health system leaders. (See Dr Gutkin's Vital Signs article in the April 2006 issue of *Canadian Family Physician* "Supporting Canada's Family Physicians—is anybody listening?" in which this issue is addressed.)

—*Louise Nasmith*, MDCM, MED, CCFP, FCFP
President, College of Family Physicians of Canada

Celebrating our role as generalists

The issue of family medicine as a specialty, while seemingly straightforward, is a critical discussion, as it speaks volumes about our own search for identity.

The question of whether family medicine *is* a specialty is subtly different from whether we wish to have it designated as such. Specialty can be a designation for a domain of knowledge, a political statement, or a prestige term. We must be clear in what sense we are using the word. In the world of medicine, the term connotes extremely focused areas of knowledge or skills.

Specialism is, by its nature, reductionist in approach. It begins with a closely defined knowledge or skill category and focuses on this category to the exclusion of others. It arises out of the production model of activity. Ursula Franklin[1] has argued that the production model is a product of prescriptive technologies, those that require complex tasks to be broken down into codified steps. In this approach a particular activity is reduced to its elements and each component is attended to by someone who is concerned only with that element, not with the overall process. Such models ignore context as an externality to be controlled for.

The growth model, on the other hand, is aligned with holistic technologies, which allow the worker control over making and doing and which emphasize context. Franklin clearly states that health care should be conducted using a growth model. Family physicians find it easy to think in terms of the growth model she describes; indeed, the fruit of this approach has been one of the contributions of family medicine to medical care in the latter part of the 20th century.

The re-emergence of family medicine as a distinct discipline began in North America 50 years ago and has grown, in part, in response to the move toward increasing specialization in medicine. Complexity science makes clear that, paradoxically, the more complex a system becomes, the greater need there is for generalist thinking.[2] Family medicine has been developing and teaching a worldview that is distinctly different from the dominant one.

Taking the title of specialist is acceding to the language of the dominant medical model. It is the language of colonization. In an attempt to become "the noblest of Romans" we risk abandoning that which makes us unique.

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It is not certain that changing the designation of our work will change others' perception of that work. We are best known for the work we do, rather than the trappings we take on. If we remain authentic to that work, labels are less important. In any case, declaring ourselves a specialty does not necessarily mean that we will be accorded greater respect by our colleagues. Doing so has not increased the status or incomes of family physicians in the United States.

As a mature discipline, we need to become less influenced by the comments of specialists and to focus on our purpose. We are no longer in our adolescence. We should take our role as the only true generalists in medicine seriously, celebrate rather than hide that role, and continue to discharge our responsibilities to our patients with confidence.

—*Tom Freeman,* MD, MCLSC, CCFP, FCFP
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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). Dr Freeman 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 ongoing deliberations at its upcoming meetings.

—*Louise Nasmith,* MD CM, MED, CCFP, FCFP
President, College of Family Physicians of Canada

Other treatments for profound anemia

In response to the Case Report on profound anemia in the March 2006 issue of *Canadian Family Physician*,[1] I question the need to transfuse 3 units of packed red blood cells to a 44-year-old woman who is asymptomatic except for nonspecific "fatigue before menstruation."[1] As outlined in an article published in the *Canadian Medical Association Journal,*[2] there is little evidence to support transfusions for chronic illnesses where there is no immediate cardiac threat from inadequate oxygen delivery to tissue. The following points are supported by level II evidence.

- Red blood cell transfusions should be administered primarily to prevent or alleviate symptoms, signs, or morbidity due to inadequate oxygen delivery to tissue (resulting from low red blood cell mass).
- There is no single value of hemoglobin concentration that justifies or requires transfusion; an evaluation of the patient's clinical situation should also be a factor in the decision.
- In the setting of acute blood loss, red blood cell transfusion should not be used to expand vascular volume when oxygen-carrying capacity is adequate.
- Anemia should not be treated with red blood cell transfusions if alternative therapies with fewer potential risks are available and appropriate.

Clearly alternative treatments were available for this patient that would also have been successful, such as iron and folate therapy. As well, I think it important to mention investigations for intestinal helminths as a possible cause of anemia in refugees, including *Ascaris lumbricoides, Trichuris trichiura,* and hookworms, among others.

—*Kieran Moore,* MD, CCFP
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2. Crosby E, Ferguson D, Hume HA, Kronick JB, Larke B, LeBlond P, et al. Guidelines for red blood cell and plasma transfusion for adults and children. *CMAJ* 1997;156(11 Suppl):S1-24.

Response

We would like to thank Dr Moore for highlighting 2 important issues related to our Case Report.