Que sera, sera; whatever will be, will be ...

Sarah Kredentser MD CCFP FCFP

While that sentiment might apply to unforeseen events in individual lives, we cannot say that it is true for the future of family medicine. I firmly believe that we have the capacity to *create* that future, but it might mean doing things differently than we are now.

We are all aware that fewer FPs are doing intrapartum, hospital, and emergency care, procedures, and on-call duty. Some policy makers seem convinced that other professionals can substitute for FPs. If adaptation is an evolutionary imperative, how might the FP of 2020 practise?

Careful what you wish for

Dr Z. practises in a small group of FPs remunerated through blended payment. His electronic medical record tracks indicators of government-identified pay-for-performance benchmarks, but its usefulness in patient care is hampered by a lack of interoperability with the community hospital and pharmacy. His practice has aged—a consequence of preventive health care now being delivered by nurse practitioners in regional clinics because there are not enough FPs to provide the necessary services. More than 50% of FPs devote substantial time to focused practices. Although different models were developed for estimating physician resource needs, none has been implemented.

Dr Z. gave up obstetrics years ago, so he rarely sees babies, children, or antenatal patients. Mostly he sees patients with multiple medical problems. Many of them visit numerous other providers for different pieces of their care. He no longer feels the same connection to his patients because he's not involved in many aspects of their care. His elderly patients comment that, despite their large circle of care providers, no one really knows them. Some days he thinks that not only has wellness *care been removed from his purview, but* illness *care has become fragmented, with different disease-specific clinics assuming his patients' care. He is not sure how to promote family medicine to the students he teaches because the old selling point—it's all about the relationship—just does not seem to apply anymore. The proportion of students choosing family medicine has not increased much in the past decade.*

Tomorrow belongs to those who prepare today

How do we achieve a different outcome? Let us imagine that stakeholders form a collective initiative to map the future of family practice in Canada. Based on evidence, universities revise medicine admission criteria to attract those more likely to choose family medicine and to more accurately reflect social accountability. Decisions are made about which core values must be maintained and sustained in family medicine. Continuity is reinforced as a key component of patient-centred care. Availability of enhanced skills programs is commensurate with the needs of the population. Interprofessional care is supported to ensure that FPs can access other health professionals within their existing practices. The mantra of the previous decade—the appropriate provider for the appropriate problem—is modified to recognize the importance of the doctor-patient relationship in the setting of team-based care.

Leadership roles are held by clinicians who motivate others to support innovation. Remuneration includes opportunities for practice assessment and ongoing change. There is flexibility and accountability within a blended payment scheme including some quality benchmarks. Patients know who their doctors are, who their nurses are, and that the care team communicates effectively.

Family doctors are integral to the undergraduate curriculum. A national collaborative estimates the required numbers in each specialty. Because we have anticipated the growth in the population of senior citizens in our country, chronic disease management strategies are well integrated into each practice. There is effective interoperability between all components of the electronic medical record.

What does this future look like for Dr Z.? He works in a group of 5, sharing resources with another group in the city. There are 3 nurses with special areas of expertise who circulate between the clinics. A mental health counselor and a pharmacist attend each clinic weekly. One nurse coordinates all home-care requirements. Some of the doctors provide intrapartum care in an FP-run obstetrics clinic, receiving a stipend plus fee-for-service payment for their time. Some members of the group provide in-hospital care; updates are automatically sent to patients' regular physicians. The clinic has extended hours twice a week and is open for 4 hours on weekend days. With 10 in the group, and added remuneration for providing this service, it is not onerous. After-hours coverage is provided by a telephone triage system backed up by an urgent care clinic. Patients understand that their care needs can be met under the umbrella of their medical home. Regular evaluation of benchmarks, patient adherence, and outcomes occurs. Care providers have a strong investment in improving care. As a result of the visibility and respect afforded to family medicine in the medical schools, and the increases in payments that have put FPs on par with most other specialists, recruitment into family medicine is at its best ever.

Which future would you and your patients prefer?

Cet article se trouve aussi en français à la **page 846.**