of uncertainty for a diagnosis is inversely related to the overlapping section of CIs for the diagnostic threshold and the posttest probability of the disease. If the posttest probability is sufficiently distant from the threshold, then you can easily distinguish between presence or absence of the disease. If the distance between posttest probability and diagnostic threshold is not large enough, however, you should suspend judgment until receiving additional information from other possible sources. Dependence or independence of the tests might have some effect for transition of the point estimates, but little effect for shift of the situation. In our scenario, for instance, if posttest probability of cancer in the patient was lower than 5% or more than 50%, physicians could decide between follow-up or therapeutic intervention. With the estimate of 20% (or somewhat lower considering dependence of the tests), however, physicians must pursue diagnosis using a paraclinical test with highly significant positive and negative LRs.

Although consideration of independence of clinical tests is proposed as an essential step before application of multiple LRs, this problem is usually resolved by using a few tests from independent body systems. Clinicians can increase their diagnostic efficiency by using tests with significant and independent LRs derived from valid research evidence instead of their own intuition or personal experience.

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Family physicians are generalists!

"If any organization is to remain healthy, it must have a balance between generalists and specialists."

—Ian McWhinney[1]

Family doctors are the ultimate generalists in Canadian medical practice. They care for people of all ages and both sexes, from preconception to grief; apply medical knowledge and basic technical skills for common problems; and coordinate referrals and consultations for complex problems requiring specialists' expertise. Knowledge of the breadth of medicine, committing to continuing personal relationships, and

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never saying "there is nothing I can do for you" are what makes them the ultimate personal physician—generalists. The system is currently in balance between generalists and specialists.

True, there are general pediatricians, general internists, general surgeons, general psychiatrists. But all of these have boundaries around their knowledge and skills—limiting practice to patients younger than 19 years, to adults with biomedical conditions, to those requiring surgical decisions and interventions, and to those with mental illness. Practice limits for other specialists are also obvious: renal disease by nephrologists, eye disease by ophthalmologists, and so on.

Family medicine was designated a "specialty" by the American Board of Medical Specialties 50 years ago, to make it equal with existing specialty boards. At that time, 18% of American doctors were family doctors. Now the proportion is lower. Specialty designation has not made family medicine a more attractive discipline.

Some say "specialist" will apply only to those who practise comprehensive family medicine; that those who limit their practice to psychotherapy, to women's health, or in other ways will not merit the designation. So generalist family doctors will be called "specialists" and those family doctors who limit their practice will not. Will this not confuse the public, students in health professions, and medical specialist colleagues?

Family doctors' education reflects generalists' knowledge and skills. To be a good generalist does require special training, but the successful outcome is an expert generalist, not a specialist.

To call ourselves "specialists" will not ensure that students will see us as equal to other specialists. There are other ways to confirm ourselves: not tolerating references to family medicine as an inferior career choice ("I'm disappointed a person of your talent chose family practice"); avoiding self-deprecation ("I'm just a GP"); pressing our professional bodies to negotiate incomes that ensure our remuneration matches that of those accepting similar responsibility (John Wade's work on relative value needs dusting off); protesting government policies that implement health system changes without our input but take for granted that family doctors will patch any gaps (a recent example is the deinstitutionalization of people with developmental disabilities without involving family doctors in the planning and without support or education for family doctors in the implementation).

To discard the generalist designation for perceived political advantage based on arguments that misuse words and fail to address the fundamental causes of the status inequities we face will find family doctors in just another of more than 50 specialties rather than, as the generalists they are, at the centre of the system, caring for most of patients' problems and referring and coordinating services for those who require specialists' expertise.

The College of Family Physicians of Canada is the leading advocate and interpreter of family practice to Canadians. Our position on this issue must be unequivocal. We are generalists!

—Brian Hennen, MD, CCFP
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by e-mail

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Response

The CFPC Board is currently exploring acknowledging family medicine as a specialty in Canada (see Vital Signs in the March 2006 issue of *Canadian Family Physician*, pages 404 and 402, and *Working Together* in the March 2006 issue of **e-news** at **www.cfpc.ca**. Dr Hennen has eloquently highlighted one of the key elements of the ongoing Board discussions: the importance of generalism in family medicine. His perspectives will be part of the Board's deliberations at its upcoming meetings.

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