We study history not to know the future, but to widen our horizons. To understand that our present situation is neither natural nor inevitable. And that we consequently have many more possibilities before us than we imagine.

Yuval Noah Harari, Sapiens

Canadian and US educators worry that the family physician’s scope of practice is becoming too narrow. But there is no evidence that patients or communities have suffered as a result. Perhaps we are wrong about what it means to be a generalist. Is it defined by the size of our basket of services or by the range of ideas and experiences at our disposal? All family physicians are trained to be competent, ethical, and law-abiding. But when called upon to engage patients and build community, they draw upon every talent and skill of the generalist tradition.

Part 1: Why residents don’t read more
After more than 3 decades in private practice, I joined the faculty of a nearby family medicine residency program. I now have the luxury of meeting with my colleagues once a week to discuss, among other things, curricular priorities, hospital politics, the budget, and “problem residents.” Not long ago a curious question arose: Why don’t residents read more? Despite our coaxing and occasional demand, residents seemed resistant to the idea of reading and reporting on original research.

Why would this be so? There are several possible explanations. Other professional priorities come first, including the inexhaustible demands of the electronic medical record. A recent time-motion study of interns showed that 66% of their time was spent in indirect patient care (documentation and review of the electronic medical record), 13% involved direct patient care, while only 7% was spent in didactic education. Residents, too, have responsibilities at home. A survey of family medicine residents discovered that half were parents or expecting their first child; a third were planning to add to their family. While it seems obvious that family medicine residency programs would cater to the needs of residents with families, fewer than half of US directors surveyed believed that their programs provided sufficient support. Additionally, residents in the United States carry hundreds of thousands of dollars in student debt, and many look to diminish that burden by moonlighting in their “free” time.

It is also tempting to say that residents are lazier today than “we were,” but that is the tired and unconvincing argument of each generation.

The most troubling conclusion is that residents have no reason to read beyond the guidelines and “best practices” endorsed by their hospital network. Thanks to the Internet, we all have instant access to the most current clinical resources. Risk scores, screening tools, and order sets have narrowed our clinical frame and provided us with the false reassurance of diagnostic certainty. Does it matter how the numbers are calculated or who collects them? It is tempting to ignore these questions because the rest of the system does, and because they stir the deep disquietude of our befuddling craft.

Reading between the lines, I understand what my faculty colleagues are really asking: Are the residents invested in their education? Or more precisely, are they acquiring an education or simply memorizing the tools that “we” taught them? Does it matter how the numbers are calculated or who collects them? It is tempting to ignore these questions because the rest of the system does, and because they stir the deep disquietude of our befuddling craft.

Part 2: Shifting landscape
The health care system our residents will inherit is, of course, a muddle of our own making. Or at least it is one that evolved under our watch. I am no student of Canadian health care, but I believe the following claims are largely true: Canadians pay half as much for health care as do Americans. There is essentially no private health insurance option in Canada, yet public spending covers only 70% of total costs. And family doctors in Canada (still) comprise almost half of the physician pool, compared with 15% in America.

Yet our similarities are more striking than our differences. In Canada, nearly a third of all primary care physicians report symptoms of burnout; in the United States, the number exceeds 50%—even among doctors in training. Rural areas in both countries lack physicians. Canada leans heavily on locum physicians to solve its maldistribution problems, while the United States relies on advanced practice clinicians. Both countries depend on foreign-trained physicians to fill the work force. And both countries have seen a rising number of family physicians cap their education with...
a fellowship, a trend that has narrowed the scope of practice overall.\textsuperscript{10,11} Finally, the family medicine centre has become a secondary point of first contact for medical services. Emergency departments in both countries have long provided default primary care; now, urgent care centres and walk-in clinics are meeting the pent-up demand for access and convenience. A quarter century ago, Barbara Starfield identified first contact, continuity, comprehensiveness, and care coordination as the 4 pillars of primary care.\textsuperscript{12} Once sacrosanct and embodied in the traditional family physician, they are now crumbling under budgetary constraints and consumer-provider preferences. How family physicians, government policy makers, and the free market respond to these challenges will reshape our discipline.

**Part 3: The value-added generalist**

Earlier this year, David Epstein published an intriguing book called *Range: Why Generalists Triumph in a Specialized World*.\textsuperscript{13} With case studies and observational research, he examines the contributions of people who came late to their area of expertise, switched directions, and remained ever open to new possibilities. He cites studies of NASA (National Aeronautics and Space Administration) engineers, West Point graduates, video game developers, Nobel prize laureates, and sports superstars, and biographies of the likes of Vincent van Gogh, Charles Darwin, and Johannes Kepler.

Epstein describes 2 kinds of learning environments. In a “kind” world, patterns repeat themselves and feedback is consistent and immediate. Here, an early start and “10 000 hours” of practice can produce an exceptional technician. Contrast this with a “wicked” world, where the rules are unclear, patterns uncertain, and feedback delayed. Repetition, practice, and expertise actually work against one’s ability to problem solve in the moment. To illustrate his point, Epstein recalls 2 famous firefighting disasters: Montana’s Mann Gulch fire of 1949 and Colorado’s Storm King fire of 1994. In both instances, and in spite of repeated warnings, seasoned firefighters lost their lives because they refused to drop their heavy backpacks and chainsaws in retreat from the raging flames. Why did they cling to their tools? Because they had never dropped them before. Epstein argues that when unfamiliar problems present themselves, solving them requires a kind of unlearning—a mental flexibility and willingness to adapt. Primary care is the prototypical “wicked” domain, where ambiguity and uncertainty are the rule, not the exception. Analogical thinking, contextual knowledge, decision making on the fly, and learning from your mistakes are the keys to survival in general practice.

Breadth of experience not only increases the odds that we will make the right career choice, but it also provides a range of potential solutions to the roadblocks of daily practice. Epstein underscores that belief by observing that Nobel laureates are at least 22 times more likely to partake in amateur acting, dancing, or the other performing arts than other scientists are.

In the *Textbook of Family Medicine*,\textsuperscript{14} Ian McWhinney and Tom Freeman identify 9 fundamental principles of family medicine. First among these is a core commitment to the person rather than to a disease. They believe it is the doctor’s role to manage community resources, place illness in its broadest context, visit patients in their homes, and contribute to the support network of a community. Medicine requires a certain sensitivity to one’s feelings and a willingness to negotiate the sharp edges of the doctor-patient relationship. And it is to our advantage that we share our patients’ habitat and serve as their point of first contact.

McWhinney believed that our greatest gift to the medical profession is the capacity for self-reflection. “It has the power to transform everything we do, both as scientists and as practitioners,” he wrote. “It can save us from those terrible things that can happen when medicine becomes captive to ideology and to its own hubris.”\textsuperscript{15} Through self-reflection, we can begin to assess our own abilities and limitations, and better understand the patient and the larger health care organization upon which we all depend—its history and traditions, general structure, goals and objectives, and relationship to the wider world. Family physicians can then serve as a communication hub for the multispoked network, help the organization adapt to change, and take ultimate responsibility for the care of the patient.

**Part 4: More than scope of practice**

Physicians are expected to be clinically competent, ethically forthright, and law-abiding. On this basis, society licenses us and our peer group certifies us. But beyond that lies a world of opportunity. Those of us who are committed to continuity of relationships attend the homebound, visit our patients in the hospital and nursing home, and honour families of the deceased with notes of condolence. We cofacilitate support groups and engage in telemedicine visits for patients of ours who, by virtue of their loss of a spouse, a driver’s licence, or physical health, have become isolated from their community. We support our patients who struggle with addiction, gender nonconformity, and mental illness by becoming their advocates and caregivers. And we raise our collective voice when unfair and self-serving hospital policies put our patients at risk (Figure 1).

What struck me most about Dr McWhinney’s principles of family medicine was the number and sources of his references. Half of the 24 authors were nonclinicians, and the list included historians, philosophers, poets, economists, theologians, and journalists.\textsuperscript{14} Elsewhere he observed that the primary care physician “will be no better for a detailed knowledge of heart surgery, renal transplantation, or the use of lasers; in fact, he might
be better employed in reading literature, philosophy, or history.”16 Through general reading, and in the idle time it requires, physicians can develop a sense of humility with regard to their own efforts to create a better world and a deeper appreciation for the contribution of others.

Which brings us back to where we started. Why don’t residents read more, and what would they read if given the chance? I’d recommend Dreamland (2015),17 which traces the origins of the opioid epidemic in digestible bites and shows the monumental error of seeking a 1-drug solution for complex conditions. Why Architecture Matters (2009)18 suggests that the greatest gift of architecture lies not in the appreciation of a single building, however magnificent it might be, but in what can happen when buildings come together to make a place, preserve a collective memory, and promote community through random encounters. Scarcity (2013)19 proves that building slack into our crowded appointment schedules can actually improve our efficiency and reduce mistakes. Tribe (2016)20 draws parallels between early American Indian tribes and modern combat units, and might help us build a healthier culture within our teaching practices. The Doctor Stories (1984)21 offers a raw, first-hand account of the emotional complexity of clinical practice, but also assures us that writing and medicine, undertaken together, give greater life to each. Teaching a Stone to Talk (1982)22 relates tales of the first polar explorers, who set off with their china place settings, English ponies, and trim uniforms of Her Majesty’s Navy—never to return. More successful were the expeditions that adapted to conditions on the ground, who balanced lofty sentiment with the use of sled dogs, igloos, and native guides, and who learned from past errors to avoid remaking them. As the author makes clear, “There is no such thing as a solitary polar explorer, fine as the conception is.”22

Rather than choose for you, let me encourage, even dare you, to open the book that is waiting on your bedside stack. They all matter, not just for our recreational pleasure, but to appreciate the full range of possibilities in every decision and to sustain our courage in difficult times.

Sadly, family physicians have painted themselves into a corner of their castle. Where once we rubbed shoulders with hospital counterparts, visited old neighbours in the nursing home, and stopped to see an ailing patient on our way home, we now travel directly, efficiently to the office and back. There, we can busy ourselves for days without acknowledging our colleagues, let alone engaging them in conversation. Is this what differentiates family medicine from the rest of the profession? Dr McWhinney never thought so. When describing his early efforts to form a family medicine department at Western University, he noted:

One of the teaching hospitals in London, Ont made a teaching practice in the hospital available to us. We, the department, very soon came to a unanimous conclusion that a hospital was not the place to run a family practice. People confused us with an outpatient department. We had to make clear the difference.16

What form might that difference take? We might become more visible in the community, not only by working there but also by shopping, relaxing, and living there. Years ago, it was commonplace for a family doctor to chair the local health board, care for the incarcerated, and perform sports physicals en masse. Opportunity has not vanished. Nowadays we can teach a class at the community college, become the medical director for a homeless shelter, or head a hospice organization. Our presence is vital. Yes, the closure of a health care facility can break the economic engine of a small town, but the loss of the family doctor—the person who was always there for the people of the town, who tipped a pint at the local pub, worked out at the YMCA, cheered alongside them at school events, and rounded at the hospital—is far more detrimental to the community’s sense of security.

Conclusion

There was never a golden age in family medicine. There were simply moments in history when rightly motivated physicians responded to their calling and put their values to work. The modern medical landscape is no less challenging than when Dr McWhinney arrived in London 52 years ago. In the age of specialization, and as lesser-paid clinicians vie for our jobs, generalist physicians must prove their added value. Can we work with consultants and the growing cast of nurse practitioners, physician assistants, clinical pharmacists, behavioural
therapists, and alternative healers? Can we solve the logistics of caring for the farthest afield without sacrificing continuity or our personal investment in their communities? Can we take time for ourselves, and thereby refresh our capacity to “read” each patient uniquely and keep our inherent biases at bay? The general practitioner might be a threatened species, as some will argue, but the need will always exist for the generalist physician. Dr McWhinney taught that our greatest contribution to the practice of medicine is not the skills we bring to the job, but the person. Our gift for self-reflection—for listening, for problem solving, for sacrifice—has the power to transform everything and everyone we encounter. Our true and added value lies in a capacity to read between the lines of what patients are asking for, while practising outside the lines to deliver it.

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