Where is family medicine heading?

Thank you, Dr Ladouceur, for pointing out the elephant in the room. Hopefully your editorial will stimulate an active and productive discussion within the discipline of family medicine and the College of Family Physicians of Canada.[1]

Family medicine has been coasting on a reputation based on principles (see Dr Michael Kidd's Dr Ian McWhinney Lecture in the same issue of *Canadian Family Physician*[2]) and practices that have been losing momentum for some time. The "primary care advantage" that has been so well documented by Starfield and others is in serious danger, as family physicians opt increasingly for focused practices and those still involved in caring for a defined practice population reduce the scope of their practices.

Bazemore and colleagues recently found that those practitioners with a wider scope of practice provided care with lower costs and tended to have fewer hospital admissions.[3] As hospital stays become shorter and more focused, and more home care becomes necessary, it is particularly concerning that fewer new family medicine graduates see doing home visits as part of their future practices. In the early days of defining family medicine as a distinct discipline, Fox made this observation: "If I wanted to discover whether a doctor had a vocation for personal care, I should begin by asking what he [*sic*] thought about housecalls."[4]

The issue of whether the development and expansion of Certificates of Added Competence is creating more focused practices or whether they are a response to larger social and system pressures is an important one to address. Currently there is no discernible link necessary between population health needs and the decision of an individual practitioner to focus his or her practice. This leaves open the impression that the shift is driven more by lifestyle and economic considerations rather than the needs of the community.

In the United Kingdom, general practitioners with special interests must continue to maintain a general practice while taking referrals from their colleagues.[5] The "expert-generalist" is a role that has particular application in rural areas, where access to specialty care is often limited.[6] In this way they serve to shorten waiting lists to see specialists, keep care closer to the patients' homes, reduce system costs, and maintain practitioner competencies. Ideally, Canadian physicians with special interests and focused practices should be required to demonstrate a need for their services in the community and there should be an outcomes framework in place before Certification. Gérvas and colleagues outline important questions about special-interest general practitioners that need to be addressed.[7] It is time that we in Canada seriously examine whether focused practices, as distinct from areas of special interest, serve community needs or professional needs.

We should not be distracted by the presumed value of specialization. The importance of comprehensiveness and continuity, key principles in family medicine, becomes very apparent in interviews with individuals who have lost the benefits of having a family physician.[8] The generalist, personal physician provides care not available through focused or specialist practices.

A common refrain is that general family medicine is too complex and difficult. The latest Commonwealth Survey reported that Canadian family physicians felt underprepared to manage care of patients in their practices with dementia (42% felt prepared), who required palliative care (42% felt prepared), and with multiple chronic conditions (70% felt prepared).[9] Some will no doubt argue that the answer to this is to train more family physicians in these special-interest areas of practice, but a better solution, surely, is to provide more focus on generalism and an approach to all problems. Generalist family physicians are the most important innovation health care has to offer patients with multiple chronic conditions.

Dr Beaulieu and colleagues have documented that family medicine is in the midst of an identity crisis.[10] As McWhinney said: "Family physicians may be differentiated, but family medicine should not fragment."[11] There is great need for our national College, provincial Chapters, educators, and researchers to take a leadership role in frankly confronting this crisis. Let 2016 be the year for this important work to begin.

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Competing interests
None declared

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Be responsive to needs of patients and communities

Roger Ladouceur says in the conclusion to his editorial that "It's time that we gave this some thought"[1] with respect to his observation that

> the more time passes, the more family medicine seems to erode. Where we once had family physicians, increasingly, we seem to have emergency physicians, hospitalists, intensive care physicians, and even palliative care physicians.[1]

As family medicine–trained emergency medicine educators, we have been thinking about these underlying issues our whole careers. Where Dr Ladouceur sees erosion, we see evolution. Where he sees failure, we see excellence to be applauded.

Dr Ladouceur mentions aesthetic medicine, phlebology, and psychotherapy as lamentable career choices for our graduates and we would agree. Of interest, he does not lament urban office-based practice that is restricted to bankers' hours; he only singles out "focused" or "specialized" practices. Yet those family physicians focusing on emergency care, hospitalist care, intensive care, and palliative care are all choosing demanding, high-acuity areas with a burden of unsocial hours. We would suggest that physicians filling gaps like these are far more responsive to the needs of our patients and communities than the urban office-based practitioners who never deliver babies, enter nursing homes (at least not after hours), or see their dying patients at home or in the hospital.

With respect to graduates of emergency medicine fellowship programs—those who receive the added competence designations Dr Ladouceur is so concerned about—we have informally and formally followed the careers of graduates of our program at the University of Toronto in Ontario.[2] We found that during their lifetimes, most graduates of the emergency medicine fellowship practised some family medicine and many (40%) ultimately chose to practise office-based family medicine exclusively. Many (40%) worked at least some time in an underserviced area and most (57%) had held leadership positions of one kind or another. Less than half were practising emergency medicine full time at the time of the survey. Thus, we found that we were graduating future leaders who chose a mix of family and emergency medicine at different times in their careers.

However, most important is that the care of certain patient populations, like those served by palliative care and emergency medicine, has improved so dramatically in the past 20 years precisely because some family physicians narrowed their clinical focus, developed an area of expertise, and provided local, national, and even international leadership to transform clinical practice. As just one example, if it were not for the late Dr Larry Librach, a family physician who became "only" a palliative care physician, palliative care would be 20 years behind where it is now.

Ultimately as educators and medical leaders we must be responsive to the needs of our patients and communities. The ideal of the comprehensive family physician is a valuable one, but embodying the role is challenging when medical knowledge is exploding and practice is increasingly complex. We all have to work together to continue to design career trajectories that are sustainable, responsive to our patients' needs, and responsive to the needs of the health care system. Rather than bemoaning the loss of the "comprehensive" family physician, we should be celebrating the successes of all our colleagues who are transforming health care for the good.

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Is family medicine ready to look where it is heading?

Dr Ladouceur is to be commended for his editorial, which opens the door to hard questions for family medicine as a discipline.[1] However, to zero in on Certificates of Added Competence as a part of the problem risks overlooking evidence of a more worrisome problem.