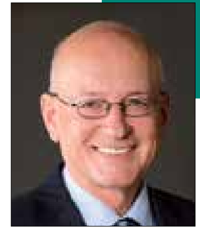

Rising to the challenge

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In my more than 35-year relationship with our College, I have not seen an environment that has so challenged our discipline as the current one does. I have been privileged in the first half of my presidency to meet educators; Chapter leaders; deans; department heads; the public; representatives from health authorities, ministries, and organizations; and many family doctors across the country.

Several themes emerge recurrently and deserve reflection. Some are contentious. All require your wisdom. They arise from rapid system change; aging patients; shrinking budgets; increasing public expectations, medical complexity, and regulatory scrutiny; and the difficulty of keeping pace with this change. Interestingly, the same pressures we encounter in practice, such as transitions of care, knowledge of populations served, access to teams and resources, and quality improvement, are mirrored in academic family medicine as it grapples with learner transitions, learning needs specific to populations, interdisciplinary training, and competency acquisition. The lines between clinical and academic family medicine are increasingly blurred as teaching becomes the norm and lifelong learning the expectation. Any distinction might now be largely irrelevant.

I present here some of the themes I have encountered for your consideration; perhaps they will stimulate questions as to the evolution of our discipline.

- It is critical that family medicine bring value for money. We are one of various health providers. Our value proposition must be clear and widely understood. We must be intentional in defining our discipline and the training and continuing professional development that support it.
- We must, as a collective, work "up to full scope." We must endorse advanced access models and other efficiencies. None of this precludes focused practice. While most of us must provide appropriately comprehensive care, colleagues providing focused care must be integrated into this fabric so there is a comprehensive "whole" meeting community needs. It might be that focused practice will be, for many, the latter part of a career continuum: begin by getting one's feet wet in comprehensive care, do the "heavy lifting" of full service, and finally but not necessarily narrow to a scope defined by practice need or interest. But collectively we must meet the primary care needs of all communities, the secondary care needs of many communities, and perhaps the tertiary care needs of some communities. Achieving this makes a powerful statement to governments placing demands on family physicians.
- Our curriculum and training must be broadly aligned with societal need and specifically aligned with community need. All I spoke with identified the threat of disconnect between the academic model and health service needs. Some worry that residency-acquired clinical skills might not adequately prepare learners for practice and that rural medicine, which is increasingly doing more teaching, is underrepresented in academic infrastructure and curriculum design. There is a sense that departments of family medicine are challenged to address these things and that solutions might be beyond their immediate control.
- There is concern that new graduates are able to access third-year residency positions directly out of residency, before comprehensive skills have been consolidated through practice and before a specific need is identified to ensure that enhanced skills acquired are relevant. There is growing interest in supporting re-entry to enhanced skills training based on community and practice need. In addition, some new graduates describe feeling anxiety on leaving residency in this world of increased medical complexity and professional scrutiny. Does all of this mean we need a longer residency to alleviate concerns about readiness for comprehensive practice, while better supporting re-entry based on community need?
- We need better metrics to track the work we do, where we do it, and the value it brings. Our American counterpart organizations have experienced important benefits by tracking such metrics, better preparing them to engage governments and funders, and to inform training.
- We need dynamic and mutually supportive relationships with our Chapters given that the "rubber hits the road" in the provinces for members, residents, students, teachers, government, universities, and health authorities.

These themes resonate with me personally. I believe we ignore them at our peril. We must deliberate, decide, and act. I believe the recent changes at the CFPC have been preparatory for these difficult conversations. Witness the proposed governance change that should better position us to consult members and act, as well as the proposed Family Medicine Specialty Committee that will better link academic family medicine with practice realities. More than ever we need our members' wisdom, actualized by our committed staff, Chapters, sections, and committees.

These remarks are based on my presentation to our board at its May meeting. The following day, the board and guests from the Royal College and the regulatory authorities of Canada engaged in a visioning exercise, trying to anticipate what family medicine might look like in 2025. That process produced bold ideas and directions to keep family medicine strong, relevant, and influential. No decisions have been taken. In the coming months these ideas will be shared with you for reflection and feedback.

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