Dream-team for optimal care

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Our College was founded with the idea of setting educational standards for training and lifelong learning for individual FPs. We have proudly advanced our discipline by engaging in key research that shows the benefit of what we do. In the past year we have declared family medicine to be a specialty. This emphasis on the education of individual FPs can often lead us to believe that all that is required for the delivery of high-quality care is well-trained, up-to-date FPs. Clearly, however, the actual delivery of high-quality care depends on much more than that.

In 1975, Dr G. Gayle Stephens elucidated 3 simple but key concepts: the FP is an individual delivering care; family practice is the organizational structure in which we as individual FPs work; and, family medicine is the discipline that we must study, research, and practice.[1]

Quality support

What is required for high-quality family practice, in addition to well-educated FPs and a robust body of family medicine knowledge? In 1994, the 5 Ontario Chairs of Family Medicine, myself included, called for a 9-point plan for primary care reform.[2] We were concerned that the graduates of our programs were moving into clinical settings that did not enable them to practise to the full scope of their training. The financial, infrastructurural, and organizational supports simply were not there.

The College of Family Physicians of Canada (CFPC) responded to this call in *Family Medicine in Canada—Vision for the Future*.[3] One of the key elements of primary care renewal was support for FPs to work in teams with other health care professionals. I plan to comment on the progress, or lack thereof, in achieving that support. Mainly, I wish to highlight a very important step that the CFPC has taken in promoting interdisciplinary collaborative care.

Partners in care

Across the country, the government has been funding FPs to work with other health care professionals in teams. Pharmacists, mental health workers, dietitians, and health educators have been added to these teams, usually with high degrees of satisfaction from patients, physicians, and the members of these professions alike.

One of the most long-standing relationships in family practice has been between FPs and nurses. All family medicine residency programs in Canada train residents in environments where nurses and FPs work together. In practice, however, many FPs do not work with nurses in their offices. Even fewer work with nurse practitioners (NPs). There are financial barriers to working with such a model, where FPs must cover the salaries of nurses or NPs as part of their overhead costs. The Canadian Nurses Association (CNA) estimates that only about 5000 registered nurses are currently working in family practice settings. There are about 1000 NPs in total in Canada.

Shared vision

Recently, our College and the CNA called for the following vision: "All people in Canada will have access to a family practice or primary care setting. Each person will be offered the opportunity to have his or her care provided by both a personal family doctor and a registered nurse or nurse practitioner. They will work together to provide the full spectrum of primary health care services for all of their patients. All patients will benefit by having their own family doctor, as well as a registered nurse or nurse practitioner. Other health care professionals, including pharmacists, physiotherapists, occupational therapists, dietitians, social workers, and medical office assistants, can also be part of these practices. In all practice settings, medical services will be provided with the assurance that all professionals will practise within the legislated scope of practice for their professions and to the best of their knowledge and skills. The Canadian health care system must ensure the necessary health resources, funding, and other resources to support this vision—this is of critical importance."

This statement is very supportive to FPs, nurses and NPs, and health care teams. Many CFPC members are concerned about models of primary care delivery, which involve nurses, NPs, or pharmacists acting alone, in a non-collaborative role, trying to substitute for FPs. The joint statement by the CFPC and the CNA firmly establishes the resolve of both organizations to increase system supports so that collaborative teams of FPs and nurses or NPs can work together. Much needs to be done to achieve this vision, but its implementation is key to the delivery of the best possible care for our patients in the future of our discipline.

References

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