Advocate for the GP specialist

In the March issue of *Canadian Family Physician,* Dr Gutkin points out that the face of family medicine is changing.[1] In the meantime, patients are often uncomfortable and unfulfilled by the patchwork model they are encountering. Some FPs limit their practices to special interest areas; others refuse to take on new patients with complex needs: the elderly, those with mental health and addiction problems, or the chronically ill. Fewer GPs have hospital privileges or do shifts in emergency departments. Many do not follow their patients into nursing homes. Less and less of what we see today conforms to our traditional concept of "full-service" or comprehensive family practice. This is the reality within which the College of Family Physicians of Canada (CFPC) must operate, and with which it must continue to grapple to serve both the needs of its members and our patients. It is not subspecialization that is killing full-service family practice: it is changing for many reasons, and the CFPC must change too and help redefine family practice for our 21st-century reality. I believe it is the mandate of the CFPC to continue to advocate for the GP to be at the forefront of primary care, but also to leave room for, respect, and advocate for the GP specialist within the CFPC. I believe FPs bring important perspective and expertise to many areas, including emergency medicine, chronic pain management, oncology, sports medicine, medical school and college administration, palliative care, mental health and addiction, geriatrics, and women's health, to name a few. We are missing a great opportunity to influence and mold these specialty areas so that they better serve our family practice populations. After many years in small-town general practice, I am now working full-time in palliative care, including tertiary inpatient care, consultations, home visits, teaching, and research. I feel strongly and passionately that I am offering comprehensive care as an FP subspecialist. I feel abandoned by the CFPC's narrow-minded enslavement to an outdated concept of comprehensive family medicine. I can scarcely believe that this is the same College that in the 1970s was visionary in advocating, against tremendous odds, for family medicine to be recognized and respected as a distinct specialty. Within palliative medicine, FPs have the necessary skills, and a unique perspective, for both symptom management and holistic end-of-life care. We have the training and experience to communicate well and work in multidisciplinary teams. We have the experience and skills to see the bigger picture; to recognize futility and advocate for compassionate end-of-life care. I believe that there is room within specialty palliative care for anesthesia, internal medicine, geriatrics, pediatrics, as well as family practice, but it would be a detriment to our patients to allow it to become solely a Royal College of Physicians and Surgeons of Canada specialty. The College needs to work harder and more collaboratively to refine the current definition of family practice. Otherwise the CFPC runs the risk of becoming irrelevant to a substantial proportion of its members, both those in office family practice and those who are working full- or part-time in subspecialties. My suggestions, with respect, are as follows.

- There must be room within the CFPC for specialty certification. The requirements of the Section of Family Physicians with Special Interests or Focused Practices are too narrowly defined.
- Comprehensive family medicine should be redefined as a more collaborative endeavor. The CFPC must abandon the fantasy that every FP must meet all the diverse needs of the 21st-century patient.
- The CFPC should broaden the path to Mainpro-C continuing professional development credits so that there is more diversity and not solely an emphasis on skills essential to the rural FP (eg, advanced cardiac life support, advanced trauma life support, neonatal resuscitation). While it is now possible to apply for Mainpro-C credits by individual consideration, this is overly cumbersome and discouraging. It fails to adequately acknowledge and credit the many intensive continuing professional development courses undertaken in subspecialty areas.

Thank you for considering these suggestions. The Canadian Society of Palliative Care Physicians is meeting in Kingston, Ont, in June, and the issue of specialty certification will again be discussed. The palliative care physician who is a family doctor must be kept relevant to this specialty, and the CFPC and the Section of Family Physicians with Special Interests or Focused Practices must find a way to collaborate with the Royal College in specialist certification in this and other subspecialties. The CFPC must pull its head out of the sand and not abandon the GP specialists who wish to remain in its embrace.

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Competing interests
None declared

Reference

1. Gutkin C. Focusing on generalism. *Can Fam Physician* 2012;58:352 (Eng), 351 (Fr).