# Family medicine in 2018

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Family medicine faces continuing physician shortages but increasing numbers of students. It is imperative that we use this opportunity of rapid expansion to ensure that family medicine resident training will provide the necessary tools for enhancing the quality of patient care in communities.

On May 4, 2008, 15 of the 17 Chairs of Canadian family medicine university departments and programs met to discuss the future of family medicine. The Chairs recognized and affirmed that with family medicine residency expansion, training will take place both in larger urban areas and, increasingly, in smaller and more rural centres. Allowing for contextual variability, the observations to follow apply equally to urban and rural or regional training sites.

Dr Richard Boulé from the University of Sherbrooke led the discussion using the *nominal group technique* (NGT).[1-9] The NGT is commonly used in consensus development.[3,7-8] Sessions using the NGT involve the following steps: silent, written generation of responses to a question; round-robin recording of ideas; discussion for clarification; and prioritization of the ideas generated.[3]

Although the NGT lacks flexibility, this highly structured format promotes equal involvement by all participants and minimizes extraneous discussion.[3,7] It is time effective and results in a concise written summary of the generated responses.[7] Consensus development can bridge the gaps in research in the context of evidence-based health care.[8] Thus, professional and peer review and evaluation are critical to validation of the concise summary developed.[9]

The Chairs were each asked to write 15 to 20 ideas about or characteristics of family medicine as they envisioned it would be in the year 2018. They were then divided into 3 groups and asked to prioritize the most important characteristics within 3 main themes. These characteristics were shared with the larger group, resulting in 43 statements about family medicine.

The Chairs awarded points ranging from 0 to 4 for each statement—statements judged to be the most likely to describe the discipline of family medicine in 2018 were awarded 4 points, while those least likely to describe family medicine in the future were awarded 0 points. A summary of this exercise was later circulated and discussed at subsequent meetings of the Chairs. Further changes were made by e-mail, with some items added and others modified. The final text follows.

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## The primary care system

The current fragmentation of the primary care system will have been addressed by a variety of stakeholders. Primary care today comprises solo and small group practices in various practice models, working in isolation with few formal links with other health care sectors or health services decision makers. Primary care will be better organized, with publicly funded administrative infrastructure support similar to other jurisdictions, including the United Kingdom, Australia, and New Zealand. British Columbia has already created a divisional system based upon the Australian model.

***Academic implications.*** All academic family medicine practices will operate within publicly funded primary care practice networks. These networks will facilitate health service integration with other disciplines and promote comprehensive, collaborative, intraprofessional, and interprofessional care. They will have formal links with academic centres in the areas of medical education and primary care research.

## Comprehensive care

Family physicians will offer more comprehensive care than they are providing now. Because it is no longer possible for individual physicians to offer all services, a comprehensive basket of services will be offered by physicians working in groups. Patients will present with more complex pathologies. Home visits will be part of comprehensive care delivery.

***Academic implications.*** To address the needs of increasingly complex patients, clinical methods that recognize and address the reality of *confluent morbidity*[10] must be developed, and educational methods for their dissemination must be implemented. Future family physicians must be trained in interprofessional clinical settings, side by side with other health care professionals. Certain components of academic medical education, both undergraduate and postgraduate, should also be interprofessional.

## Shared care

There will be an increase in shared-care models of

service. The family physician will work as a part of an interprofessional team. Family physicians will often lead these teams, be the most familiar with the overall vision of the care required, and assume ultimate responsibility for the care provided by the team, depending upon the needs of the patient.

*Academic implications.* Future family physicians must be trained in team dynamics and team leadership and participation. Family medicine teaching units must model teamwork in the delivery of health care and the education of residents and students.

## Doctor–patient relationships

The doctor-patient relationship will change as a result of the team structure of care delivery. In many ways, it will become more complex, with possible confusion over lines of responsibility and accountability. Nevertheless, the continuity of this relationship will remain vitally important and will continue to be valued by patients.

*Academic implications.* Trainees must participate in shared care and be guided in learning how to maintain meaningful physician-patient relationships. Patient-centred care with an emphasis on continuity of the relationship will remain essential for this discipline.

## Social accountability

Family physicians will need to be very flexible, adapting rapidly to patient and system needs. They will need to enhance both focus on social accountability and devotion to the marginalized and the underserviced, continuing a tradition of family medicine seen since its earliest days. Physicians will remain advocates for the community, representing community needs at various levels of societal organization.

*Academic implications.* All family medicine residents must be involved in providing care to marginalized populations. Research in this area should be strongly encouraged by the faculty members of family medicine departments, and rewards for those involved in care of marginalized groups should be increased. Residents need to be aware of how resources for communities are organized and of the methods for influencing the allocation of those resources.

## Undergraduate education

Family physicians will progressively increase their role in undergraduate medical education and by 2018 might be responsible for as much as 50% of the teaching load.

*Academic implications.* Family medicine residents and community family medicine faculty must be taught to teach, especially at the undergraduate level, because a great many more family physician teachers will be needed as the family physician's contribution to undergraduate teaching becomes more important. A cultural change in support of generalism will be necessary throughout undergraduate medical education.

## Length of residency training

The time allotted to family medicine residency is very short compared with all other specialties. With increasing multimorbidity associated with longer patient lifespan, it will become increasingly difficult to become a competent family physician in just 2 years.

*Academic implications.* New stressors will appear for family medicine educators and curriculum designers as they strive to teach and model comprehensive care. These stressors will lead to the development of extended residency programs.

## Training in areas of special interest

A greater number of family physicians will be involved in areas of special interest either during residency or during career modification later in practice. Increasing numbers of graduating family physicians will choose to immediately limit the scope of their practices. In certain fields, in which there are considerable shortfalls in human resources (eg, obstetrics), this trend could have a substantial effect on overall family physician supply. It is important, however, that family physicians with special interests continue to practise collaboratively in family medicine settings where comprehensive care can be provided, as the demand will remain high for comprehensive care.

*Academic implications.* We will continue to train family medicine residents in comprehensive care, while recognizing that there will be graduates who focus their practices. Residency training programs must develop more options, enabling those with special interests to get the training they need, perhaps in a vertically integrated manner. Practical mechanisms of blending and delivering focused practice with comprehensive care will need to be developed and modeled. Professional development opportunities in areas of special interest must also be offered to practising physicians.

## Effect of information technology

The increasing technological literacy of patients will have an effect on the role of the family physician. The family physician will increasingly act as a knowledge broker, both with patients and within the health care team. Patients will develop new expectations regarding modes of communication and interaction with their family physicians.

*Academic implications.* Training programs must use information technology to enhance the learning and sharing of information between physicians and patients.

Rapid social adaptation to evolving technologies must be embraced and mirrored within training sites and within the discipline generally.

## Remuneration

Although fee-for-service remuneration will continue to be important for many family physicians, there will be a great number of blended models, alternative funding models, and incentive-driven models. Funding of practices will usually be linked to measurable outcomes of performance. The practice of family medicine will become increasingly evidence-based and outcomes will be routinely measured.

***Academic implications.*** Trainees must be exposed to outcome measurements in the practices where they train. Family medicine faculties must participate in the development and implementation of important and relevant quality outcome indicators, such as access and continuity of care, avoiding the exclusive use of simplistic measures such as biochemical markers.

## Research

Research in family medicine is essential to ensuring the future health of Canadians, both at the population and the individual levels. Meaningful research will allow the primary care system to remain responsive to the health care needs of the population, accountable to funders, and adaptable to changing environments. There will be much more research undertaken in family medicine as funding agencies start to recognize the importance of disease prevalence and disease state in primary care settings. More family physicians will adopt scientific careers that will allow them to pursue research while continuing to practise family medicine. The routine use of electronic medical records will make audits and knowledge translation automatic functions. The routine use of pharmacogenomics, alternate care settings (such as hospital-at-home made possible by point-of-care testing), and interprofessional care with overlapping responsibilities will all be important areas of research. In some family medicine departments, research will be a special interest focus in the same way that obstetrics, palliative care, and emergency medicine are now.

***Academic implications.*** All university departments will develop research programs that will enable residents to experience and learn some of the basics of research in family practice. Many more schools will have a third-year clinical scholars program that focuses especially on research. For career scientists, many more schools will have master's and doctoral programs. All schools will have research networks, and all teaching practices, including preceptor practices, will take lesser or greater roles in this activity. Cross-school collaboration will be the normal process for research.

## Leadership and scholarly skills

Equipping future leaders of family medicine with leadership and scholarly skills will be essential. Family physicians will chair meetings and committees and influence health care policy. Some will lead initiatives at the local, provincial, and national levels. Currently there are few if any courses in leadership at either the undergraduate or postgraduate level of medical education.

***Academic implications.*** At the undergraduate and postgraduate levels, departments of family medicine will implement educational programs designed to develop leadership competencies in graduates of family medicine residencies.

## Conclusion

The Canadian departments of family medicine are committed to working together to advocate for system changes as necessary, ensuring that the graduates of our family medicine programs can meet the future health care needs of Canadians.

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**Competing interests**
None declared

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**References**

1. Dunnette MD, Campbell JD, Jaastad K. The effect of group participation on brainstorming effectiveness for two industrial samples. *J Appl Psychol* 1963;47(1):30-7.
2. Delbecq AL, Vande Ven AH. A group process model for problem identification and program planning. *J Appl Behav Sci* 1971;7(4):466-92.
3. Delbecq AL, Vande Ven AH, Gustafson DH. *Group techniques for program planners*. Glenview, IL: Scott Foresman and Company; 1975.
4. Gustafson DH, Shukla RK, Delbecq AL, Walster GW. A comparative study of differences in subjective likelihood estimates made by individuals, interacting groups, Delphi groups, and nominal groups. *Organ Behav Hum Perform* 1973;9(2):280-91.
5. Vande Ven AH, Delbecq AL. The effectiveness of nominal, Delphi, and interacting group decision making processes. *Acad Manage J* 1974;17(4):605-21.
6. Bartunek JM, Murnighan JK. The nominal group technique: expanding the basic procedure and underlying assumptions. *Group Organ Stud* 1984;9(3):417-32.
7. Kristofco R, Shewchuk R, Casebeer L, Bellande B, Bennett N. Attributes of an ideal continuing medical education institution identified through nominal group technique. *J Contin Educ Health Prof* 2005;25(3):221-8.
8. Jackson A, Hettinga DM, Mead J, Mercer C. Using consensus methods in developing clinical guidelines for exercise in managing persistent low back pain. *Physiotherapy* 2009;95(4):302-11.
9. Kennedy A, Clinton C. Identifying the professional development needs of early career teachers in Scotland using nominal group technique. *Teach Dev* 2009;13(1):29-41.
10. Upshur REG, Tracy S. Chronicity and complexity. Is what's good for the diseases always good for the patients? *Can Fam Physician* 2008;54:1655-8 (Eng), CFPlus (Fr).