Update on special interests and focused practices

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Dear Colleagues,

The new Section of Family Physicians with Special Interests or Focused Practices has occupied a considerable amount of my energy since I began my tenure in my current position. This article aims to remind us where we came from, clarify misconceptions, update you on our progress in education, and be up front about uncertainties.

The incorporation of enhanced skills into family practice is not a new phenomenon. In a clinical career spanning more than 30 years, I started as a GP anesthetist who also provided substantial intrapartum care in my community. My role evolved to incorporate more emergency care and assume more administrative responsibilities. Primary drivers of such areas of special interest include community needs and professional interest.[1] The 2010 National Physician Survey results showed that about 30% of FPs have developed areas of special interest or focused practices.[2]

The area for which the CFPC has defined enhanced skills competencies and offered a credential the longest is emergency medicine. Our objective was to better equip FPs providing emergency care to meet the needs of their communities. The relative shortage of physicians in Canada associated with a need to provide emergency department coverage resulted in a shift toward full-time commitment in emergency medicine by many of our FPs. I mention this to remind us that the determination of scopes of practice for all physicians is multifactorial, and is influenced by factors beyond the educational standards for which the Royal College of Physicians and Surgeons of Canada and the CFPC are responsible. I also want to remind us that many FPs continue to incorporate emergency care into comprehensive practices, and that most emergency care in this country is provided by FPs.

Palliative medicine is an enhanced skills area that the Royal College and the CFPC are accrediting conjointly. The creation of this enhanced skills area has improved access to end-of-life care for Canadians, and it is an important societal need. Most palliative care in Canada is provided by FPs within either comprehensive care practices or focused practices. Whereas most FP leaders in this area embraced it after spending several years in traditional family practice, most of those who chose this focused practice area in recent years did so before providing continuing comprehensive care in family practices. This will have implications as we consider the future of enhanced skills training.

The CFPC Board of Directors has approved the granting of certificates of added competence (CACs) in 3 additional areas: GP anesthesia, care of the elderly, and sports and exercise medicine. In addition, the Board has approved 3 routes leading to CACs: enhanced skills training; a time-limited leaders' route, meant to recognize FP leaders and facilitate their acquisition of CACs; and a practice-eligible route, which has not yet been developed.[3] It will involve the submission of a portfolio and possibly a peer-review process. We also need to remind ourselves of important emerging areas relevant to family practice, where additional competencies have frequently been acquired by FP leaders (eg, HIV care, addiction, pain management).[4]

We have been cautioned by the Board of Directors and other stakeholders about the risk of fragmenting our profession.[5] We understand this tension. We have also received positive comments about this initiative. Some of the identified positive influences are the inclusion of FPs with enhanced skills as part of our professional home; the definition of the competencies of FPs with enhanced skills; better integration of FPs with enhanced skills into family practice and into acting as resources for their colleagues; advocacy and health policy in these clinical areas; and redefinition of what should be core competencies for all FPs.

If something requires "energy," that does not mean that it should be abandoned. Several questions need to be answered: Which areas should be granted CACs? What should the requirements be for the maintenance of CACs? Should FPs who acquire CACs maintain competence in their primary specialty, family medicine—if so, how will the CFPC monitor this? Most would agree that it is important for the CFPC to define enhanced skills competencies. What role should we play in ensuring that these FPs are really competent in providing quality care? Do we know that such practitioners contribute to the provision of effective care that meets societal needs? Will we need to charge an additional fee for those who wish to acquire CACs? These are only some of the considerations being discussed.[6]

I will be pleased to provide you with further updates as these and other issues are being considered. Your comments and feedback, both to the CFPC and your respective Chapters, are welcome.

Cet article se trouve aussi en français à la **page 899.**

References

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