalism among physicians. As a consequence, on the 50th anniversary of their graduation, the class created a professionalism sculpture at Western University and an annual final-year medical student prize for professionalism (**www.schulich.uwo.ca/meds66**).

Comprehensive care. Rural and smaller cities still have to attract FPs willing to provide a wide scope of comprehensive care. Thus, Canadian family medicine training programs must ensure a sufficient number of FPs will practise in rural and smaller communities and offer training that prepares them to comfortably practise in these more challenging locations. The increased sense of accomplishment from offering a wider comprehensive practice is obvious. Perhaps these physicians should also be compensated at a higher rate than those who are only prepared (or who are forced by lack of access to city hospitals) to offer an office-only practice in a large city. However, those who practise only in an office can still provide very valuable and rewarding services, and can still derive the satisfaction of providing continuity of care. General practitioners and FPs should be prepared to accept patients of all age groups and provide a wide spectrum of comprehensive primary care, plus have arrangements that all patients with urgent issues will be seen within 48 hours and all patients who call up to 9 PM will be seen by the GP-FP on call for the group. Sloughing patients to the emergency department is to be discouraged. Family physicians should not be permitted to cherry pick patients (ie, accept only the healthy) and should be prepared to accept most of those who request to be patients up to the desired number of registered patients.

Recently, 3 retired GP-FPs of the University of Western Ontario Faculty of Medicine Class of 1966 reflected on their good fortunes to have practised as FPs. All of them believed that being an FP, with its meaningful personal relationships, was one of the most rewarding roles that one could have had in life! From time to time we all receive those welcomed hugs from former patients.

—Ross McElroy DDS MD CCFP(LM)
Tavistock, Ont

Competing interests
None declared

References

1. Freeman TR, Boisvert L, Wong E, Wetmore S, Maddocks H. Comprehensive practice. Normative definition across 3 generations of alumni from a single family practice program, 1985 to 2012. *Can Fam Physician* 2018;64:750-9.
2. Starfield B. *Primary care: concept, evaluation, and policy*. New York, NY: Oxford University Press; 1992.
3. Health Quality Ontario. *Measuring up 2017: a yearly report on how Ontario's health system is performing*. Toronto, ON: Queen's Printer for Ontario; 2017. Available from: **www.hqontario.ca/portals/0/Documents/pr/measuring-up-2017-en.pdf**. Accessed 2018 Nov 12.