I'm a GP

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I'm a GP, not a family physician. I'm swimming against the tide. But there are problems with calling ourselves *family physicians,* and it hampers efforts to develop the footing of what we do.

Family physician is inaccurate, of course. You don't have to be part of a family to have a family physician; we aren't specialists in families; and the term is peculiarly inapt for hospitalists, those working in prisons, and others. (Once, working in India, a colleague asked me whether *family physician* meant a doctor whose job was to look after one rich family.) But the meanings of words evolve. September is no longer the seventh month of the year. Residents are no longer usually resident in hospitals. The inaccuracy we can live with.

The real problem with *family physician* is that it's discriminatory. It marginalizes people.

The overtones of the word *family,* like *police,* depend on the cards life has dealt you. If you associate family with home baking and bedtime stories, that's great. But it's far from universal. The screen stereotype of the slim opposite-sex couple with two well-adjusted children, a just-brushed golden retriever, and an unnaturally tidy garage exists. But it's just one piece of the patchwork.

Many aren't part of families or, worse, associate families with sadness or trauma, through infertility, death, children being removed, relationship breakdown, estrangement, failure to find someone to love, or the boundless forms of family unhappiness. Others don't have families through choice.

This isn't neutral. It's women who are more likely than men to be judged for not having children.[1] It's Indigenous people whose families have been violated by colonial policies, including residential schools. It's LGBTQ2S+ people who may, for a variety of reasons, be less likely to have children.[2] Some folk fashion beautiful new meanings of family. But that's of little comfort to those who can't.

We don't intend it but, when we call ourselves family physicians, the quiet implication, the message that will be understood by some of our patients and some of those considering becoming GPs, is that normality means being part of a family, that if you're not part of a family you haven't fulfilled your human calling, that we do what we do without you in mind.

But, colleagues told me when I arrived in Canada from the United Kingdom, GPs here used to be doctors without postgraduate qualifications, and that history still echoes. Calling ourselves family physicians is important, colleagues said. And it's true that the requirement for Certification is comparatively recent across Canada, and that, to my foreign eye, Canadian GPs don't always have the parity of status within the profession enjoyed by GPs in some other jurisdictions.

It's true, too, that language matters. *Chairman* is the right word only when you're talking about Mao, and we expose our prejudices when we describe someone as an addict. It's right to avoid words that exclude or stigmatize. But *GP* does neither. *Family physician,* however, can do both.

There's an irony in attempting an excision biopsy of the term *family physician* in the pages of a journal entitled *Canadian Family Physician*. It's via our most inspiring leaders that *family physician* has become a shibboleth.

But admonishing people for calling us GPs, or insisting we be called specialists: these do little to inflate our status. To the bemused specialist they betray insecurity. The public doesn't know it's meant to be more impressed by *family physician*. When we declare that we're "specialist generalists"[3] we concede that being a specialist is better, senior, more skilled. It isn't. Breadth is no less important than depth. We generalists have training and expertise that specialists lack, comprehensiveness, and an ability to integrate across the wide landscape of medical practice. Specialists have other skills. Health care needs us both. And our salience bias allows us to forget that, for every patient who asks to see a specialist for something we can easily diagnose and manage, many more would rather see us.

When I was doing my postgraduate training, one of my preceptors suggested we should aim to be better community cardiologists than anyone but a cardiologist, better community gynecologists than anyone but a gynecologist. Two decades later I encourage fledgling GPs to set their sights higher still: the breadth of our expertise, our relationships with our patients, our art of integrating evidence with our patients' complex lives, and our knowledge of our communities mean that, most of the time, we can be better at these things than anyone else.

What, then, should we do? The antiracist activist Ibram X. Kendi shows that it doesn't work to change people's minds in the hope that policy change will follow: you have to change policy first, and opinion follows.[4] We can take on leadership roles locally, provincially, nationally, internationally. We could work toward longer postgraduate training (although it seems to me other parts

of the world might learn a thing or two from Canada's efficient, high-quality postgraduate programs, and duration of training should be determined by evidence, not aspiration to keep up with the neurosurgeons). We can write impressive referral letters that capture our skilled assessments and specify the (often narrow) involvement we require of specialists. We can play a major role in students' and residents' training, quietly modeling our skill, humanity, and leadership. We can insist upon equal pay. We can cordially but firmly call out specialists who instruct us to "kindly" organize their investigations for them, or who ask us to make referrals to rheumatologists when, if they don't know how to deal with something, they're able to refer patients themselves—and when they apparently don't realize that we're perfectly capable of assessing and managing whatever it is they're unable to handle. We can push back against some of the more frustrating form-filling that somehow only GPs are capable of completing. Add your own ideas here.

Whatever we do, though, let's do it aware of all that *family* can mean, and let's be proud of being GPs.

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Competing interests
None declared

References

1. Berdahl JL, Moon SH. Workplace mistreatment of middle class workers based on sex, parenthood, and caregiving. *J Soc Issues* 2013;69(2):341-66.
2. *Same-sex couples in Canada in 2016.* Ottawa, ON: Statistics Canada; 2017. Available from: **https://www12.statcan.gc.ca/census-recensement/2016/as-sa/98-200-x/2016007/98-200-x2016007-eng.cfm**. Accessed 2021 Aug 10.
3. Woods NN, Mylopoulos M, Nutik M, Freeman R. Defining the *specialist generalist.* The imperative for adaptive expertise in family medicine. *Can Fam Physician* 2021;67:321-2 (Eng), 326-8 (Fr).
4. Kendi IX. *How to be an antiracist.* New York, NY: Random House; 2019.

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