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-gpwsi-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. Gérvas 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 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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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.

Why are new graduates restricting or focusing their practices? Outside of those working in only emergency medicine (which has been an issue for at least 20 years), there can only be 2 broad categories of reasons: remuneration and satisfaction.

Remuneration, under which I would include the economics of covering inpatients and housecalls, is largely beyond the control of the College. This is to be negotiated between the government and the medical associations (or, increasingly, imposed by provincial ministries).

If new doctors are dissatisfied, it is vital for the College of Family Physicians of Canada to determine the main reasons why, and it needs to be done soon.

Is it the increasing burden on family physicians to care for patients with mental illness, pain, and addictions? That can be addressed in residency and continuing medical education.

Is it the increasing burden on family physicians to play quarterback for patients with multiple chronic illnesses? That can also be addressed in residency, and with expanded support for primary care–driven guidelines (such as the excellent new guidelines for lipid management[2]).

However, if new doctors are more globally dissatisfied with primary care, the discipline has a serious problem on its hands and by extension so do the medical education and health human resource–planning systems. If everyone operates under the broad assumption that most family doctors practise family medicine, but new family doctors do not want the job, what will primary care look like in 10 years? Will a full-service family practice be a quaint, romantic ideal for all but the most isolated and devoted practitioners? If that is the case, should the College continue to promote a vision of family medicine that is out of step with huge swaths of its work force? Or should the College take the lead and reinvent the profession, taking a hard look at every now-sacred cow?

Unfortunately, the consequence of inaction is having family medicine defined by specialist whims and government mandates.

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Competing interests
None declared

References
1. Ladouceur R. Where is family medicine heading? *Can Fam Physician* 2015;61:1029 (Eng), 1030 (Fr).
2. Allan GM, Lindblad AJ, Comeau A, Coppola J, Hudson B, Mannarino M, et al. Simplified lipid guidelines. Prevention and management of cardiovascular disease in primary care. *Can Fam Physician* 2015;61:857-67 (Eng), e439-50 (Fr).

Responsibility and professionalism in family medicine

What has happened to responsibility and professionalism in family medicine? I am grateful to Dr Ladouceur for bringing up this question in his December editorial, "Where is family medicine heading?"[1]

It is a question I have been asking for 26 years. In 1989, the town of Woodstock, Ont, (an ideal location for traditional GPs and FPs) was struggling to recruit traditional GPs and FPs. A survey of family medicine residents in Ontario at that time indicated that only 50% intended to be traditional GPs and FPs (telephone communication in 1990 with Dr Jacqueline McClaran, family medicine instructor at McGill University, and Dr Walter Rossiter, Chair of Family Medicine at Queen's University).

To support Dr Ladouceur's concerns, in the past 7 years the Woodstock hospital granted privileges to 24 emergency medicine GPs and FPs and to 18 hospitalist GPs and FPs, but to no traditional GPs or FPs. During those 7 years, 2 busy traditional GPs and FPs retired, leaving 4700 orphan patients. Fifteen years ago with Dr Bruce Halliday (Past President of the College of Family Physicians of Canada), I listened to Dr Ian McWhinney (the father of family medicine in Canada) share his concerns about the fragmentation of family medicine (office discussion in 2000).

Are we witnessing an erosion of responsibility and professionalism in family medicine?

In the December 2015 issue of the *CMAJ,* Dr Cindy Forbes (President of the Canadian Medical Association) announced that the Canadian Medical Association will have a new strategic plan to focus on "hugely important issues next year such as professionalism."[2] The 1966 medical school graduates of Western University in London, Ont, will celebrate the 50th anniversary of their graduation in 2016 by instituting an annual medical student prize for professionalism.

Family physicians need to recognize the obvious: that medical schools exist to meet the primary care health care needs of Canadians and not just the lifestyle goals of GPs and FPs.

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Competing interests
None declared

References
1. Ladouceur R. Where is family medicine heading? *Can Fam Physician* 2015;61:1029 (Eng), 1030 (Fr).
2. Forbes C. A challenging year of action. *CMAJ* 2015;187(18):1404.

Correction

In the Cover Story in the January issue of *Canadian Family Physician,*[1] Caroline Michell was incorrectly identified as Caroline George in the photo of the Tachet drummers and dancers. The correct description of the photo is as follows:

Dr Pawlovich and Dr Bria Sharkey with Tachet drummers and dancers: Vaughan Michell, Summer Michell, Christian Issack, Jordan Johnson, Anthony George, Harley George, and Caroline Michell.

Canadian Family Physician apologizes for the error.

Reference
1. De Leeuw S. Indigenous relationships, logging roads, and first-class medicine [Cover Story]. *Can Fam Physician* 2016;62:68-71 (Eng), e44-7 (Fr).