The times, are they a-changin’?

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This year we celebrate an important anniversary. Forty years ago, the College of Family Physicians of Canada (CFPC) established the Section of Teachers of Family Medicine (SOT) as a national home for family medicine teachers and the academic community. Anniversaries are an opportune time to remember past accomplishments and to look to the challenges of the future.

By many measures family medicine is in good shape in Canada. Interest in family medicine residency has been high in recent years. More than half of all physicians in Canada are family physicians, and Canada is sought out for advice by others trying to advance family medicine in their countries. Critical to this success are the many family physicians committing time and energy to teaching in their practices, providing lectures and seminars, participating in research, and publishing. Strong academic departments of family medicine exist in every medical school in Canada, and family physicians have taken up many leadership roles including medical school deans. Family medicine researchers are active in urban academic centres and in rural and remote communities. We should be proud of these achievements and celebrate them. But anniversaries are also a time to reflect.

Looking back

Earlier this year an article in *CMAJ* reviewed the status of family medicine in Canada and the world. The good news was that in Canada and many other jurisdictions, family medicine is recognized as a specialty, but the bad news was that family physicians are still not recognized as “experts” and are still seen by the public and many other specialists as merely “gatekeepers” referring patients.

This attitude is not new. In 1929, the Royal College of Physicians and Surgeons of Canada was founded to provide a home and be a standard-setting body for emerging medical specialties. This was done in recognition of a considerable change in medical practice, from most physicians having similar training and functioning as generalists to more specialized practice. The exponential growth of medical knowledge and technology supported this shift, and general practice was essentially abandoned. It was increasingly difficult to attract medical students to general practice. Medical school faculty were dominated by the new specialists who became role models for graduates who themselves increasingly sought discipline-specific training. There were few general practitioners with faculty appointments and little recognition of the unique nature of general practice as a discipline. It was simply the old way of doing things.

Seeing the threat to the existence of general practice, leaders like W. Victor Johnston and Murray Stalker lobbied the Canadian Medical Association to provide a home, the College of General Practice of Canada, to support and nurture general practice. They saw that training standards and Certification were needed to compete for new practitioners and establish the discipline as having an expert and unique role. The struggle was long and hard, but within 2 decades the College, now the CFPC, conducted its first Certification examination and set standards for training that supported family medicine residencies in all medical schools in Canada. With a base in the medical schools, academic leaders like Ian McWhinney were attracted to Canada. They started building the academic and research base for what would ultimately become the specialty of family medicine.

The CFPC was innovative in addressing the challenge of defining family medicine as a specialty with expertise in generalism. In the 1960s and 1970s, the College developed behavioural educational objectives to guide residency training and required a commitment to continuing professional education in order to be a member of the discipline. It was first to introduce objective structured clinical examinations and written simulations to the Certification process. These innovations were ahead of their time and, in some cases, matched by other organizations only decades later.

The key role of family medicine teachers and preceptors, along with the growth of the family medicine academic community, led to the establishment of the SOT to provide a home for the academic members of the new discipline and to be a resource to the CFPC for educational and academic issues. For its first 25 years, the SOT held an annual conference, bringing together teachers from across the country to share ideas and skills and build a consistent, unified approach to teaching the discipline. This was later combined with the CFPC’s annual conference, Family Medicine Forum. The SOT also shared challenges and provided feedback to the CFPC on Certification and accreditation. Over the years the SOT has built on earlier innovations and originated curriculum initiatives leading to development of the 4 principles of family medicine, the Triple C Competency-based Curriculum, and CanMEDS–Family Medicine. It has also provided support for changes in resident evaluation, including introduction of qualitative assessment tools.

There has also been an effort by the CFPC and SOT to protect and promote the scope of family practice and the place of areas of special interest or added competence. This was and is meant to support the generalist foundation of the discipline and family physicians who deliver care in important clinical areas to communities underserved by specialist colleagues. However, despite the hard work of the past half century to protect general practice and enhance its
profile as equivalent to any specialty, important challenges remain. In a recent article in Canadian Family Physician, a family medicine resident challenged the College’s priorities and questioned the notion of generalism as the basis of the discipline. Lerner observed that many students enter family medicine residency to prepare for a career in a focused area of practice and have no interest in generalism. He challenged the CFPC to get its act together about whether it supports focused practice or will insist only on preparing students and residents to be expert generalists.

Every year, more and more medical students match to family medicine with the intention of pursuing a focused practice. If the CFPC is going to commit to generalism, it needs to do so now. Physicians with focused practices will continue to grow, especially as more Certificates of Added Competence are approved. If the CFPC waits long enough, eventually, it will be the generalists who seem out of place.\(^2\)

This sounds eerily reminiscent of 1929. One can argue with Lerner about the mission of residency and whether the College is clear in its goals, but the troubling part is that he seems disconnected from the ideas that founded the College and form the foundation of the discipline. In 1954 when the College was founded, generalism and general practice were in decline and not understood or appreciated by the public or the profession at large. Reviving the discipline was successful to some extent, but having general practice and family medicine recognized and valued as a specialty continues to be a challenge 60 years later. The issue is how to define and communicate to our new recruits and to others what it means to be an expert generalist.

**Looking ahead**

Much has changed since the 1950s, and the principles that have guided the discipline might need to be adapted. The 4 principles of family medicine, based in part on principles defined by McWhinney,\(^3\) emphasize that practitioners are skilled clinicians; focused on providing continuous care based on the patient-physician relationship; community based and knowledgeable about the context in which their patients live and work; and a resource to their community through the continuity of care they provide and by thinking critically about their practice, seeing it as a population at risk and instituting care to ensure maintenance of health and early diagnosis. It might be that the context in which these principles were developed was different, but the principles themselves are sound. They might need review or reinterpretation to clearly establish that family physicians are not simply specialists but expert generalists.

**What is an expert generalist?**

On one level it seems easy to define expert generalist. But organizations around the world have found it challenging to explain family physicians’ expertise to the public. The Royal Australian College of General Practitioners tried: *I’m not just a GP. I’m your specialist in life.* The American Academy of Family Physicians tried: *Family physicians: the doctors that specialize in you.* These slogans point at the fundamental concept of generalism and define the care unique to the discipline, but they do not capture the perspectives, talents, or approaches to care that set family medicine apart.

In his 1996 William Pickles Lecture,\(^4\) McWhinney defined the discipline not as a set of clinical skills but by family physicians’ perspectives and ways of thinking. McWhinney was not so interested in distinguishing family medicine from other specialties as in moving medical practice in new directions by capturing what general practice brings to care delivery, including more abstract approaches to disease management and knowledge of self and how that might aid or hinder care. These are not on the usual list of competencies to be acquired and assessed but reflect the context in which learning occurs and the teacher-student relationship.

Similar sentiments are found in Iona Heath’s 2011 Harveian Oration, in which she grounds the ultimate purpose of medicine and general practice in the doctor-patient relationship.

The doctor, while using the generalisations of biomedical science, has a constant responsibility to refocus on the individual, the detail of their story and the meaning they attach to it. … [W]e teach communication and consultation skills to medical students and young doctors. My worry is that we are teaching these as techniques to be used instrumentally, making the relationship between doctor and patients a means to an end rather than an end in itself.\(^5\)

Heath’s lecture echoes McWhinney’s challenge and is relevant today. But the world has changed dramatically since 1996. How do we define the challenges in the current context and move the discipline forward? As we focus more on core competencies and examination and workplace-based assessments, the SOT might need to ask, “Are we modeling, teaching, and assessing expert generalism? We have made progress, but have we really defined the elements of expert generalism crucial for our discipline to thrive?”

**Focused practice and added competence**

The demands of clinical practice often impede new physicians’ ability to deliver generalist care, perhaps more so in urban centres, where it can be difficult to provide the full range of care physicians provided in the past. The drift toward focused practice is happening in the other specialties as well. This has resulted in increasing need and opportunity for family physicians with added skill in areas like emergency, addiction, or sports medicine, care of the elderly, general practice anesthesia, and palliative or hospital care. These are all recognized by the CFPC and have accredited training programs, but other areas of focused practice are emerging, putting additional pressure on the CFPC to recognize them and, in doing so, potentially further diminishing the attraction of generalism. From this trend arises the question of whether
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Threats to continuity of care

While many new physicians will not become full-time family medicine or a new category of specialist. It raises further questions, at least in the mind of Lerner, about the range of skills required on graduation. If one’s career goal is palliative care, what need does one have of skills in intrapartum care? Can a program not be tailored to one’s career? At issue for the College and academic programs is not the philosophy of family medicine education but communicating that philosophy effectively to learners. This is difficult but important, as the future is very much in the hands and perceptions of new physicians entering the discipline. One solution is to engage teachers with focused practices more directly in the academic community. But we also need to infuse family medicine residents with the principles and approaches to care McWhinney defined. While clinical competencies are important, relying on competency alone can be reductive and diminish the discipline. We must not forget to include our context and our philosophy of care as we look to the future of family medicine training.

Call to arms?

Despite the challenges, it is a time for celebration. The CFPC and SOT have made great strides in 40 years, establishing family medicine as a key specialty choice in Canada and leading the way in developing innovative curricula and evaluation methods. But we must not be complacent; we must always review and revitalize what we do. The Family Medicine Professional Profile is the most recent example of how the CFPC has reflected on our discipline. Family medicine has come very far in 60 years. The teachers, preceptors, and academic leaders who make up the SOT have been key to its development. However, the ambitions so passionately articulated by McWhinney and others are still to be fully realized. It might be time for a neo-McWhinneyan revolution, as indeed the times they are a-changin’ and family medicine should lead the charge!

A common criticism of family medicine residency has been that residents are not taught in “real” practice settings. Gerada’s perception that continuity is “largely disappearing” must be addressed if we believe that teaching continuity in family medicine is essential. Among the challenges facing family medicine educators is the rapidly changing practice environment. Patient expectations for access, system and fiscal efficiency demands by government, and generational differences in work-life balance are challenging the principles of family medicine the CFPC upholds. To what extent can training programs apply perspectives McWhinney advocated 20 years ago? Is the context in 2018 different enough from the 1950s to stimulate a reevaluation of our principles and hence how, what, and where we teach?

Family medicine research agenda

While many new physicians will not become full-time researchers, we need to promote critical thinking in our discipline to encourage research addressing issues like the loss of continuity and to reflect on generalism’s contribution, through family medicine, to the health care system. Advancing family medicine–specific research that can influence education and the discipline requires a strong academic and research community supported by the CFPC. A national home for this community fosters research and educational thinking. The SOT has supported teachers, preceptors, and academic leaders but it is also, with the Section of Researchers, nurturing a hub for educational researchers. Through communities of practice we can bring together family physicians engaged in all forms of teaching, preceptorship, leadership, and educational research, creating active dialogue to question, debate, and strengthen the core values and concepts of our discipline. Times change, and the means to maintain that hub might need to change, but engaging family physician teachers and researchers in a robust common community will prevent the discipline from being diminished and strengthen it to its full potential.

References

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