Gratitude and admiration

I am writing to express my gratitude and admiration to Drs Meili, Buchman, Goel, and Woollard for their articles that so eloquently call for social and political engagement from those of us working in primary care.[1-4]

After 20-odd years of practising family medicine in marginalized and disadvantaged communities, I find it heartening to read such credible and cogent arguments for the importance of addressing the broader determinants of health if we want our work to be about more than just applying Band-Aids.

I also want to express my appreciation to the editors and publishers of *Canadian Family Physician* for providing an appropriately prominent forum for making this argument.

I have always hoped that by helping individuals heal one at a time, I might be contributing to making the world a better place for all of us. Thank you for validating my idealism, and for reminding us that the equation works in both directions!

—Adam I. Newman MD CCFP FCFP
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Competing interests
Dr Newman is a member of Canadian Doctors for Medicare and of Upstream.

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Alternative, science-based definition

Although I am very proud of the contributions the authors of the Besrour Papers series are making to the profession, I profoundly disagree with their putative definition of *family medicine* as a discipline.[1]

For me, the definition is not social but scientific. *Family medicine* is the practice of general medicine for all ages in a context of low prevalence of disease, multiple accumulating comorbidities, and an ongoing doctor-patient relationship. Respect for the epidemiology of general practice is paramount and it is what sets us apart from specialists who treat body systems. We treat the whole patient—all their diseases—in addition to providing prevention and screening. We see patients over time. We see symptoms evolve—either resolving or mutating into diseases. We manage multiple comorbidities where evidence is scanty. We should recognize comorbidity as an urgent area of research in family medicine.

It is this scientific approach that I believe is necessary to gain and maintain respect within the larger medical community. We are not just relationship oriented. Relationships with specialists and patients are important but not sufficient. We practise scientific generalism over time, with a known, defined group of patients as a practice denominator.

I do not know or understand what the term *family physician* actually means, as the definition of *family* is so fluid. I consider myself a generalist physician and wear the label *GP* proudly.

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Competing interests
None declared

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Primary care guidelines—a resident's perspective

The family medicine residency program is based on 99 priority topics set out by the College of Family Physicians of Canada (CFPC). The national consensus on and clarity of these topics is contrasted by the 387 guidelines from various organizations pertaining to family practice in Canada, of which a number have been endorsed by the CFPC.[1]

With this avalanche of guidelines and opinions, it is not surprising that guidelines are poorly implemented.[2,3] As a family medicine resident, I come across this phenomenon in daily practice manifested as different habits in diagnosis, treatment, and preventive care guided largely by academic reading patterns and personal preferences.

To study for the CFPC examination, I use the highest-yield documents and try to work my way through an array of literature often not applicable to Canada. At graduation I will have inherited a number of personal preferences from my preceptors, which are undoubtedly helpful but not necessarily effective or evidence-based.

International examples show us that this is not a necessary outcome of guidelines in primary care. A core role of the Dutch College of General Practitioners has been the development of primary care guidelines that are led by family physicians, allowing substantial patient, specialist, and funding agency input. Currently 91 guidelines are in use, which cover 70% to 80% of the conditions seen in family practice.[4] The guidelines have been shown to improve the process and structure of care as well as patient outcomes.[5]

If the CFPC can reach consensus on the 99 topics, it will also be able to spearhead the development of primary care guidelines that better reflect primary care, lead to better health outcomes, and have a positive effect on the well-being of family medicine residents.[6]

—Ruben Hummelen MD MSc PhD
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Competing interests
None declared

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