Engagement and action

Nicholas Pimlott MD CCFP, SCIENTIFIC EDITOR

An ounce of action is worth a ton of theory.
Friedrich Engels

Medicine is learned one patient at a time—so said Sir William Osler. Early in my family medicine residency at Toronto General Hospital (as it was then known), I met one of my most memorable patients while working in the emergency department. He was a slender man in his mid-50s who had come to Canada from India several years earlier. He came in complaining of chronic fatigue that had recently worsened. A careful history uncovered only the additional new symptom of shortness of breath on exertion. On examination his conjunctiva and palmar creases were pale. Complete blood count revealed a hemoglobin level in the high 40s, and other markers were consistent with microcytic, hypochromic anemia. The attending physician happened to be an experienced gastroenterologist who correctly deduced that the underlying cause was chronic hookworm infection, the single-largest cause of iron deficiency anemia worldwide.

So began my education in global health. Training and practising family medicine in Toronto—a city that attracts people from around the world, which has the largest population of aboriginal people in Canada, and that is home to some of the wealthiest people in the country and some of the very poorest and most disadvantaged—has provided the unstructured opportunity to practise global health. Over the years in different settings, including a family practice inpatient ward, I have looked after people with tuberculosis, malaria, leprosy, HIV, and many other diseases, often exacerbated by poverty or social isolation.

In 2007 the Council of Science Editors organized a global theme issue on poverty and human development; more than 200 journals, including *Canadian Family Physician,* dedicated issues to the topic. In our issue, Dr Peter Singer made a compelling case that Canadian physicians should participate in research, education, and patient care in the developing world.[1] In an accompanying commentary[2] and an earlier article,[3] members of the International Health Committee of the College of Family Physicians of Canada outlined why international health is relevant for Canadian FPs, as well as some guiding principles and practical ideas to become more engaged in global health.

This issue again focuses on global health, beginning with a thoughtful commentary by members of the College's Section of Residents, which provides a resident perspective on the family medicine global health curriculum (**page 143**).[4] As Dr Gupta and colleagues point out, family medicine programs across Canada are finding creative ways to include global health concepts in formal teaching, and 88% of these programs have some kind of formal global health curriculum. However, as the authors also point out, most programs devote less than 10 hours to global health during a 2-year residency, and it remains a key area for curriculum development, "thus preparing us to be well-rounded physicians who can practise in any population."[4]

Another key point Dr Gupta and colleagues make is that "global health does not only involve going overseas ... but also includes advocating and providing care for underserved populations within Canada."[4] As Dr James Taylor describes (**page 147**),[5] the new Health for All family medicine teaching unit in Markham, Ont, embraces this aspect of the definition of global health and is proactively identifying barriers to accessing primary care in the community.[5]

This issue also includes a reflection (**page 226**) by Lajeunesse on his international elective in Zamboanga City in the Philippines,[6] and 2 research articles that address issues that fit within this broader definition of global health. Willows et al (**page e101**) examined the prevalence of anemia among Quebec Cree infants over time and found that the 12.5% prevalence of anemia between 2002 and 2007 was much lower than that between 1995 and 2000, but higher than among nonaboriginal infants (8.0%).[7] Patapas et al (**page e107**) compared quality-of-care indicators for Cree and nonaboriginal patients in Quebec who had chronic kidney disease and diabetes and found that although overall management was similar in both groups, management of anemia was suboptimal for Cree patients.[8]

Canadian family medicine has moved beyond wondering whether involvement in global health is relevant, to fully embracing it within its broad definition. The next challenge is to develop a strong global health curriculum in family medicine training programs across the country.

Cet article se trouve aussi en français à la **page 142.**

Competing interests
None declared

References

1. Singer PA. Motivating action. Why should Canadian physicians participate in research, education, or patient care in the developing world? *Can Fam Physician* 2007;53:1849-51 (Eng), 1863-5 (Fr).
2. Pottie K, Redwood-Campbell L, Rouleau K, Ouellette V, Lemire F. Degrees of engagement. Family physicians and global health. *Can Fam Physician* 2007;53:1853-7 (Eng), 1866-70 (Fr).
3. Redwood-Campbell L, Ouellette V, Rouleau K, Pottie K, Lemire F. International health and Canadian family practice. Relevant to me, is it? *Can Fam Physician* 2007;53:600-2 (Eng), 608-10 (Fr).
4. Gupta A, Talavlikar R, Ng V, Chorny Y, Chawla A, Farrugia M, et al. Global health curriculum in family medicine. Resident perspective. *Can Fam Physician* 2012;58:143-6 (Eng), e82-6 (Fr).
5. Taylor J. Primary care outreach in Markham, Ontario. *Can Fam Physician* 2012;58:147-8 (Eng), e87-9 (Fr).
6. Lajeunesse AR. Doing more. *Can Fam Physician* 2012;58:226 (Eng), e123-4 (Fr).
7. Willows N, Dannenbaum D, Vadeboncoeur S. Prevalence of anemia among Quebec Cree infants from 2002 to 2007 compared with 1995 to 2000. *Can Fam Physician* 2012;58:e101-6.
8. Patapas J, Blanchard A, Igbal S, Vasilevsky M, Dannenbaum D. Quality-of-care indicators for the management of aboriginal and nonaboriginal patients with chronic kidney disease in Quebec. *Can Fam Physician* 2012;58:e107-12.