statements that suggest it is simply the payment models or financial imperatives that are driving the challenges we observe in access to in-person care. In our health care system there is no choice but for most practices to be both businesses and places of care, so these should not be seen as incompatible concepts. A bankrupt practice cannot deliver care to the patients it serves. We should be supporting all of our colleagues with the recovery and restoration of more usual service delivery with concrete advice on how to move forward, rather than pointing fingers.

—Michael E. Green MD CCFP FCFP
Kingston, Ont

Competing interests
None declared

Reference
1. Ladouceur R. Family medicine is not a business. *Can Fam Physician* 2021;67:396 (Eng), 397 (Fr).

Can Fam Physician 2021;67:563-4. DOI: 10.46747/cfp.6708563

Benefits of salaried model

Reading Dr Ladouceur's June editorial[1] reminded me of a story from about 20 years ago, when I worked at a community health centre as a salaried family physician. I was asked by the executive director to meet with a group of medical students who were visiting from across the border at a nearby university in upstate New York.

Thinking that this was my chance to enlighten them on the benefits of universal, single-payer health care, I spent some time describing the salaried model, which allowed me to spend the necessary time with the patients at our clinic who lived in an impoverished community and had complex medical problems that often required attention to the broadest possible determinants of health. All of these benefits were made possible by the multidisciplinary team in which I had the privilege of working.

In summing up, I made a statement to the effect that "If you want to practice medicine without having to worry about overhead and billing and measuring productivity, this is the way to practise; otherwise, you might as well have studied for an MBA rather than an MD!" There was a moment of awkward silence, followed by a few nervous laughs. I asked the students whether I had said something they disagreed with, at which point one of them informed me that they were all enrolled in a joint MD-MBA program, and had come to learn about the pitfalls of socialized medicine!

Plus ça change ... thank you, Dr Ladouceur!

—Adam I. Newman MD CCFP(AM) FCFP
Kingston, Ont

Competing interests
None declared

Reference
1. Ladouceur R. Family medicine is not a business. *Can Fam Physician* 2021;67:396 (Eng), 397 (Fr).

Can Fam Physician 2021;67:564. DOI: 10.46747/cfp.6708564

Choosing to practise telemedicine

Dr Ladouceur's editorial[1] outlines the very awkward position in which many patients have found themselves during the pandemic.

The most telemedicine I practised in my office during these past months has been 20% per day, with most days less than 10%. We have been careful to follow the guidelines that were appropriately developed and we were happy to be there for all our frightened, lonely, and sick patients in need of care.

I also work in the emergency department about 15 hours a week. There, I have seen and managed situations involving varying degrees of consequences on both morbidity and mortality, because physicians—not patients!—chose to practise telemedicine. These patients understandably felt abandoned by their caregivers.

I have felt quite embarrassed by a lot of the telemedicine practised within my profession during this pandemic. I sincerely hope fees will rapidly decrease to roughly one-third of on-site visits. This should go a long way toward fixing the problem.

Merci, Dr Ladouceur.

—Ruth E. Vander Stelt MD CCMF FCMF
Gatineau, Que

Competing interests
None declared

Reference
1. Ladouceur R. Family medicine is not a business. *Can Fam Physician* 2021;67:396 (Eng), 397 (Fr).

Can Fam Physician 2021;67:564-5. DOI: 10.46747/cfp.6708564_1

Response

I wrote the June editorial in *Canadian Family Physician,* "Family medicine is not a business,"[1] because it is my role as a writer and journal editor to bring in ideas, discuss topics relevant to family medicine, and offer opinions, even if they are controversial or unpopular.

I love family medicine. It is an amazing profession. Family medicine has shaped my life and has given me so much. I never would have thought that the "*p'tit-gars-de-St-Stan-que-je-suis*" could one day become a doctor and be one for his entire life.

The editorial was strongly worded and accusatory. I am sorry if, in the process, I have harmed or hurt some of my colleagues who are devoted to their practices and to our profession. That was not my intention. I simply thought that it was necessary to challenge us. I dared to speak about difficult subjects that are almost taboo.

I wrote "Family medicine is not a business" because I love my profession and I have dedicated my life to caring for my patients and community. It is an extraordinary, unique profession and I hope that it will stay that way. I strongly believe that it is so much more than just a business.

—Roger Ladouceur MD CCMF(SP) FCMF
Verdun, Que

Competing interests
None declared

Reference
1. Ladouceur R. Family medicine is not a business. *Can Fam Physician* 2021;67:396 (Eng), 397 (Fr).

Can Fam Physician 2021;67:565. DOI: 10.46747/cfp.6708565

Learning from each other: lessons from COVID-19

As family physicians we spend much of our patient interactions trying to understand patients who present with undifferentiated problems. We live with the uncertainty associated with ambiguous symptoms, unusual clinical presentations, and diagnostic challenges. "Long COVID" is an exemplar of this uncertainty. There are no widely accepted definitions (although some have been proposed), patient presentations are noteworthy because of their diversity rather than their commonality, and even when we think we know the diagnosis there is no path to confirmation or treatment available.

It often takes time for new illnesses to be fully understood. Coronavirus disease 2019 has taught us that we do not always have that time. Many people died because of our lack of understanding about how severe acute respiratory syndrome coronavirus 2 spreads and because we did not know how useful high-dose steroids would be. Many people continue to suffer because of our lack of understanding of the syndrome that follows infection with the virus. We do not even have an agreed-upon name for this diverse group of symptoms. We do know that patients may struggle to get a diagnosis or feel heard by clinicians. We do not know how prevalent the syndrome is or how it is related to the severity of the initial infection. We do know that is causing an unknown amount of suffering.

While we learn about this syndrome, there are things we can do as family doctors. We can listen to our patients with empathy. We can undertake the journey of dealing with their symptoms with them rather than referring them to multiple specialists who are less comfortable with uncertainty and may have little to offer. We can build on our relationships with patients for their benefit. We can engage in joint decision making through honest discussion of the challenges they face and limited proven treatments. We can be there for our patients.

One of the foundations of learning health systems is that every encounter becomes an opportunity for improvement. We need to establish mechanisms where we can share our experiences as colleagues, both to support and to learn from each other. What works for one doctor-patient dyad may not work for another, but we will never know unless we share those experiences. The College of Family Physicians of Canada can and should provide the venue for this sharing.

—Alan Katz MB ChB MSc CCFP FCFP
Winnipeg, Man

Competing interests
None declared

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