Changing face of family medicine

We are now celebrating the 60th anniversary of the founding of the College of Family Physicians of Canada (CFPC). There have been some important changes in family medicine and what being an FP encompasses in the 21st century. After reading well written articles about these changes in the January 2014 issue of *Canadian Family Physician*,[1-5] I was moved to reflect on how I would like to see the FP evolve. These articles included those on Dr Ian McWhinney and how his and others' visions have shaped family medicine, as well as what the authors thought Dr McWhinney's wishes would be for the CFPC as we go forward.

I do not profess to have the wisdom and insight of Dr Ian McWhinney and the authors of the recent articles, but having taught and practised family medicine in Canada for more than 30 years I would like to give you my wishes and hopes for the CFPC and for FPs in the 21st century.

Protect the underlying theme of the comprehensive FP. I am well aware of the subspecialties in our College and the good they do in helping our patients. In addition, I know that the day of the all-inclusive FP doing hospital care, obstetrics, and pediatrics along with an office practice has faded. But we must continue to train our family medicine residents to look after the "bread and butter" medical and psychosocial conditions that we endeavour to help our patients with every day. With no disrespect to our fellow specialists, some have become so subspecialized that they only look after knees or ears. This is not the way I would like us to venture.

Promote family medicine as a career choice. We must continue to promote our specialty of family medicine with passion through teaching of and encounters with medical students, residents, and colleagues. The exposure to these groups through teaching is important to this concept and cannot be overemphasized.

Improve the balance in our lives. We must accept the fact that our younger colleagues appear to have a better balance between their personal lives and professional lives than we ever did. They are sharing family medicine practices, and both "father FPs" and "mother FPs" are taking time off to be with their newborns. We should embrace this balance and refrain from using the classic line "I remember when I was ...." We should learn from their example.

Support one another. We should all have our own FPs that we can rely on for our health needs. This support should start at the medical student level. As well, we should try and help one another when our health or that of our family members fails. We should also assist our colleagues who need a break or time off because they are afraid of burnout. It might involve a little extra work or call time but it will be appreciated and usually reciprocated when you need the same courtesy. We should at least treat one another as well as we treat our patients—have compassion for one another, always.

Advocate for patients. We must continue to advocate for our patients, especially in these times of turmoil and disjointedness in our health care system. This is one of the most important roles we play for our patients.

Participate in continuing professional development. We should continue to learn and strive to be the best FPs possible. The manner in which individual FPs decide to accomplish this task should be up to them, as I still believe each of us understands how we learn best. This will prevent stagnation and prevent the physician's knowledge from becoming outdated, allowing him or her to give the most up-to-date care to his or her patients.

Honour traditions. We should remember to learn from our past and from traditions. Not all that is old is wrong. For example, the tradition of the housecall should not be abandoned, as it serves a purpose in certain situations. This is despite the fact that many physicians might believe this is outdated and unnecessary. I disagree, as housecalls might be the only way certain patients can see FPs. This promotes continuity of care. As well, the tradition of a housecall by the FP supports and comforts the patient. It accomplishes something sacred to our role as a physician.

The above is my vision for what I believe is important for FPs and family medicine. The face of family medicine might be changing in the 21st century. My vision for the new face continues to include the 4 principles of family medicine and is consistent with the 3 *C*'s in the Triple C Competency-based Curriculum, but I believe it

goes beyond it. I believe the above statements are important to reflect upon to help guide us forward. This will allow us to continue the strong tradition of family medicine in Canada that Dr Ian McWhinney and others have envisioned.

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Competing interests
None declared

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Benefits of CBT for OCD in pregnancy

We read with great interest the article by Namouz-Haddad and Nulman,[1] which discussed treatment options for obsessive-compulsive disorder (OCD) in pregnancy and puerperium. This issue is of critical importance given its prevalence, the level of impairment caused by OCD, and the need for clinicians to consider risks that occur when treating this population that would otherwise be absent in nongravid patients. We appreciate their informative and concise review of the literature and the authors' resolve to present available treatment options. Within the article's many strengths, there are 3 concerns that we would like to address.

First, the article lacks relative equipoise with cognitive-behavioural therapy (CBT) in relation to selective serotonin reuptake inhibitors (SSRIs). The authors supplied an excellent discussion of pharmacologic treatment; however, they provided only a 1-sentence rationale in favour of CBT for OCD. Indeed, CBT with exposure and response prevention has been shown to display more robust treatment outcomes than pharmacotherapy using serotonin reuptake inhibitors (SRIs)[2,3] and has been recommended as the front-line treatment option for nongravid patients with OCD.[4] Preliminary data support CBT for OCD in pregnancy and puerperium as monotherapy[5] and in combination with an SRI.[6] In addition to the aforementioned efficacy of treatment, CBT lacks the negative side effect profile discussed by Namouz-Haddad and Nulman that is associated with SSRIs.[1]

Second, patient considerations must be taken into account when prescribing a treatment plan.[4] This is even more prudent when working with vulnerable populations such as pregnant and postpartum women. As discussed by Namouz-Haddad and Nulman,[1] there is a lack of clinical agreement regarding the safety of exposing an infant to SSRIs through breast milk. Data suggest that CBT is a well regarded treatment approach relative to SSRI monotherapy among nongravid individuals with OCD.[7] Given this, a behavioural approach that lacks these risks should always be considered in the initial treatment plan.

Third, although efficacious, treatment with SRIs rarely produces remission. In fact, using SRIs alone, only approximately 40% to 60% of individuals achieve a clinically meaningful treatment response.[8] There are additional concerns to consider such as the substantial rates of relapse after medication is discontinued.[9] This leaves the clinician at a loss for what to do next. There is clear support for providing CBT in an augmentation approach[10,11]; however, as discussed above, CBT alone should always be considered as an