

4. Fox TF. The personal doctor and his relation to the hospital. Observations and reflections on some American experiments in general practice by groups. *Lancet* 1960;1(7127):743-60.
5. Royal College of General Practitioners [website]. *GP with a special interest (GPwSI) accreditation*. London, UK: Royal College of General Practitioners. Available from: www.rcgp.org.uk/clinical-and-research/a-to-z-clinical-resources/gp-with-a-special-interest-gpws-i-accreditation.aspx. Accessed 2015 Dec 18.
6. Fins JJ. The expert-generalist: a contradiction whose time has come. *Acad Med* 2015;90(8):1010-4.
7. Gervas J, Starfield B, Violán C, Minué S. GPs with special interests: unanswered questions. *Br J Gen Pract* 2007;57(544):912-7.
8. Freeman T, Brown JB, Reid G, Stewart M, Thind A, Vingilis E. Patients' perceptions on losing access to FPs. Qualitative study. *Can Fam Physician* 2013;59:e195-201. Available from: www.cfp.ca/content/59/4/e195.full.pdf+html. Accessed 2016 Jan 12.
9. Osborn R, Moulds D, Schneider EC, Doty MM, Squires D, Sarnak DO. Primary care physicians in ten countries report challenges caring for patients with complex health needs. *Health Aff (Millwood)* 2015;34(12):2104-12.
10. Beaulieu MD, Rioux M, Rocher G, Samson L, Boucher L. Family practice: professional identity in transition. A case study of family medicine in Canada. *Soc Sci Med* 2008;67(7):1153-63. Epub 2008 Jul 20.
11. McWhinney IR, Freeman T. *Textbook of family medicine*. 3rd ed. New York, NY: Oxford University Press; 2009. p. 26.

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 underserved 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.

—Howard Ovens MD CCFP(EM) FCFP
Toronto, Ont

—Eric Letovsky MD CM MCFP(EM) FRCP
Mississauga, Ont

—John R. Foote MD CCFP(EM)
Toronto, Ont

Competing interests

None declared

References

1. Ladouceur R. Where is family medicine heading? *Can Fam Physician* 2015;61:1029 (Eng), 1030 (Fr).
2. Varner C, Ovens H, Letovsky E, Borgundvaag B. Practice patterns of graduates of a CCFP(EM) residency program. A survey. *Can Fam Physician* 2012;58:e385-9. Available from: www.cfp.ca/content/58/7/e385.full.pdf+html. Accessed 2015 Jan 12.

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.