Millennium Series

The College and the groves of Academe

We've come a long way, Victor!

B. Hennen, MD, CCFP, FCFP

The challenge of condensing the story of the development of the College of Family Physicians of Canada and the academic discipline of family medicine from their inseparable beginnings was a welcome one. The starting place was an editor's selection from a decade of articles in the *Bulletin* of the College of General Practice (CGP) and the early issues of its sequel, the *Journal* of the CGP, which first appeared in May 1961. Have a look at the articles in **Figure 1,** then consider them in today's context.

In 1954, the second College President, Howard Black, acclaimed Victor Johnston, first Executive Director of the College of General Practitioners of Canada, and the Canadian Medical Association (CMA) as the College's parents and looks back at its first 6 years. If he and Victor Johnston looked back now, another 50 years later, and measured progress toward their hopes, they would be gratified. They would see an evolving system for continuing medical education credits for College members; medical undergraduate curricula embracing the principles of family medicine and taught by family physicians; specific postgraduate residency programs as part of the certification and licensure process for family practice; Fellowship recognition for members who stand out for their contributions; departments of family practice in most hospitals; specific facilities for training in family medicine in all cities with medical schools and at many rural sites; and more than 2000 recognized teaching family practices across the country.

Black, Johnston, and many others recite the mantra that the College's primary reason for being is education. Johnston argued that education and research reflect the focus of the ideal professional who seeks excellence for its own sake to maintain an edge of competence and, secondarily, to attract adequate remuneration. He leaves medical economics and medical politics to the CMA and its provincial divisions as their "time-honoured functions."

Education

The Annual Medical Study Requirements and Estimation of Study Credits set out by Johnston in 1959 provided the template that the College still follows. The complexity of having to accommodate both membership and certification categories adds to the struggle between what constitutes voluntary adherence (self-reporting) and mandated compliance (documented participation) to satisfy the need for public accountability.

When the College was born in 1954, some medical schools, led by deans such as Chester Stewart (Dalhousie) and J. Wendell Macleod (Saskatchewan) had developed preceptorships in which medical students spent time with general practitioners in their offices at rural and urban sites. In 1961, University of British Columbia Dean John F. McCreary expressed what was a changing attitude: "I feel very strongly that it is very wrong for medical students to be exposed only to specialists in their undergraduate curriculum." John Hastings from the School of Hygiene at University of Toronto said in an article in the *Canadian Medical Association Journal*, "There is little value in complaining about the number of students who want to specialize and bemoaning the decline of general practice when medical education presents the specialties as the only fields of interest and prestige in medicine." Now, family medicine clerkships are universal, with full-time and part-time family physician faculty who also teach basic clinical skills, evidence-based decision making, community and social aspects of medicine, and elective family practice programs, and lead the development of academic rural medicine.

Fellowships and internships

A higher qualification for general practice, comparable with Fellowship in the Royal College of Physicians and Surgeons for specialists, was another repeated theme in the early years. "It seems to me that the time is here when the College of General Practice should consider recognizing the general practitioners who have a special interest and special training along a certain line," said Dr Arthur C. Hill of Sherbrooke, Que.

The College sponsored two pilot residency programs at the Calgary General and St Joseph's (London) hospitals. Prior to their development, 2-year general practice internships were approved by the College in some 34 hospitals, mostly not traditional teaching hospitals.

The internships were very hospital-focused and service-oriented and had varying faculty direction and mentorship by GPs. Family medicine residencies had particularly designed curricula and were accredited by the College based on learning objectives, properly evaluated and appropriately administered by family physicians. Once the certification process was established, Fellowship became recognition of a select number of members who had made exceptional contributions to the College and community and were nominated by colleagues through their provincial chapters.

Fund-raising

In 1954, a Foundation Fund raised $21 695 from 246 members; 186 donations were for $100 or more (average $88 per donor). In 1956, the Foundation Fund was replaced by the Sustaining Fund to support new projects, especially

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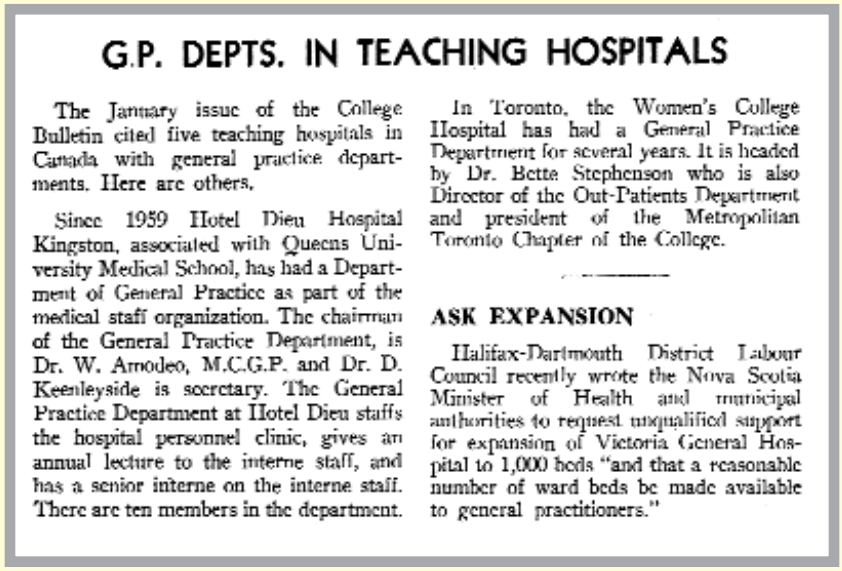
Figure 1. **Measuring progress toward our founders' hopes:** *Articles in the predecessors to* Canadian Family Physician *mark family medicine's evolution in a changing environment.*



G.P. DEPTS. IN TEACHING HOSPITALS

The January issue of the College Bulletin cited five teaching hospitals in Canada with general practice departments. Here are others.

Since 1959 Hotel Dieu Hospital Kingston, associated with Queens University Medical School, has had a Department of General Practice as part of the medical staff organization. The chairman of the General Practice Department, is Dr. W. Amodeo, M.C.G.P. and Dr. D. Keenleyside is secretary. The General Practice Department at Hotel Dieu staffs the hospital personnel clinic, gives an annual lecture to the interne staff, and has a senior interne on the interne staff. There are ten members in the department.

In Toronto, the Women's College Hospital has had a General Practice Department for several years. It is headed by Dr. Bette Stephenson who is also Director of the Out-Patients Department and president of the Metropolitan Toronto Chapter of the College.

ASK EXPANSION

Halifax-Dartmouth District Labour Council recently wrote the Nova Scotia Minister of Health and municipal authorities to request unqualified support for expansion of Victoria General Hospital to 1,000 beds "and that a reasonable number of ward beds be made available to general practitioners."

Figure 1. *continued*

Dr. J. G. Bonnier Suggests

Some Introductory Steps To General Practice

The transition from hospital and specialized medicine to general practice can be very difficult for the medical student. However, there are various ways of helping him and preceptorship is by no means the only one. Here are a few thoughts on what an introduction to general practice could embrace.

1. Sociology

The student should be properly instructed in sociology. He should take an active part in public welfare organizations where he will be brought into close contact with social problems. This, in turn, will encourage him to fight for his ideals and enhance his human values. This is a pre-requisite of the family doctor, who, in addition might be asked to look over a small number of families.

2. General Practice Knowledge

"How can one love what he knows not?" If the student plans to enter general practice it is logical that he should know what general practice is.

A. *Preceptorship*

Preceptorship constitutes a unique opportunity for the student to learn about general practice. He sees at first hand the life of the general practitioner — night and day. He can assess the role he is expected to play in the community. All the small details which contribute to the full life in his intended profession are revealed by actual experience.

B. *Visits to G.P.'s Offices*

Small groups of interested medical students could visit offices of established general practitioners. The differences between group practice and solo practice would be made apparent and the students would be able to question senior general practitioners on the problems of establishing an office, record keeping, telephone services, etc.

C. *Personal Contact With Own Family Doctor*

This might be a more delicate matter but it is practical. The student should try to make close contact with the doctor in his locality and during week-ends and holidays he might arrange to accompany this doctor on home or hospital calls.

D. *Course in General Practice*

A number of prominent general practitioners should be called upon to participate in medical training in the fields of pediatrics, medicine and obstetrics.

An introductory course could also embrace such matters as the number of persons required per doctor in a community, a general knowledge of insurance matters, basic accounting practice, etc. A competent general practitioner could very well teach such subjects.

3. Internship

Surgery — Choose a hospital which presents excellent clinical and minor surgery facilities.

Pediatrics — Spend some time at the nursery to familiarize himself with dietetics, circumcision, contagious diseases.

Obstetrics — Perform as many deliveries as possible. Master the use of forceps and episiotomies.

Gynecology — Ask for demonstrations of cervix cauterization and perform it under supervision as often as possible.

During his internship the physician to-be will observe his teachers at work. He will choose his consultants from these specialists. In addition to competence, a consultant must offer humanitarian treatment to the patient, and integrity in his association with the referring doctor. The importance of consultations as a means of medical training cannot be over-emphasized.

Figure 1. *continued*

Committee Chairman Asks:

Why College Membership?

By GARTH R. DIEHL, M.D.
Chairman:
Membership Committee

Only through continuous education can general physicians maintain an up-to-date medical knowledge and only through continuous education of general practitioners can the Canadian public receive the type of practice and service expected from their family doctors.

But to understand the role of the family doctor's educational agency it is necessary to understand the elements of all of organized medicine's units.

The Canadian Medical Association binds together all medical factions through its provincial divisions, made up of sections of all the specialties and the sections of general practice.

In some sections of Canada there are general practitioner associations and other separate medical groups but the key question is: how does the College of General Practice of Canada fit into this medical pattern?

At the national level, the College is administered by its Executive, its Board of Representatives and its Executive Director. At this level there is essential liaison with the C.M.A. It is at the provincial level that most of the close association takes place directly with the other general practitioner organizations.

Many of our College members hold executive or committee posts in many of these organizations and still more are very active general members. By mutual arrangements at this level, many provincial chapters handle all matters pertaining to education by refresher courses, annual meetings etc. and the other organizations can thus concentrate on the other general practitioner problems.

It is by these arrangements, then, that we general physicians have a voice both in the economic field, through the general practice sections of the C.M.A. or the other associations, including the Syndicate of Quebec, and also in the educational field, through the College.

The College may be considered purely educational in nature because it avoids any embroilment in economic or other problems not of an educational nature. Also, it closely supervises its own members on the maintenance of its mandatory 100 hours of formal postgraduate studies every two years, the prime requirement for continued active membership.

The educational programs that are arranged, sponsored and carried out by the College, both at the national and provincial levels, are open to all physicians. Similarly, the College efforts in research, promotion of general practitioner residencies, encouragement toward the formation of hospital departments of general practice, distribution of our Journal etc. are almost equally of benefit to all general practitioners in Canada — members and non-members alike. The College can be regarded as the educational arm of all general practitioners in Canada whether they be members or not.

It should be remembered that the compulsory College requirement of

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MEMBERSHIP (Cont'd)

postgraduate studies does not in itself always guarantee a "best" practicing physician. But as the number of members increases it will promote a higher standard of up-to-date medical practice to more and more of the Canadian public.

It is true that many non-members maintain their standards by obtaining at least as many hours of study. But the question must be asked, why do they then refrain from joining the College and their fellow practitioners who are organized to maintain these aims and objectives and who, by doing so, would lend their increased strength to such a movement.

It is often difficult to explain to non-members exactly and precisely why they should join the College. One of the reasons for this is that many realize they can derive almost as much benefit from College efforts without formal membership and also because thus far there is no obvious economic necessity or gain visible to them.

Perhaps eventually it will be possible to broaden acceptance of the "service above self" principle so that we will be able to attain the membership total that the College of General Practice movement really deserves.

Present figures indicate that about 22% of the Canadian general practitioners belong to the College and voluntarily apply themselves to maintain the necessary study credits. The ultimate membership suggested is in the range of 40%. When, or if, this figure will be reached is dependent not only on the applications of non-members but also upon the combined efforts of each and every existing College member in encouraging suitable fellow practitioners to make application.

educational ones. In April 1961, an appeal for "birthday gifts" raised $8038 from 230 donors (average $36 per donor). When we consider the incomes of those days, these were generous contributions beyond membership fees. Today, the Research and Education Foundation continues to raise funds to support the academic work of members.

Figure 1. *continued*

Preceptorship Program in Kingston

The Kingston Chapter of the College is working closely with Queen's University School of Medicine, to provide preceptorship experience for final year students.

"Here at Queen's students in their final undergraduate year are now being more exposed to the general practitioner", reports Dr. J. T. Tweddell, who is a member of the College and a lecturer. Dr. G. C. Lindsay, another Queen's lecturer, is also a College member.

These two members each take a different final year student each week to work along with them in the mornings. Each day following lunch, the student returns to the hospital and reviews all the patients he has seen on the doctors' rounds. The student writes progress notes on these cases.

"On new patients it is the student's responsibility to see the patient, write the history, do the physical examination, outline the orders for investigation and treatment, and then check with the man that he is assigned to," states Dr. Tweddell. "A discussion as to the addition or subtraction of further investigation or treatment is given."

This part of their final year is so popular with Queen's medical students that there are more applicants for each week's training than can be handled. Additionally Dr. Tweddell brings four students who have done the preceptorship week with him to his office for an evening's discussion concerning patient records, accounting methods, various types of insurance and other matters relevant to practice. Office equipment is demonstrated and queries are answered. "The boys feel they have been able to get closer to the bed-side of a patient and to see a doctor actually practising than at any time since their first introduction in the clinical years", he advises.

Dr. Tweddell states he has not had a single complaint from private patients. He introduces the preceptee to the patient as an associate and explains the preceptorship arrangement. Patients have made many favourable comments about the preceptees. "The patient will receive far more attention than if he were being cared for by a graduate intern as due to the work load on the interns. These students are very keen and the detailing of definite responsibility stimulates them and they go all out to do a good job".

At the term end the preceptor submits a report on each man as (a) a student (b) on his approach to the patient (c) the quality of reporting on assigned work.

This individual preceptorship work with one of the two College members of Queen's Faculty during their final undergraduate year, is additional to the preceptorship program which is available to students in their third year at Queen's Medical School. Students in third year spend two weeks in a doctor's home and with him on his rounds. This program has been well received by both doctors and third year term students.

A third member of the Kingston Chapter of the College, Dr. Merrill Trotter, addressed the medical students at Queen's at a banquet this past winter which Dean Harold Ettinger tenders for final year students. Dr. Tweddell estimates that "at least fifty per cent of the practitioners in this area are ready to do some undergraduate teaching."

Coping with change

Reflecting on what our founders wrote in their early *Bulletin* and *Journal*, I am in awe of their foresight and clear vision. Their dreams were revolutionary but also realistic. The structures they established in the College and the implicit and explicit strategies they implemented in their relationships with medical schools, governments, hospitals, other colleges and licensing bodies, and corporate and industrial partners have been highly effective. Where we have failed to fully accomplish their expressed goals we ought to ask why, reflect on the barriers to success, and consider immediate next steps for the College's 50th anniversary in 2004, and beyond.

The inherent conservatism of family physicians has been both a strength and a weakness. Healthy skepticism is a virtue when it protects the public from untested promises of new products and prevents unwarranted spending of scarce resources. Resistance to change, even when we know we are locked into patterns of behaviour that have not moved us forward for years, can prevent us from taking reasonable risks of disrupting our usual and frequently comfortable ways of doing things.

Donald Rice, the College's second Executive Director, eloquently described in 1968 the phenomenon of GPs of 15 or 20 years' experience. They were well established in community practice despite some competition, felt undergraduate training and experience had prepared them well, regularly attended refresher courses, were actively involved in hospital practice and affairs, were sufficiently financially secure to sometimes leave night call to younger colleagues, and generally were respected citizens.

In refusing to acknowledge the changing context of medical knowledge and training and feeling threatened with talk of new training and an inference of being second class, many GPs were passively if not vocally resistant to new training programs. They frequently had influence with political, academic, and hospital leaders whose support the College and departments of family medicine sorely needed. In 1990, I received a letter from such a colleague, a man who had unquestionably given substantially as a practitioner and preceptor (and had not left night call to younger colleagues) and whose integrity is certainly confirmed by his writing the letter. He also had the ear of government.

He wrote, "As you are well aware, at the outset I was very much against the development of postgraduate training in Family Medicine. In retrospect, I think my main concern was that the undergraduate program and its influence on the then 'teachers of medicine' many of whom had no practical knowledge of the requirements and skills necessary to produce a good family doctor, would fall by the wayside and drift off into oblivion. I also felt quite strongly that a proper restructuring of the undergraduate program could produce a well-trained family doctor. Be that as it may, it is obvious that I have been wrong on both counts, and happily, the College has done very well indeed largely through the guidance, patience and dedication of family doctors...." The point of the example is that we had failed to convince a good physician with good intentions of the need for change, and we will need to succeed in that again and again if we are to keep up with the pace of change about us.

Incomes

Fundamental is the reality that incomes in family practice have not achieved equity with specialty practice. In most provinces, our negotiators have failed to have the worth of good family practice recognized. Maybe, Victor Johnston, we have been wrong in limiting the College's mandate to education and research!

To the extent that fee-for-service has failed family practice, corrections are possible and should be entertained. Can we convince our change-resistant colleagues to risk making those corrections?

Service

We have also not presented to Canadians a comprehensive system of family practice services that meet their primary care needs. The Ontario College (and the five Ontario departments of family medicine) are asking us to support a new way of organizing family practice and have got the government's attention to a degree never before realized. Will the family practice membership support them?

Committed family physicians have kept hospital departments functioning and, in many situations, growing with new activities to bind hospital services with the community. Urban hospital departments, such as the one in the new Scarborough, Ont, hospital, exemplify the great potential for a hospital, its specialists, and family physicians to truly meet a community's needs. Other physicians, mainly discouraged by unrewarding fee schedules and threats to reasonable lifestyles, are pulling out.

In Winnipeg, my new home, I see great opportunities through a new Winnipeg Regional Health Authority for better arrangements for family physicians to properly include hospital care in their service to patients. But the fee schedule for hospital care fails them, while the health authority is pressured to support a new breed of "hospitalist" with its available dollars. One of our community hospitals is facing a dramatic withdrawal of most of its largest family practice groups, and one of our two large teaching hospitals has no family practice department at all.

Research

What about research? The 1954 to 1964 decade of Canadian medicine had little vision of primary care research. Struggling to enter the groves of Academe, most family physicians felt the priority was on teaching. In fact, establishing educational expertise was an appropriate lead into medical schools and universities in general. The prevalent belief among academics at that time was that good practice and good research were sufficient to assure good educational practice. Because this was not the case, paying attention to educational methods, developing a Section of Teachers, and supporting new teachers with educational workshops were strategically correct. But just as practice and research were necessary but not sufficient to assure good teaching, so good practice and good teaching are necessary but not sufficient to sustain academic clinical disciplines.

Research in primary care is essential to support family medicine education and good family practice. Whether or not the new Canadian Institutes of Health Research explicitly acknowledge a Primary Care Research Institute, family medicine research will play an important role.

So there we are, Victor Johnston and College founders. It is now up to us to carry on with the new challenges: organizing our family practice services in new ways, strengthening our hospital components, and enhancing our research capability. As these are accomplished, they can only improve the College structures for which you gave us the foundation and which will support the educational programs basic to good family practice services for Canadians.

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