



The College of
Family Physicians
of Canada

Le Collège des
médecins de famille
du Canada



FAMILY MEDICINE IN CANADA VISION FOR THE FUTURE

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Executive Summary

Canada is facing a crisis. Timely access to health care services is getting progressively worse for Canadians. The single biggest reason for this is a severe shortage of health professionals. High on the list of those in short supply are family doctors. More than 4 million Canadians cannot find family physicians to care for them¹; compared to people with family physicians, those that have no family doctors are more vulnerable to prolonged wait times throughout the system² and are less satisfied with the performance of all other health professionals, institutions, and governments.³ Recognizing this, the people of Canada continue to place high value on the role of family physicians. More than two thirds indicate that family physicians are their most important caregivers.⁴

For family physicians, system support has not kept pace with public support. Because of changes in the health care environment, many family doctors have had to assume greater responsibility for increasingly acute and complex patients, with little health system understanding or acknowledgment of their changing role. Because of increased workload and time commitments to their office and community practices, their role in medical schools and hospitals has often been undermined. For many family physicians, trying to maintain a commitment to comprehensive, continuing care, something Canadians still want and need, has become a major challenge. For medical students—our physicians of the future—the image of family medicine as a career choice has been tarnished, and increasing numbers of them are turning their backs on the opportunity to become part of one of the most rewarding and satisfying branches of the medical profession.

This must change. *Family Medicine in Canada—Vision for the Future* presents solutions. It reviews evidence of the access issues faced by Canadians and public poll indicators of their perceptions and preferences, discusses medical student and resident training challenges, and provides an analysis of the many factors related to these issues as well as opportunities that could be pursued. It follows with recommendations for the following.

- Promoting access to care for patients, from *patients'* perspective, which means measuring wait times from when symptoms are first experienced not from the much later point of a visit to a specialist (specific strategies for promoting access for underserved populations are required)
- Supporting access to medical care that recognizes patients' need for personal, comprehensive, continuing care from public health and illness prevention strategies through to palliative care in a variety of settings, including homes, hospitals, and the community
- Coordinating access for patients to the full continuum of care from family physicians to specialists and to shared care for chronic diseases
- Ensuring a sustainable supply of family physicians through health human resource planning that accounts for the changing demographics and practice patterns of family physicians, ensures sufficient positions for medical students and residents, and ensures this discipline remains an attractive choice for medical students
- Educating and training our future family physicians by ensuring highly visible, credible, well supported roles for the discipline of family medicine and family physician teachers and

¹ Decima public poll (CFPC, Oct 2004)

² Ibid

³ Ipsos Reid/CMA, Aug 2003

⁴ Decima public poll (CFPC, Oct 2003)

researchers in our medical schools and teaching centres and by reinforcing the importance of family medicine residency programs producing graduates with the knowledge, skills, and attitudes that will enable them to provide comprehensive continuing care for patients in rural or urban communities across Canada

- Promoting innovation and quality in family medicine through support for family medicine research, strategies to transfer new ideas and knowledge into practice, and recognition for family physicians committed to lifelong learning
- Understanding and promoting the value of family physicians in order to achieve sustainable success in implementing all the recommendations. Solutions to access to care and lengthy wait times will not be found unless we discover ways to rejuvenate family medicine in Canada. Our system must recognize and support family doctors in their important roles as teachers, researchers, and providers of care for millions of Canadians in rural outposts, small towns, large suburbs, and inner cities throughout this nation.

It is critical to restore and strengthen the role of Canada's family physicians who are at the centre of our health care system providing personal, comprehensive, continuing care for patients and families. It is equally important to understand and support the vital role family doctors can and should play as the link between advances in science and technology and day-to-day patient care. The future role of family physicians in ensuring our nation's ability to deal with what will be a never-ending stream of medical breakthroughs, along with hidden challenges in public and population health and the appropriate use of electronic health records, will be immense.

The College of Family Physicians of Canada's "Vision" paper highlights concerns and recommends steps that must be taken by governments, medical schools, and health professionals to ensure that family doctors and the discipline of family medicine will be the vital entity that Canadians want at the centre of their health care system long into the future.

1 INTRODUCTION AND BACKGROUND

*[Family physicians] are the doctors closest to people. They heal most of the broken-hearted, repair more of the injured and deprived, and live with the poor and dying who are without hope. Adaptation is the juice of family medicine—the FP adapts to the needs of people, or closes up shop.*⁵

William Victor Johnston, MD,
First Executive Director of the College of Family Physicians of
Canada, 1956-1965

While this statement was made several decades ago, it still captures the intrinsic value of family medicine. Objective evidence has also demonstrated this value. Studies have shown that, controlling for all other factors, health outcomes of populations are positively affected by access to primary care and family physicians.⁶ Public surveys tell us that Canadians recognize this fact.

- About 80% of Canadians reported they preferred to access care through their family physicians.⁷
- About 88% agree that having a family doctor allows them to feel more confident about access to other services.⁸
- More than 80% of Canadians rate the quality of care of family physicians as good to excellent.⁹
- More than 66% identify family physicians as the most important caregivers for them and their families.¹⁰

In the spirit expressed by Dr Johnston, the College of Family Physicians of Canada (CFPC) strives to improve the health of Canadians by promoting high standards of medical education and care in family practice, by contributing to public understanding of healthful living, by supporting ready access to family physicians' services, and by encouraging research and dissemination of knowledge about family medicine. To mark its 50th Anniversary, the CFPC has produced *Family Medicine in Canada—Vision for the Future* to document today's opportunities and challenges and make recommendations to ensure that Canadians, for many years to come, will have access to high quality, comprehensive, continuing care provided by family doctors.

*...the members of the College of Family Physicians of Canada ...are a firm foundation on which to build the reformed system. They are part of the solution.*¹¹

Dr Carolyn Bennett,
Minister of State (Public Health), Government of Canada

⁵ Quoted in *Strength in Study* (CFPC, 1979)

⁶ Starfield, B. Is primary care essential? *Lancet* 1994;344:1129-33. Dr Starfield reiterated this conclusion in an address to a joint meeting of the World Organization of Family Doctors and the American Academy of Family Physicians on Oct 13, 2004. The *WONCA World Herald* for that meeting stated: "Citing international studies, Dr Starfield said increasing the number of primary care physicians is positively associated with improved health outcomes. ... Likewise, worse outcomes were directly related to a decline in the supply of primary care physicians."

⁷ Statistics Canada. Access to Health Care Services Survey, 2001

⁸ Decima public poll (CFPC, Oct 2004)

⁹ Decima public poll (CFPC, Oct 2002). A poll by Macleans magazine 1 year later found that 90% gave a good-to-excellent rating.

¹⁰ Decima public poll (CFPC, Oct 2003)

¹¹ Carolyn Bennett. *Kill or Cure—How Canadians Can Remake their Health Care System* (Harper Canada, 2000)

1.1 Vision for family medicine

Canada's family physicians are dedicated professionals, committed to the values and principles of family medicine. These values and principles are captured formally in a Declaration of Commitment approved in April 2004 by the CFPC Board of Directors as a recommitment to Canadians on behalf of the members of our College.

As Family Physicians and members of the College of Family Physicians of Canada, we value:

- the trust placed in us by our patients, our peers, and our communities;
- the privilege of being the personal physicians for the individuals and families who are our patients;
- the role we play in meeting the changing health care needs of the people of Canada; and
- the importance of our College motto, "In study lies our strength," which inspires us to maintain the highest standards in practice, teaching, research, and lifelong learning.

As family physicians who care for patients, teach students, and conduct research, we are guided by our College's Principles of Family Medicine:

- The patient-doctor relationship and the needs of our patients are central to all we do.
- We are skilled clinicians providing and coordinating a broad range of evidence-based health care for individuals and families throughout their lives.
- We are community-based physicians responding to patient and community needs in our offices, hospitals, patients' homes, and other community settings.
- We are a resource to our practice populations promoting health to prevent illness, providing and explaining health information, collaborating and facilitating access to other caregivers, and advocating for patients throughout the health care system.

On this, the 50th Anniversary of the founding of College of Family Physicians of Canada, we recommit our College and its members to the values and principles of the College that define the discipline of family medicine.

To a large extent, the future of family medicine and our health care system in Canada will be shaped by the degree to which all Canadians—patients, physicians, other health care providers, policy-makers, and medical school and government leaders—value this discipline.

1.2 The College of Family Physicians of Canada

From the beginning of the 20th century, Canada's medical care system was built on the strength of its general practitioners. By the 1950s, development of medical and surgical specialties as academic disciplines defined by undergraduate, postgraduate, and continuing education programs, left general practice with a less prestigious image and few medical school graduates selecting it as a career of choice. Concern spread across the nation that general practice would not survive.

In 1954, The College of General Practice of Canada (later The College of Family Physicians of Canada) was founded by a group of community general practitioners who realized that their branch of the medical profession was as deserving as any other of recognition as a credible and special medical discipline. Thanks to the foresight of these pioneers the next few decades saw the

development of the education, training, and research activities that have come to define the discipline of family medicine. Today there are strong family medicine departments and residency training programs in every Canadian medical school, with family physicians playing key roles as teachers, researchers, and medical school leaders. Across Canada half the practising physicians are family doctors.

The CFPC is the voice of family medicine in Canada. Representing 17 000 members across the country, it is the professional organization responsible for establishing standards for training, certification, and lifelong education of family physicians and for advocating on behalf of family medicine, family physicians, and their patients. Our mission is to strive to improve the health of Canadians by promoting high standards of medical education and care in family practice, by contributing to public understanding of healthful living, by supporting ready access to family physicians' services, and by encouraging research and dissemination of knowledge about family medicine.

1.3 Genesis of this paper

Recognizing the developing needs of Canada's population and the ongoing evolution of health care in Canada, the CFPC has held two Summits on the Future of Family Medicine in Canada. The first, held in May 2000, led to publication of *Primary Care and Family Medicine in Canada—A Prescription for Renewal*,¹² which provided the basis for key discussions with federal, provincial, and territorial governments, the Romanow Commission, and the Kirby Committee, among others.

A second Summit was held in May 2003. It brought together CFPC Board members, chairs of university family medicine departments, residents, medical students, a cross-section of CFPC committee chairs and staff from national and chapter levels, and other physician and non-physician guests to provide advice on the policies, positions, and key messages needed:

- To contribute to improved access to family physicians and family practice services for the people of Canada, and
- To re-energize our branch of the medical profession through:
 - increased pride in those who are family doctors;
 - enhanced respect and prestige for family medicine in medical schools, governments, hospitals, and public domains;
 - greater interest among medical students to pursue careers in family medicine;
 - enhanced support for Canadian family medicine residents, teachers, researchers, and practising family physicians; and
 - achievement of greater balance in personal and professional life for Canada's family doctors.

Ongoing input to the development of this Vision paper has been provided by various College committees, task forces, and working groups focused on the following:

- Undergraduate curriculums
- Medical students' career choices
- Future of research in family medicine
- Rural family practice residency training

¹² *Primary Care and Family Medicine in Canada—A Prescription for Renewal (CFPC, Oct 2000)*

- In-training evaluation
- Procedural skills in family medicine residency training
- Key features and objectives of the Certification Examination
- Meaning of Certification and Fellowship
- Future of continuing medical education and continuing professional development (CME/CPD)
- Primary care renewal—models of practice and interdisciplinary and collaborative care
- Defining the scope of family practice
- Family physician resources in Canada
- Medical informatics and electronic medical health records
- Family practice concepts and values (ethical perspectives of primary care renewal)
- Family physicians' role in hospitals
- Home care
- Diversity and equity in family practice

2 FAMILY MEDICINE: KEY ISSUES FOR CANADIANS

By the end of the September 2004 First Ministers' meeting, "First Ministers agree(d) that access to timely care across Canada is our biggest concern and a national priority."¹³ Key factors affecting access to care are the availability of health professionals with appropriate skills to provide the required services, the optimum mix and organization of skilled providers to deliver the required services in appropriate locations, and mechanisms to advance and assure the quality of this service.

2.1 Wait times and family physician shortages

2.1.1 Measuring wait times

The September 2004 First Ministers' Accord established a commitment "to achieve meaningful reductions in wait times in priority areas such as cancer, heart, diagnostic imaging, joint replacements, and sight restoration by March 31, 2007."¹⁴ While each of these five areas requires attention, there is concern that identification of these as priorities will lead to our system's diminishing the importance of a lengthy list of other problems (perhaps led by mental health disorders) where wait times are currently unacceptable.

Recognizing the key factors affecting wait times, the Accord established a Wait Times Reduction Fund to "primarily be used for jurisdictional priorities such as training and hiring more health professionals, clearing backlogs, building capacity for regional centres of excellence, expanding appropriate ambulatory and community care programs and/or tools to manage wait times." Despite these words, there is still concern that the First Ministers' Accord left the provinces and territories less accountable than they should be for how they spend the dollars allocated to them to address wait times.

The severe shortages of family physicians, specialists, nurses, and other health professionals across Canada have been well documented. In the realm of medical care, Canada is experiencing shortages of both family physicians and specialists. This causes a multiplying effect for Canadian

¹³ A 10-year plan to strengthen health care. Office of the Prime Minister. News release, Sept 16, 2004

¹⁴ Ibid

patients: wait times and wait lists for both family physicians and specialists and specialty services increase as access to family physicians diminishes. The performance of all players in the Canadian health care system, including specialists, hospitals, and even governments, is rated higher by patients who have family doctors than by those who do not.¹⁵ When Canadians first look for health care services, more than 80% seek care from their family doctors.¹⁶ When they consider all aspects of their health care, 66% believe that their family doctors are their and their families' most important caregivers for gaining them access to a variety of health care services, including those in primary, secondary, and higher levels of care.¹⁷

While valuable wait-time initiatives are being carried out in various parts of Canada, most studies have focused mainly on time from specialist attention to specialty treatments. It appears that the September 2004 First Ministers' Accord, which gives priority to achieving measurable reductions in wait times for cancer and heart treatments, diagnostic imaging, joint replacements, and sight restoration, continues this trend.

Canadians know the clock starts ticking much sooner. When asked at what point Canadians believe governments should start to measure their wait time for health care services, 46% said it should start when they first see a family doctor. Another 33% thought it should start when they first experience a medical problem and seek help. Only 15% thought it should start when they first see a specialist. In this same poll, more than 90% of Canadians believed that any plan to address wait times should also include strategies to tackle the shortage of family doctors in Canada.¹⁸

2.1.2 Access and the impact of changing demographics

The number of Canadians without access to a family physician is large. A 2004 Decima poll found that 5 million (16%) Canadians older than 18 years tried, but were unable to find, a family doctor for themselves or their families during the previous 12 months.¹⁹ For 2003, Statistics Canada reported that 3.6 million Canadians (almost 14%) had no regular family physicians, and almost 16% reported difficulty accessing routine or ongoing care.²⁰ In 2002, the CFPC estimated that Canada was short 3000 family physicians and that this number would double by the end of the decade unless new recruitment and retention strategies were put in place. This estimate was based on Statistics Canada population and physician census data and the known decrease of about 250 to 300 entry positions each year from 1992 on in family medicine residency programs.²¹

Access to family physician care is becoming more difficult. The 2004 National Physician Survey (NPS)²² found that 60% of family physicians are either limiting the number of new patients they see or not taking new patients at all. In 2004, only 20% of family physician practices were fully

¹⁵ Ipsos Reid/CMA, Aug 2003

¹⁶ Statistics Canada. Health Services Access Study (July 2001)

¹⁷ Decima public poll (CFPC, Oct 2003)

¹⁸ Decima public poll (CFPC, Oct 2004)

¹⁹ Decima public poll (CFPC, Oct 2004)

²⁰ Statistics Canada. Canadian Community Health Survey, 2003

²¹ Thurber AD, Busing N. Decreasing supply of family physicians and general practitioners. Serious implications for the future. *Can Fam Physician* 1999;45:2084-9.

²² National Physician Survey Database, part of the NPS project co-led by the CFPC, the Canadian Medical Association (CMA), and the Royal College of Physicians and Surgeons of Canada (RCPSC), and supported by the Canadian Institute for Health Information (CIHI) and Health Canada.

open to new patients, down from 24% in 2001.²³ As family physicians struggle with the challenge of work-life balance, the 2004 survey found that one quarter intended to reduce their regularly scheduled working hours within the next 2 years.

During the next few years, it will likely become increasingly difficult to access family physician care. Extrapolating from the 2004 NPS, up to 3800 physicians, about 1400 of whom are family doctors,²⁴ are expected to retire in the next 2 years. The rate of expected retirements is increasing. Specifically, the rate in the 2004 survey was 5% compared with 3.9% in the 2001 survey.

The increase in the number of women family physicians will change some of the parameters used to date to estimate physician resource needs. While a predominantly male generation is retiring, an increasing female population is taking its place. Overall, about 38.5% of family doctors are women; however, among family doctors younger than 35, 60% are women (compared with 10% among those older than 65). The effect on physician supply arises because the survey shows that female doctors overall work about 7 to 8 fewer hours a week than their male colleagues due to family responsibilities such as child rearing and caring for aging parents.²⁵

If our system is truly going to support women in medicine, it will have to do more than just boast about the increasing numbers of female physicians. It will have to make certain that we have created a medical workforce and environment that allows women to have the balanced professional, personal, and family lives they need, without being made to feel they are further compromising the workload of their physician colleagues or adding to the access-to-care woes of their patients. We should note that the hours worked by women physicians, though fewer than men physicians, are still well above the average worked by most Canadians. All physicians—men and women—should be looking toward a future with decreased work hours, giving them a chance for healthier professional, personal, and family lives.

If the number of family physicians continues to decrease, the role of specialists in Canada will also be strongly affected by a progressive shift from consultative care in areas of expertise to the provision of more first-response medical care. Specialists are better able to focus on their own areas of expertise when they work cohesively with appropriate numbers of skilled family physicians in communities and hospitals. With increasing wait times for specialty care, family doctors' workload grows because they must care for their patients while they wait.

2.2 Access to comprehensive continuing care

Each patient is a complex human being whose health status and need for care change over time. While all people will likely experience episodic acute illnesses and injuries requiring medical intervention by various physicians at various times throughout their lives, most indicate that they prefer not only to have these episodic occurrences managed by their own physicians, but that it is a priority for them to try to find doctors who will be their first contact for all their medical

²³ College of Family Physicians of Canada. *The 2001 CFPC National Family Physician Workforce Survey. Part of the JANUS Project: family physicians meeting the needs of tomorrow's society.* Mississauga, Ont: CFPC; 2001.

²⁴ If we assume approximately 28 000 Canadian family doctors in active practice in 2004 (CIHI indicates the total FP workforce was 30 660 in 2003, but we know not all of these are in active practice), this translates into approximately 1400 FPs planning to retire in next 2 years compared with approximately 1000 in 2001, an increase of about 150%.

²⁵ On average, the NPS found women FPs work 44 hours per week and men FPs work 52 hours per week. This does not include on-call hours; the NPS indicates more than 60% of FPs are working at least 120 hours per month on-call.

problems.²⁶ They want someone who will link all their health issues together throughout their lives—a personal, comprehensive, continuing care physician. Historically for Canadians, this kind of relationship has been established with their family doctors, the physicians who are best trained and prepared to provide first-line medical care for all people for any undifferentiated health care concerns they might have. With the recent family physician shortages, however, increasing numbers of Canadians have been deprived of this benefit. Most indicate they want it back.

While personal, comprehensive, continuing care remains the cornerstone of family practice and the discipline of family medicine, our changing world demands that our understanding of the meaning of these elements must also evolve. Today’s patients and family physicians expect that, while each person should have his or her own family doctor who will know him or her best, provide and coordinate most of his or her medical care, and advocate on his or her behalf with others in the health care system, one physician usually cannot do it all. Provision of comprehensive family practice services will often need to be shared among several family physicians, and the spectrum of primary care services will be delivered by family physicians working with other health professionals. Continuity will be provided in part by individual family physicians, but provision of care will also rely on the input of other family physician group and primary health care team members, and very importantly, will depend on continuity of information.

The kinds of services patients need that we might expect would be provided by family physicians, working alone or in groups, have been defined in many ways. One mode, frequently referred to as a guide to the “basket of services” for family practice was described in 1996 by the Provincial Coordinating Committee on Community and Academic Health Science Centre Relations (PCCCAR) as follows.

Common set of mandatory functions

- Health assessment
- Clinical evidence-based illness prevention and health promotion
- Appropriate interventions for episodic illness and injury
- Primary reproductive care
- Early detection and initial and ongoing treatment of chronic illnesses
- Care for the majority of illnesses (in conjunction with specialists as needed)
- Education and support for self-care
- Support for in-home, long-term care facility, and hospital care
- Arrangements for 24-hour, 7-day-a-week response
- Service coordination and referral
- Maintenance of comprehensive client health records for all rostered patients in primary health care agencies
- Advocacy
- Primary mental health care including psychosocial counseling
- Coordination and access to rehabilitation
- Support for people with terminal illnesses

²⁶ Statistics Canada. Access to Health Care Services Survey, 2001; Decima public poll (CFPC, Oct 2004); Decima public poll (CFPC, Oct 2003)

Studies, including the 2001 National Family Physician Workforce Survey (NFPWS) and 2004 NPS, inform us that, despite decreasing numbers and changing patterns of practice, most family physicians in Canada today are still providing a broad spectrum of services delivered over time to the populations they serve (ie, most are, in fact, still providing comprehensive continuing care). Preliminary results from the 2004 NPS indicate that a large proportion of family doctors continue to be involved in a range of areas of practice in their offices. They provide, for example, chronic disease management; gynecologic care; palliative care; care of newborns, infants, and children; obstetric and maternity care; and psychotherapy and counseling. They also provide care in other settings, such as patients' homes, emergency departments, and hospitals. Many family physicians continue to provide a range of procedures, including pap smears, minor surgical procedures (eg, incision and drainage, cryotherapy, joint injection), skin biopsies, and suturing. The 2004 NPS also reports that family physicians in Canada are working an average of 49 regularly scheduled hours per week and that the 70% of family physicians who also provide after-hours on-call service are working an average of more than 75 hours per week—an unsustainable workload.²⁷

With ongoing shortages of physicians and other health professionals, economic pressures, an aging and growing population, increasing complexity of disease, and restructuring of hospital and institutional care, the need for better support for family doctors who provide comprehensive continuing care has never been greater. Without these doctors, the implications for worsening access to care and longer wait times for patients are alarming.

2.2.1 Family physicians with focused areas of practice

While most family doctors still provide a spectrum of services, growing numbers are moving into more focused areas of practice. Reasons for this include the following.²⁸

- Shortages and changing practice patterns of specialists have created gaps in specialty services. Clinical areas in which this is occurring include, but are not limited to, palliative care, care of the elderly, advanced maternity care, mental health services, emergency care, acute in-patient care in hospitals, general surgery, and anesthesia.
- The increasing needs of patients in specific areas of care in many communities.
- The excessive workload and lack of system support for traditional, comprehensive, continuing care family practice.
- Personal interest in special or added-skills areas, such as sports medicine or occupational medicine.
- The perceived lifestyle and financial benefits of focused practice as compared with broad-scope practice.

Also noted in recent years is the fact that increased numbers of newly graduated family physicians are opting to work as locum tenens or in walk-in clinics. The net effect of focused practices, locums, and walk-in clinics is a further reduction of the already shrinking pool of family physicians available to accept and care for patients in more traditional, comprehensive, continuing care settings.

²⁷2004 National Physician Survey Database, part of the NPS project co-led by the CFPC, the CMA, and the RCPSC and supported by the CIHI and Health Canada.

²⁸Gutkin C. Family practice subspecialists. *Can Fam Physician* 2004;50:1175-6.

Despite this, the contribution of family physicians in focused practices is notable. As a discipline, family medicine has responded to societal needs and quite appropriately assumed responsibility for providing and coordinating added-skills education and training and CME/CPD programs to support these areas. The fact that we end up stealing from our own pool of family physicians (residents and practising physicians) to meet these focused-care needs is one of the unfolding tragedies of Canadian medicine. Rather than blaming CFPC and our university departments of family medicine for producing more special-skills family doctors and fewer comprehensive-care doctors, the real solution to this dilemma is to support our discipline to produce the appropriate numbers of each. The College and university departments, with the right kind of system understanding and support, are prepared to be the lifelong professional organizational home for all types of physicians who are and should be part of the discipline of family medicine and who can contribute through group and team strategies to the future delivery of primary care and family practice services to all Canadians.

2.2.2 Care in hospital and at home

Hospital restructuring and the need to manage patients outside hospitals wherever possible have had major effects on where, how, and by whom medical care is provided. Decreased access to hospitalization has increased the acuity and complexity of patients being managed by family physicians in their offices and has changed the role of family physicians in hospitals themselves.²⁹

The role of family physicians in hospitals across Canada, particularly in larger urban and suburban hospitals, has been changing over the past decade. While, more than 80% of Canadians report they highly value having their own family physicians caring for them or participating in their care when they are admitted to hospital,³⁰ the reality is that many family physicians are no longer involved in this aspect of practice.³¹ Preliminary findings from the 2004 NPS indicate that 44.2% of family physicians participate in some hospital-based care.

From patients' perspective, the issue is quality of care. Not having their own family physicians present in hospital clearly disconcerts patients.³² For family physicians, it means loss of visibility as part of the team of health professionals caring for patients and as role models for students and residents. It means fewer opportunities to meet, talk with, and learn from colleagues. Very importantly, it results in less opportunity to provide the comprehensive continuing care that defines family medicine.

While specialists or family physicians or both can provide acute in-hospital medical care for most Canadians, most patients prefer to turn to their trusted family physicians (who know their complete history) for help in making informed decisions about the complicated array of treatments and other choices confronting them when they are in hospital. From quality-of-care and cost-effectiveness perspectives, the continuity of care provided by family physicians can help avoid the cost of repeat investigations or consultations.³³

²⁹ These aspects of family physician practice are presented in detail in two CFPC Discussion Papers: *Family Physicians Caring for Hospital Inpatients* (Oct 2003) and *The Role of the Family Physician in Home Care* (Dec 2000).

³⁰ Decima public poll (CFPC, Oct 2003)

³¹ 2004 National Physician Survey Database, part of the NPS project co-led by the CFPC, the CMA and the RCPSC and supported by the CIHI and Health Canada.

³² Decima public poll (CFPC, Oct 2003)

³³ CFPC Discussion Paper: *Family Physicians Caring for Hospital Inpatients* (Oct 2003)

In many big-city academic hospitals, community-based family physicians are no longer eligible or welcome to have admitting privileges. In community hospitals, granting privileges ranges from highly encouraged (particularly in rural and smaller town settings where hospitals and communities rely on family physicians to provide in-hospital care) to restrictive in many larger urban and suburban settings. Hospital restructuring and downsizing have increased the focus on specialized care in hospital. With the absence of family doctors and the increased workload on a diminished supply of nurses, patients have lost access to two of their main caregiver advocates.

Patients whose family doctors have not been part of their in-hospital care rely on good communication between the hospitals and their family physicians. Unfortunately, some hospitals, particularly in large urban settings, do not routinely provide information to family physicians regarding admission and discharge of their patients,³⁴ leaving huge gaps in the information essential for appropriate follow up. When asked to rate their satisfaction with their relationships with hospitals, 19% of family physicians indicated they were very or somewhat dissatisfied.³⁵

For many family physicians, workload and burnout have been strong reasons to curtail hospital work. The move toward shorter hospital stays and earlier discharges has resulted in the need for family physicians working in hospitals to care for greater numbers of inpatients with severe and complex illnesses and has increased the acuity and workload in their community practices where increased numbers of patients cannot access hospital care. As a condition of privileges, many hospitals insist that physicians also care for “orphan” patients and do mandatory committee work, thereby increasing workload further. Relatively low remuneration for hospital visits has been the “last straw” that causes many family doctors to discontinue this aspect of their practice. The need for a paradigm shift that would see family doctors welcomed into all hospitals where they would be properly supported and respected for the important role they can play in providing care for and information about patients, as well as serve as an essential link between hospitals and the community at large, is critical. Ensuring that hospitals provide meaningful roles for the family physicians in their communities should be a standard for consideration for the Canadian Council on Health Services Accreditation (CCHSA) of all Canadian hospitals.

In the last few years, creative collaboration among hospitals, physicians, and communities has led to “hospitalist” models that appear to be filling some of the gaps.³⁶ Initially, most family physicians who became hospitalists totally sacrificed their community practices. In some communities, this exacerbated family doctor shortages. More recently, some hospitalist programs have encouraged family physicians to maintain at least part-time community practice, a strategy favoured by the CFPC and many others concerned about access to physician care in all settings.

Home care has always played an essential part in the continuum of health services. Recently, home care has received increased attention from government, particularly as a substitute for acute care. Originally, home care primarily provided an alternative to long-term care, enabling patients to

³⁴ Ibid

³⁵ 2004 National Physician Survey Database, part of the NPS project co-led by the CFPC, the CMA, and the RCPSC and supported by the CIHI and Health Canada

³⁶ Hospitalists are the physicians who are most responsible for inpatient care of hospitalized patients and who usually focus most of their professional time on in-hospital responsibilities. The CFPC Discussion Paper: *Family Physicians Caring for Hospital Inpatients* (Oct 2003) includes further information on this topic.

delay institutionalization as long as possible. More recently, increasingly complex medical interventions have been added to the traditional personal and social support services expected to be provided in patients' homes. More and more frequently, home care is being viewed as a substitute for hospitalization, enabling patients to be discharged sooner or to be kept out of hospital by provision of short-term acute care at home.

When home care substitutes for hospital care, it is important that our system provide the appropriate funding, human resources, and supplies that will ensure access to all essential elements of care that patients would have otherwise received in hospital, including insured access to prescription medications. The 2004 First Ministers' Accord took steps to address some, but not all, of these issues. Included in the funding agreement for home care were:

- short-term acute home care for 2 weeks' case management, intravenous medications related to the discharge diagnosis, and nursing and personal care;
- short-term acute community mental health care for 2 weeks' case management and crisis response services; and
- end-of-life care for case management, nursing, palliative-specific drugs, and personal care.³⁷

These supports, while helpful, still fall far short of meeting the home care needs of millions of patients in both range of clinical situations and length of time services will be supported.

To provide patients with comprehensive continuing care, the important role family physicians play in home care must be recognized and supported. In a 1998 survey, family physicians reported many concerns related to timeliness and appropriateness of care.³⁸ The following statement still rings true.

Perhaps the most significant finding of the survey was the reported isolation of family physicians from the home care process. Sixty per cent said that they are not informed when their patients are referred into home care, and 49% said that they are not consulted on their patients' care plans. Ninety-six per cent of those surveyed indicated that they would like to see a formal mechanism requiring hospitals and other providers to involve family physicians in the home care process reaffirming their overwhelming commitment to their role as patient advocates and continuity to care.³⁹

Family physicians are willing and able to play an important part in caring for patients at home. Their role in overseeing the medical aspects of care and being part of the team coordinating and keeping one another informed of all aspects of care is essential.

2.2.3 Public health and health promotion

The focus on many of the core elements of our nation's public health programs has never been greater. From the tragedies of September 11, 2001, and subsequent concerns about bioterrorism to SARS, BSE (mad cow disease), *e-coli* contamination of water supply, new strains of influenza, West Nile virus, and institutional outbreaks of *clostridium difficile*, the public is concerned about how they will be protected and how quickly and effectively our system can react to these threats.

³⁷ "A 10-year plan to strengthen health care." Office of the Prime Minister. News release, Sept 16, 2004

³⁸ Survey of Family Physicians on Home Care Services (CFPC, 1998)

³⁹ *The Role of the Family Physician in Home Care* (CFPC, Dec 2000)

As a society we have finally become more aware of and committed to programs aimed at illness and injury prevention and health promotion, including activities related to smoking cessation, healthy eating, weight control, physical activity, substance abuse, and management of chronic diseases such as HIV-AIDS, diabetes, hypertension, asthma, and coronary artery disease. All these demand a strong and cohesive public health strategy, one that should include public health leaders and networks of caregivers in the community.

The SARS crisis of 2003 focused governments on strengthening our public health infrastructure. In December 2003, Dr Carolyn Bennett, a family physician, was appointed federal Minister of State for Public Health. The past few months have seen the introduction of the Canadian Public Health Agency and a Chief Public Health Officer for Canada, Dr David Butler-Jones, who is also a family medicine graduate. The September 2004 First Ministers' Accord included federal, provincial, and territorial commitments to develop a new Public Health Network to coordinate responses to infectious disease outbreaks and public health emergencies and to accelerate work on a Pan-Canadian Public Health Strategy to address common risk factors, such as physical inactivity.

For the past many years, the CFPC and many Canadian family physicians have been active in public health strategies and programs in areas such as immunization, physical activity, smoking cessation, alcohol abuse, and HIV/AIDS. Family physicians across Canada have always played a key role in surveillance and treatment of disease outbreaks, promoting good health, screening for early detection of disease, and managing chronic diseases as core elements in their provision of comprehensive continuing care. Unfortunately, the supports they require to fulfil this role effectively have not always been there. The Naylor Report, *Learning from SARS*, emphasized the challenges family doctors face when the health care system pays insufficient attention to their role.⁴⁰

An effective public health system will require at least the following.

- Governments, medical schools, and professional colleges to ensure that family physicians have the opportunity to acquire the knowledge and skills they need to deal with public health issues and crises
- Public health officials, hospitals, and regional health authorities to work collaboratively with family physicians in managing and effectively containing population-based outbreaks
- Appropriate and timely communications supported by up-to-date information and communication networks linking public health authorities and offices with family doctors in our communities across Canada
- Supplies, distribution systems, and other supports for office practice
- Support to carry out disease surveillance and ongoing research related to community-based public health issues

For family physicians, the issues that define the public health agenda have always been a core part of their day-to-day work. The role of family doctors in evolving public health strategies is potentially immense, but to date has largely been overlooked.

⁴⁰National Advisory Committee on SARS and Public Health. *Learning from SARS: renewal of public health in Canada*. Ottawa, Ont: Health Canada; 2003.

2.2.4 Underserved populations

Family physician shortages, pose even greater problems for populations that have historically faced disproportionately greater challenges in accessing health care services. In Canada, this includes those living in rural and remote areas, some inner-city populations, and those who face added difficulties in accessing care due to disability, language, culture, lack of education, or other barriers.

Aboriginal communities

One of our nation's most serious population health challenges is that confronting our Aboriginal communities. Access to care problems, combined with a frightening increase in the incidence, morbidity, and mortality of diseases such as diabetes make it imperative to address Aboriginal health as a priority. In the Report of the Commission on the Future of Health Care in Canada (Romanow) stated:

One of the important issues affecting access for Aboriginal peoples, and for all Canadians, is the supply and distribution of health care providers. ... In 1997/98, there were almost 2000 qualified Aboriginal health care workers in Canada, including 800 nurses and 67 doctors. This makes up less than 1% of the health care providers in Canada, far lower than the proportion of Aboriginal peoples to the general population.⁴¹

An Aboriginal Health Human Resources Initiative was announced as an outcome of the September 2004 First Ministers' meeting with leaders of the Assembly of First Nations, the Inuit Tapiriit Kanatami, the Métis National Council, the Congress of Aboriginal Peoples, and the Native Women's Association of Canada. Its objectives are to increase the number of Aboriginal people choosing health care professions; to adapt current health profession curriculums to provide a more culturally sensitive focus; and to improve the retention of health workers serving all Aboriginal peoples, including First Nations, Inuit and Métis.⁴² The CFPC looks forward to working collaboratively with these populations and other health care professionals to help bring the objectives of this initiative to fruition.

Rural communities

Approximately 30% of Canada's population lives in rural, remote, and northern areas of the country.⁴³ The Romanow report stated:

People in rural communities have poorer health status and greater needs for primary health care, yet they are not as well served and have more difficulty accessing health care services than people in urban centres. ... Problems in access to health services often stem from serious shortages in health care providers in rural communities.⁴⁴

⁴¹ Commission on the Future of Health Care in Canada. Roy J. Romanow, Commissioner, *Final Report: Building on Values—The Future of Health Care in Canada*, Nov 28, 2002, p. 220.

⁴² "Improving Aboriginal Health: First Ministers' and Aboriginal Leaders' Meeting." Office of the Prime Minister. News release, Sept 15, 2004

⁴³ Taking action on Rural Health. Health Canada, 2000

⁴⁴ Ibid, p. 162

In their 2001 submission to the Canadian Senate’s Kirby Committee, the Society of Rural Physicians of Canada (SRPC) pointed out that only about 17% of family physicians and 4% of specialists practise in rural areas⁴⁵ and that the numbers are projected to decrease. They cited a 1999 Health Canada–funded study that projected a decline in the ratio of physicians per 1000 people during the period 1998 to 2021. The study estimated the decline to be 24% for urban areas (from 1.82 to 1.39 per 1000) and 33% for rural areas (from the already low 0.79 to 0.53 per 1000).⁴⁶ To try to increase the focus on rural family medicine training in our medical schools and attract medical students and residents interested in careers in rural practice, the CFPC’s Working Group on Postgraduate Education for Rural Family Practice produced a report and recommendations⁴⁷ that outline an appropriate curriculum for preparing new family physicians for the challenges of rural practice. This report now serves as a guide for rural family medicine residency programs across the country. The Romanow Report recognized and applauded the effort of the CFPC and SRPC in developing this national curriculum and guidelines.⁴⁸

Other underserved populations

In discussing underserved populations (as distinct from underserved regions), a Health Canada report stated that “...individuals who belong to a certain population (and people can belong to more than one) may experience difficulties in obtaining needed care, receive less care or a lower standard of care, experience different treatment by health care providers, receive treatment that does not adequately meet their needs, or that they will be less satisfied with health care services than the general population,” and lists “people who do not speak either of Canada's official languages, people with alternate sexual orientation, immigrants, refugees, ethnically or racially diverse populations, people with disabilities, the homeless, sex trade workers, and people with low incomes” as populations that meet this definition.⁴⁹

The Health Canada report suggested some ways to improve access for all of these groups. One is for academic health centres and other educational institutions that educate health professionals to play a greater role in promotion of diversity training, in development of training for alternative health professionals, and in promoting research on underserved communities. It is critical for our medical school undergraduate curriculums, residency training programs, and CME/CPD activities to focus on the needs of these populations.

In 2003, the CFPC introduced a Diversity and Equity Committee to focus on these issues. The College also developed a Diversity and Equity Award to recognize physicians who have made an outstanding contribution to the care of underserved populations.

⁴⁵ The SRPC cites the CMA physician resource database as the source of these figures.

⁴⁶ Buske LM, Yager SN, Adams OB, Marcus L, Lefebvre FA. *Rural community development tools from the medical perspective: a national framework of rurality and projections for physician workforce supply in rural and remote areas of Canada*. Report to Health Canada, April 1999

⁴⁷ Postgraduate Education for Rural Family Practice: Vision and Recommendations for the New Millennium, report of the Working Group on Postgraduate Education for Rural Family Practice, approved by the CFPC Board, May 12, 1999

⁴⁸ Romanow report, p. 163

⁴⁹ Bowen S. Access to health services for underserved populations in Canada. In: Health Canada. *Certain circumstances: issues in equity and responsiveness in access to health care in Canada*. Ottawa, Ont: Health Canada; 2001.

Elderly people

An underserved population that is superimposed on all others is elderly people, whose increasing numbers and complexity of medical problems will present a major challenge to our health system during the next many years. While the CFPC accredits, and university departments of family medicine offer added-skills training in care of the elderly, we recognize the need for a greatly increased role for our College and for family physicians in addressing the needs of our elderly population in the future.

2.3 Factors affecting the supply of new family physicians

While there are shifts in who is delivering which services where, the fundamental factor affecting access to care is the critical shortage of qualified health professionals. The shortage of family doctors, nurses, medical specialists, and other care providers has been of concern for a long time. The Canadian Medical Forum⁵⁰ spawned two task forces to study and make recommendations on both immediate and long-term physician resource needs in Canada. This supply crisis and need for further action was also recognized in the September 2004 First Ministers' Accord.

In the Accord, the federal, provincial, and territorial governments committed to:

- accelerate their work on health human resource action plans to ensure an adequate supply and appropriate mix of health care professionals;
- build on current work in the areas of labour relations, interdisciplinary training, investments in postsecondary education, and credentialing of health professionals; and
- increase the supply of health professionals and make their action plans public, including targets for training, recruitment, and retention, by the end of 2005.

The federal government committed to:

- accelerate and expand the assessment and integration of internationally trained health care graduates for participating governments;
- target efforts in support of Aboriginal communities and official language minority communities to increase the supply of health care professionals for these communities;
- introduce measures to reduce the financial burden on students in certain health education programs; and
- participate in health human resource planning with interested jurisdictions.⁵¹

The September 2004 First Ministers' Accord likely falls far short of assuring Canadians that the future will not repeat the past. The CFPC believes that, in addition to commitments made in the Accord, a federal-provincial-territorial infrastructure to study, monitor, and make recommendations related to Canada's health human resources is essential. We need a national framework defining our health human resource needs, goals, and strategies, with provincial

⁵⁰The Canadian Medical Forum (CMF) is comprised of the Presidents and CEOs of the CMA, CFPC, RCPSC, Medical Council of Canada, Federation of Medical Regulatory Authorities of Canada, Association of Faculties of Medicine of Canada, Canadian Association of Internes and Residents, Canadian Federation of Medical Students, and the Association of Canadian Academic Health Organizations. The CMF Task Force 1 (1999) studied and made recommendations for immediate physician resource needs. Task Force 2, with support from the HRDC and Health Canada, is currently studying other models of practice that will be needed to address physician resources over the longer term in Canada. It will report in 2005.

⁵¹ "A 10-year plan to strengthen health care." Office of the Prime Minister. News release, Sept 16, 2004.

commitments to meet these goals. Provinces should be accountable for the funding they receive for physician education and training, for recruitment and retention programs, and for the outcomes they achieve.

2.3.1 Canada's capacity to train medical students and residents

During the past few decades, Canada compared poorly to other nations regarding medical school entry positions per capita.⁵² The inadequacy of the number of medical school entry and residency training positions was intensified in the early 1990s by federal and provincial cutbacks based on recommendations of the Barer-Stoddart Report.⁵³ During the September 2004 First Ministers' meetings, these cutbacks were acknowledged by many as critical contributors to the physician shortages we face today and will face for the next many years.

Family physician training was further compromised in 1993 when rotating internships were eliminated.⁵⁴ These internships had up to that time, along with the 2-year family medicine residency programs, been the route to family practice. With the loss of rotating internships, 250 to 300 more positions needed to be added to the 2-year family medicine programs in order to maintain the same number of new family doctors entering practice each year. These positions never materialized, resulting in a cumulative loss of 2500 to 3000 family doctors—enough to eliminate many of the shortages we face across Canada today!

In November 1999, the Canadian Medical Forum's Task Force 1 presented its report to the federal, provincial, and territorial Ministers and Deputy Ministers of Health, recommending an immediate increase in medical school entry positions from 1500 to 2000.⁵⁵ Many schools expanded their classes, and there are now approximately 2200 positions. Analysis of future needs has led to a further recommendation to increase entry positions to 2500 in the next few years.⁵⁶

As medical school positions increase, it is imperative that postgraduate residency posts also increase. To date, the number of residency positions available in Canada has not been keeping pace with growing demand. This demand comes from increased numbers of Canadian medical school graduates, foreign medical graduates, residents requesting special skills training, and physicians seeking re-entry positions. Increasing the capacity of our residency training programs is critical to allowing more flexibility for residents to transfer from one program to another.

2.3.2 Educating and training the right numbers of family physicians and specialists

For the past two decades, the goal in Canada has been to sustain a 50/50 balance between family physicians and other specialists in practising populations. We seek to maintain this ratio by various

⁵² Tyrell L, Dauphinee D. Report of the Task Force on Physician Supply in Canada (CMFF, Nov 1999). The report went on to cite comparative data for 1998, where Canada had one first-year medical school position per 19 000 citizens, compared with one per 12 200 in the UK and one per 13 500 in Australia.

⁵³ Barer ML, Stoddart GL. *Toward integrated medical resource policies for Canada*. Prepared for the Federal/Provincial/Territorial Conference of Deputy Ministers of Health, 1991.

⁵⁴ In the late 1980s, two major CMA task forces (Wilson, Cox) studied the most effective way to educate and train family physicians in Canada. They concluded that 2-year family medicine residency training, overseen and accredited by the CFPC and leading to Certification in Family Medicine, was the best preparation for Canada's family physicians and should become the requirement for all new graduates from Canadian medical schools heading into family practice.

⁵⁵ Report of the CMF's Task Force 1, Nov 1999

⁵⁶ CFPC supports this recommendation that was formulated at recent meetings of the CMF

recruitment and retention strategies, but the main resource is graduates of Canadian medical schools. To maintain this 50/50 balance, the ratio of postgraduate year 1 (PGY-1) positions across Canada was determined at 40/60 (family medicine/other specialties). With decreasing numbers of family physicians now in practice and many family medicine residents interested in focused practices,⁵⁷ the number of PGY-1 positions needed to produce the supply of family doctors providing comprehensive continuing care needs to be even further increased to 45/55, if not 50/50.

In 2001, a multi-organizational Steering Committee led by representatives from Canada's medical colleges published an important document based on the World Health Organization's work defining the social accountability of medical schools.⁵⁸ The report emphasized the importance of medical schools' producing the right number and mix of physicians needed by Canadian society. Unfortunately, over the past few years, the number and proportion of family medicine residency entry positions has decreased compared with specialty positions offered in the first round of the Canadian Resident Matching Service (CaRMS)⁵⁹ program, leaving the impression that some medical schools are decreasing their commitment to and responsibility for maintaining the supply of family doctors. The match for residencies beginning in mid-2005 indicates that 38% of positions offered are in family medicine and the remainder are in Royal College of Physicians and Surgeons of Canada (RCPSC) specialties.⁶⁰

Since Canada needs more physicians, not only in family medicine but in many other specialties, it will be critical to increase the total number of residency positions while ensuring the appropriate proportion for family medicine.

Medical student career choice

During the past several years, the number of Canadian medical school graduates selecting family medicine as their first choice careers has decreased from more than 40% in the early 1990s to 25% in 2003 and slightly more than 26% in 2004.⁶¹

Numerous factors have been identified by students in focus groups and published reports^{62,63,64} that are viewed as having contributed to this downturn in the popularity of family practice as a preferred career choice. Some are related to the image and role of family medicine in medical schools (involving admission, undergraduate curriculum, timing of the CaRMS match, and inadequate flexibility in residency training) and some are related to societal, remuneration, and practice environment issues.

⁵⁷Gutkin C. Added skills in family practice: are they necessary? *Can Fam Physician* 2002;48:648. Gutkin C. Family practice subspecialists. *Can Fam Physician* 2004, 50:1175-6.

⁵⁸*Social Accountability: A Vision for Canadian Medical Schools* (Health Canada, 2001)

⁵⁹The CaRMS program involves the 13 English-language medical schools in Canada. Canada also has three French-language medical schools that use other means for resident matching.

⁶⁰Data supplied by CaRMS, Oct 26, 2004

⁶¹CaRMS data: Match history of Family Medicine 1990-2000

⁶²CaRMS/CFPC study of 2000 graduates

⁶³*Primary Importance: New Physicians and the Future of Family Medicine* (Professional Association of Internes and Residents of Ontario (PAIRO), June 2004)

⁶⁴Gutkin C. Perceptions and realities: what students need to know about family practice. *Can Fam Physician* 2002;48:423-4.

Admission to medical school

While admission criteria and policies vary in medical schools across Canada, many believe that greater balance is needed to ensure that appropriate numbers of students with attributes that are consistent with likely future careers as rural or urban family physicians are being selected. Studies are beginning to emerge to help us better understand the profile of these students.⁶⁵

Undergraduate curriculum issues

Students at many medical schools report much less exposure to family doctors and the discipline of family medicine than to other specialties. With specialists teaching most core clinical topics and providing most of the role models in lectures, small group learning sessions, and hospitals, students report they are often left with the impression that family physicians play a minor role in care of Canadian patients and that they must be RCPSC specialists or subspecialists to be acknowledged as having the required medical expertise. Students indicate that, in many schools, family physicians play a secondary role as clinical teachers and role models and that less prestige and value seem to be attached to what they do.

The CFPC thinks the time has come for a major review of the admission policies and undergraduate curriculums of our medical schools with a specific focus on the need for increased credible roles and prestige for family physician teachers and the discipline of family medicine and greater emphasis on producing more family physicians. At a recent meeting of the Canadian Federation of Medical Students, students asked why physicians who carry out studies in family medicine, succeed in the family medicine Certification Examination, and are awarded Certification in the CCFP are not recognized as specialists in family medicine the same way specialists are recognized in the RCPSC. The CFPC has heard this from many family physicians, specialist colleagues, licensing authority leaders, and now from medical students as well. This will be studied further, and a solution that recognizes the value of both certified and non-certified family physicians will be developed.

Examples have been given of many schools using clinical modules that inappropriately denigrate the role of family doctors by presenting cases with “missed” diagnoses or incorrect treatment carried out by a family physician leading to a specialist coming to the rescue. Some schools have now reviewed and removed such case presentations. All must do so.

Many students leaning toward careers in family medicine also report having residents or teachers suggest that, based on their academic standing and demonstrated skills, they should be aiming higher. This kind of feedback is inappropriate (some students have labeled it harassment) and should be strongly discouraged by all medical schools.

Students have also indicated that their preparation for the Medical Council of Canada (MCC) Licensing Examination (Part 1) has historically focused their attention on objectives related to surgery, medicine, pediatrics, psychiatry, and obstetrics and gynecology. Family medicine is noticeably absent. Medical schools need feedback after the MCC examinations regarding the

⁶⁵Wright B, Scott I, Woloschuk W, Brenneis F. Career choice of new medical students at three Canadian universities: family medicine versus specialty medicine. *CMA J* 2004;170:1920-4.

performance of students in all these disciplines, including family medicine, but for family medicine, it is not available.

These medical school and MCC messages, unintentional as they might be, are clearly leaving medical students with the impression that family medicine is not as credible or respected a discipline or career choice as many other specialties.

The good news is that meetings held by the CFPC leadership with the medical school Deans and Associate Deans responsible for postgraduate and undergraduate education and with MCC leaders, have shown great sensitivity and interest in addressing and correcting these situations.

CaRMS match

For several years, students have expressed concern that they are forced to choose residency programs—and hence, in many cases, their careers—too early. Since many have not yet had much exposure to family medicine, this could result in fewer selecting family practice than might be the case if the match were made later. Fortunately, the CaRMS match is now fully computerized, and the match date has actually been moved so that it is now closer to the end of medical school. To move it back even further will require the cooperation and agreement of the medical schools and teaching hospitals that stipulate the latest acceptable date by which they must be informed of their new residents. The CFPC strongly supports moving the match to the latest possible date.

Residency training

Once accepted into postgraduate (residency) training programs, students and residents indicate they believe the system is too inflexible. It does not leave them enough opportunity to change their minds and transfer from one program to another. Historically, transfers have always been more difficult from family medicine to an RCPSC specialty program than vice-versa. This has had a strong effect on medical student career choice, as those who are still uncertain about whether they want to be family physicians or specialists will choose to apply to an RCPSC specialty program first. The CFPC and the RCPSC are currently addressing this issue and expect to present a pathway with much greater recognition of training already completed for those seeking transfers in either direction. To provide positions for many, however, will require other changes as well, changes that are beyond the control of the Colleges and that will lead to more capacity in the residency system and funding to support residents moving from shorter training programs in family medicine (2 or 3 years) to longer programs in RCPSC specialties (4 to 6 years). There is also a working group on implementing a new optional common PGY-1 year to try to address these same challenges. Medical students and residents should benefit from these activities. With the changes about to be introduced, those considering family medicine as a first choice for residency training should be able to make this decision with increased comfort.

Financial and remuneration issues affecting students' career choices

Remuneration issues are among the factors outside the medical school environment that students identify as affecting their career choices. Although the cost-effectiveness of family physician services and the high value Canadians place on their family doctors have been widely acknowledged both nationally and internationally, Canada's family physicians remain relatively

undervalued and underpaid by our system. Most provincial and territorial fee schedules reward episodic, procedural, and specialty services more than those related to comprehensive continuing care, preventive medicine, and other elements that define family practice. An Ontario Medical Association (OMA) study comparing billings to the provincial health plan found that, in 2000-2001, a family physician's average gross billing was 61.8% of that of a specialist. After expenses, an average family physician was earning 54.6% of that earned by a specialist. In terms of gross billings, the proportion had declined from 71.2% 20 years earlier.⁶⁶ Based on their 2002 Physician Resource Questionnaire, the CMA estimated that net fee-for-service income in 2001-2002 was \$124 103 for family physicians and \$183 775 for specialists, representing a 33% differential.⁶⁷

This issue has become particularly acute in times of increasing student debt since branches of medicine that currently offer less income-earning potential, such as family practice, compared with other specialties, will have ongoing difficulties convincing students to make them first choice for their future careers. Future physician demographics will be strongly affected unless these issues are addressed. Currently underserved populations, including rural and Aboriginal communities, will face even greater physician shortages. The CFPC joins its medical association colleagues in strongly recommending that increases in medical school tuition fees be controlled and that financial support for medical students be greatly augmented.

While some new provincial agreements have finally begun to provide remunerative incentives and increases for family medicine services, particularly if comprehensive care is provided or chronic disease management plans are implemented, increased recognition of the work of family doctors through provincial and territorial remuneration models must still be addressed as a priority. As noted elsewhere in this paper, concerns related to family physician remuneration and increased resource support extend beyond the realm of practice to those carrying out critical roles as family medicine teachers and researchers.

Newer practice models: effect on students' career choice

Newer models offering incentives to support continuing comprehensive care and enhanced access to care for populations of patients through groups, networks, teams, interdisciplinary care strategies, and enhanced access to information technology have generated interest and received the support of medical students.⁶⁸ At the same time, many students report they are confused by the terminology and objectives of some primary care reform and renewal (PCR) models. They are concerned that the role of family physicians as skilled practitioners playing a critical role in delivery of medical care could be greatly diminished in some of these PCR models, with family physicians' responsibilities becoming blended with, or even replaced by, those of other primary care providers. They question the need to go through 6 to 7 years of medical school and residency training if their ultimate role and responsibilities could be carried out by people in other health professions who have less education or training. The perception of some is that, if family doctors are to be defined as nothing more than another primary health care provider, all those years of study to earn an MD would only be worthwhile if they had selected an RCPSC specialty.

⁶⁶ OMA Section on General and Family Practice. Family medicine in Ontario: present and future challenges. *Ont Med Rev* 2003

⁶⁷ Canadian Medical Association. Physician billing highest in Ontario, lowest in Quebec. *CMAJ* 2004;170:776.

⁶⁸ *Primary Importance: New Physicians and the Future of Family Medicine* (PAIRO, June 2004)

The CFPC understands this concern. We also understand that it is mostly a myth. While family physicians play a critical role in primary care in our health care system, they are providers of not only primary medical care services, but also a great deal of secondary and even tertiary medical care for patients in hospitals and other health institutions across the country. They do this because they can, because they are educated, trained, licensed, and certified to do so. It is important for students to know, as this paper highlights, that the future will likely provide much-needed and highly respected roles for family physicians at the forefront of some of the most exciting and challenging areas of medicine.

It is also important to note that, to date, most of the PCR models being promoted and introduced across Canada (that we know about) highly value and respect the role of family physicians as skilled and knowledgeable medical doctors whose roles and responsibilities are appropriate and challenging. Group practices and collaborative care models involving nurses and other health professionals as part of the team are being introduced with the support and reported satisfaction of family physicians, nurses, and patients. Most surveys indicate growing numbers of family doctors in Canada are in favour of, and would be interested in, considering these practice approaches.

The CFPC advocates and strongly supports all Canadians having their own family physicians, who are the central providers of medical care in each practice. Nurses and other health professionals should play increased, well supported roles in new models of practice, but not as replacements for family physicians. We believe that PCR models that respect and protect the role of family physicians as skilled and knowledgeable medical doctors will provide excellent career opportunities for new medical school graduates.

2.3.3 *International medical graduates*

Canada is in the midst of a paradox: we have a severe shortage of physicians, and we have large numbers of international medical graduates (IMGs) with degrees from outside Canada seeking opportunities to practise medicine in communities across Canada. Historically, requirements for licensure for IMGs have varied from one provincial jurisdiction to another, which has presented challenges for IMGs.

Thanks to the collaborative efforts of a national task force of governments, medical associations, and others, programs for IMG assessment and training are now unfolding. We hope these programs will provide IMGs with the chance to be assessed and, where appropriate, to receive additional training to ensure they can meet Canadian standards for licensure. Achieving this will require funding and resources to support both the IMGs and those responsible for carrying out assessment and training. The CFPC supports the requirement for medical licences to become standardized across all Canadian jurisdictions. The CFPC also welcomes the opportunity to support IMG family physicians as part of our College and to give them an opportunity to access the pathway leading to CFPC Certification.

The CFPC would also support any efforts Canada could make to attract Canadian citizens, who have completed medical school in accredited schools in other countries, back home for residency training and practice opportunities.

2.4 Optimizing delivery of care with scarce resources

2.4.1 Access to the continuum of care

As noted earlier, there are shortages of family physicians, RCPSC specialists, nurses, and other health professionals across Canada. In addition to recruiting and retaining new family physicians, we must do all we can to use the physicians we have as effectively as possible.

We need to focus on providing the full continuum of care for our patients, from comprehensive continuing care by family physicians to episodic specialty interventions and back again. As family doctors, we are educated and trained to deliver and coordinate the medical care needed by any person for any health concern. We are not defined by a body part or a specific disease. Unlike other specialists, we are prepared to deal with undifferentiated problems, to manage uncertainty, and to help decrease inappropriate use of other health system resources.⁶⁹

Inadequate support for family physicians in Canada has contributed to increased costs and wait times through patients' use of higher-cost emergency departments, hospitals, specialists, and specialized care when they cannot access a family doctor. The frustration of not having support to accomplish what could be achieved by family medicine and witnessing the decreasing access to care for our patients and the diminished morale among family doctors must come to an end. Alternative strategies with augmented support for family physicians are essential.

2.4.2 Primary care renewal

In October 2000, the CFPC published *A Prescription for Renewal* to inform and guide PCR in Canada. The principles underlying the recommendations in this document are still supported today.

- Every person in Canada should have the opportunity to have his or her own family physician.
- A family physician should be the entry point to medical care for each patient.
- Throughout their lives, patients should receive personal, comprehensive, continuing care from their family physicians.⁷⁰
- The spectrum of primary health care services can be delivered by interdisciplinary integrated care teams in real or virtual groups through office or community-based strategies.
- Primary care groups, teams, and networks should have systems in place to ensure they respond to the needs of their patients 24 hours a day, 7 days a week, 365 days a year.
- Family physicians and groups, networks, and teams should be supported to acquire and maintain computerized information and communications systems.
- Patients should own their health records; family physicians should be custodians of their records. As their patients move from one to another, their health records should move with them.
- Primary care models should support and encourage CME/CPD for every health care professional in a team.
- While the principles and concepts of PCR should be encouraged and well supported, the CFPC believes physicians and patients should have a choice regarding specific model of practice. We do not support physicians being mandated or coerced into practice models with which they do

⁶⁹The Future of General Practice. Statement of the Royal College of General Practitioners. London, Engl, Sept 2004

⁷⁰As defined in the PCCCAR list of primary care/family physician mandatory functions (see section 2.2 of this paper).

not agree. As is being demonstrated across Canada already, various practice models and strategies are being introduced that each have the goal of meeting PCR objectives. We believe that those that are well supported will have the best chance of producing positive patient and professional outcomes, measured by health and satisfaction indicators. These are the models that will likely find family doctors and patients lined up to join them and that will define the future of health care in Canada.

The September 2004 First Ministers' Accord confirms that "timely access to family and community care through primary health care reform is a high priority for all jurisdictions"⁷¹ and acknowledges the progress underway in all jurisdictions to meet the objective of 50% of Canadians having 24/7 access to multidisciplinary teams by 2011. The First Ministers agreed to:

- establish a best practices network to share information and find solutions to barriers to progress;
- regularly report on progress;
- work with Canada Health Infoway to accelerate implementation of electronic health records, including e-prescribing; and
- accelerate efforts to improve access to Telehealth for remote and rural communities.

For the past decade, PCR has been a major focus of health system review for governments and medical organizations across Canada. Historically, Canadian family doctors in solo, small, or large groups have provided high-quality care for our population. As population needs, system demands, physician resources, and patterns of practice have changed, many family physicians in Canada and around the world have been part of reform or renewal initiatives, trying to define the best ways to adapt to changes and improve outcomes for patients and family physicians.

In Canada, PCR initiatives have looked at models of practice that hope to improve access to care for patients while at the same time supporting balanced and healthy lifestyles for health care professionals. Many of these models of groups, teams, or networks of family physicians offer patients access to a broader array of services and after-hours care than a single family physician could offer alone. Many incorporate nurses or nurse practitioners into the practice. While most of these groups, teams, and networks involve family physicians and others working under the same roof, many are groups without walls that even include solo physicians who are linked with others to share in provision of services and after-hours call. Most offer access to computerized billing and recall systems. Some models offer a team approach to all patients in the practice; others focus on teams to provide improved management for patients with specific, complex, high-intensity needs (eg, patients with chronic diseases). Patients are sometimes rostered to these practices. Remuneration has varied from fee-for-service to capitation to salary to blended funding systems. Some have offered financial incentives for commitment to comprehensive continuing care; others have provided increased payments for caring for defined patient populations.

The CFPC maintains its position that, regardless of practice model chosen, every Canadian should have the opportunity to have a family physician of his or her own. Canadians themselves have indicated strong support for having their own family physicians, acknowledging their family doctors as the most important caregivers in the health care system.⁷² They also recognize the value

⁷¹ "A 10-year plan to strengthen health care." Office of the Prime Minister. News release, Sept 16, 2004

⁷² Decima public poll (CFPC, Oct 2003)

of other members of the health care team who together can ensure that patients gain access to the full spectrum of primary medical and health care services.

Initial feedback on some PCR models indicates that both patients and family physicians are highly satisfied.⁷³ The next few years will be critical for determining whether PCR strategies are indeed improving patient access and outcomes. The other important question is whether health professionals, including family physicians, have been appropriately supported in their roles, allowing them to achieve greater professional and personal satisfaction and a healthy balance in their lives. For family doctors who choose to participate in these new strategies, the next few years will be critical. If they determine these models work for them and their patients, they could be defining the future of family medicine for all.

2.4.3 Access to specialty care

One of the major challenges facing family physicians and their patients is access to specialists and specialty care.⁷⁴ While less than 10% of patient visits involve referral to specialists,⁷⁵ the shortage of specialists severely compounds the problem of access Canadians are facing. For family physicians, the wait for specialist and specialty service appointments means they must provide more complex care for their patients while they wait and will, therefore, have less time to attend to the needs of others.

With growing wait times and shortages of both family doctors and specialists, we need to find optimal models that address the full continuum of care. Inefficiencies in the referral process from family physicians to specialists have negative implications on cost and quality of care that go beyond just wait times. They also lead to unfocused ordering or repetition of tests, overmedication and possible drug interactions, and added pressure on emergency rooms.⁷⁶

The move to family practice groups, networks, and teams presents many opportunities to organize and coordinate care in new ways, including ways the referral process is carried out. Strategies to help deal with shortages of specialists include incorporating family physicians who have added skills or focused practices into care⁷⁷ and exploring shared-care models,⁷⁸ particularly for patients with mental health problems or chronic diseases.

⁷³ Overall, family physicians rated their satisfaction with current professional life higher in the 2004 NPS than in the 2001 NFPWS. In 2004, 66% rated themselves very or somewhat satisfied, compared with 50% in 2001. In a project in Taber, Alta, provider satisfaction was found to be significantly higher after implementation in the categories of communication flow, amount of time available to spend with patients and colleagues discussing care, ability to affect patient health behaviour, and the quality of care they feel they can provide. All providers thought their autonomy in performing their jobs improved, as did their job satisfaction. Final Report of the Taber Integrated Primary Care Project: Turning Vision Into Reality (Aug 2003), www.uleth.ca/man/taberresearch/finalreport.shtml

⁷⁴ Write-in answers to the 2004 NPS indicated that problems in accessing other types of care for their patients was one of the three most stressful professional activities reported by family physicians. Access to specialty care, particularly for patients with complex mental health problems, was a prime concern.

⁷⁵ A joint task force report of the CFPC and the RCPSC, *The Relationship between Family Physicians and Specialists/Consultants in the Provision of Patient Care* (1993), cited three studies (1977, 1991, 1992) and put the figure at 3.9% to 7.5%. An important American study found this figure to be in the range of 10% to 20%. Green LA. The ecology of medical care revisited. *N Engl J Med* 2001;344:2021-5.

⁷⁶ College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of Canada. *The relationship between family physicians and specialists/consultants in the provision of patient care*. Mississauga, Ont: CFPC and RCPSC; 1993. p. 14.

⁷⁷ See section 2.2.1

2.4.4 Opportunities presented by information and communications technology

Information and communications technologies (ICT) are being introduced worldwide to improve patient care. As of 2001, about 90% of Canadian physicians were using computers, but only about 10% had introduced electronic health records into their practices.⁷⁹ If all providers in Canada used compatible e-health records, benefits would include:

- enhanced information-sharing and communication among all providers that would increase the timeliness, efficiency, and quality of care;
- reduced risk of adverse events (eg, drug interactions);
- the possibility of linking all family physicians as part of an effective public health network;
- the ability to carry out surveillance and research and measure health care outcomes in community practices across Canada; and
- greater accountability to all Canadians.

While more doctors might be using ICT,⁸⁰ there remain many challenges to obtaining the full benefits. These include the need for a well supported infrastructure; development of good-quality hardware and software; the assurance of systems' interoperability and the expansion of broadband networks; the assurance of security, privacy, and confidentiality of all patient and physician information; and the development of standardized nomenclature.⁸¹

To be successful, PCR models must include effective information systems. To ensure better access to good-quality care and better outcomes, all family physicians should be supported to incorporate ICT systems and to use electronic health records.

2.5 Innovation and quality in family practice

Canadians want and deserve timely access to care. They also want to be confident in the quality of care they receive. Critical components to advance and ensure quality in family medicine are:

- research, to advance knowledge and ensure evidence-based practice;
- education and training standards to ensure those entering the field have the opportunity to acquire the necessary skills and knowledge;
- certification and lifelong learning to ensure those entering and continuing in the field have and maintain the requisite skills and knowledge; and
- strategies to facilitate transfer of new evidence-based knowledge into practice.

2.5.1 Research

Ensuring a sustainable, high-quality primary health care system requires a commitment to ongoing research. Despite a climate of evidence-based medicine, there is still a critical need for evidence to

⁷⁸One example of the Canadian Collaborative Mental Health Project, established in 1997 by the Canadian Psychiatric Association and the CFPC after publication of the conjoint report on Shared Mental Health Care in Canada.

⁷⁹2001 Physician resource questionnaire (PRQ) results, *Canadian Medical Association Journal* webpage

⁸⁰The CMA's 2003 PRQ results indicated that, overall, 88% of Canadian physicians personally use the Internet, a statistic that remains unchanged from the 2002 PRQ findings.

⁸¹The CFPC will pursue discussions with governments and Canada Health Infoway to encourage adoption in Canada of the International Classification of Primary Care (ICPC-2) developed by WONCA and the *WONCA Dictionary of General/Family Practice* endorsed by the WHO and linked to the WHO's International Classification of Disease codes (ICD 9 and 10).

support many elements of care that are part of family medicine.⁸² Research is also essential to measure the patient and health system outcomes of new strategies and models of practice being introduced as part of PCR across Canada.

As an academic discipline with networks of community-based resources, family medicine is ideally placed to lead these research initiatives. The CFPC and the university departments of family medicine are committed to playing a leadership role in the future of primary care and family medicine research in Canada. This commitment was formalized with the approval of the CFPC Board of Directors for the Task Force on the Future of Family Medicine Research in Canada Report (2002). The Task Force, convened by the CFPC, had representatives of Department of Family Medicine Chairs, Research Directors, and the CFPC's Section of Researchers. Some of the recommendations of this Task Force are incorporated into this Vision paper (section 6.1).

The value of family medicine research in both clinical care and health service delivery is undervalued and undersupported in the Canadian health care system today. Resources to help build family medicine research capacity and to support family medicine researchers are needed in both community practice and academic centres. Support for family medicine research from the Canadian Institutes of Health Research (CIHR) should include family physicians playing both lead and support roles in many of its key activities.

2.5.2 Education and training standards

From its inception in 1954, the CFPC has made the education of family physicians a priority. The College's motto, "In study lies our strength," reflects the organization's leadership role in all facets of family physicians' education, training, and lifelong learning. In keeping with the authority granted to the College by the federal government, the CFPC is responsible for accreditation standards for all Canadian family medicine residency programs. The CFPC's leadership role continues throughout family physicians' professional lives because the College conducts national Certification Examinations and confers Certification (CCFP) and Fellowship (FCFP) on family physicians who have demonstrated special competence in family medicine and who maintain it by meeting the CFPC's CME/CPD requirements in accredited programs.

At the undergraduate level, the CFPC participates actively in accreditation of Canadian medical schools. In September 2000, the CFPC's Section of Teachers issued a report calling for development of a national standard for program requirements in undergraduate family medicine education.⁸³ To address some of the issues raised in the Section's report, CFPC sponsored a multistakeholder Working Group on Undergraduate Education whose recommendations were approved by CFPC's Board in May 2002. As noted earlier, the CFPC will advocate for a review of undergraduate curriculums with a focus on an increased role and greater support for family physicians and the discipline of family medicine throughout medical school. This and some recommendations from the Working Group Report have been incorporated into this Vision paper (see section 5.1).

⁸² Report of the Task Force on the Future of Family Medicine Research in Canada (CFPC, 2002)

⁸³ *The Present and Promise of Family Medicine in Undergraduate Education: A Discussion Paper* by Dr Robert Woollard et al on behalf of the CFPC Section of Teachers (CFPC, Sept 2000)

Since the late 1960s when family medicine residency training began in Canada, the CFPC (responsible for accreditation) and the university departments of family medicine (responsible for developing and delivering programs) have collaborated to create one of the most highly respected family practice teaching models in the world. As with any program, there is ongoing need for review to ensure programs are meeting the changing needs of the population, the physician workforce, and trainees. During the past few years, the CFPC has strongly focused on residency program curriculum review. This has led to approval of Guidelines for Postgraduate Education for Rural Family Practice to address growing concerns about the need to produce more rural family doctors (see section 2.2.4). It also stimulated task forces to study in-training evaluation and assessment of the procedural skills being learned by residents. Another task force is studying the Certification Examination to ensure it is relevant to the realities of family practice in communities across Canada today.

It has long been recognized that Canada's 2-year family medicine residency training is the shortest of any family medicine program in the world. It is also acknowledged that there is a growing list of areas that many practising physicians and educators believe should be added to the core curriculum of family practice training programs. Also, up to half the residents in family medicine programs show interest in a third year of training to enhance their skills in specific areas. This is voluntary, however, and residents have generally indicated that, while they would like to see an increased number of optional add-on third-year opportunities, most think that the 2-year training they have received has prepared them well for practice. They do not currently favour mandatory 3-year programs in all universities. While the CFPC continues to support 2-year residency programs as the requirement across Canada, it is interested in the potential introduction of 3-year family medicine residency programs in Quebec. Results of the Quebec approach will be carefully observed.

Special skills training is also a challenge in family medicine. Originally, the goal of these programs in areas such as emergency medicine, palliative care, care of the elderly, and anesthesia was to produce family doctors who would add these skills to their regular comprehensive continuing care practices. What has unfolded, however, is that many who train in these areas end up practising solely in the special skills field, leaving behind the concept of providing a broad-scope practice. As a result, the number of family physicians offering comprehensive continuing care has been further compromised, and the number of Canadians unable to access a family doctor who will attend to any concern they have continues to grow.

To meet the needs of Canadians for both personal comprehensive continuing care (traditional family practice) and special services not otherwise available in many communities, we will need new education and training strategies. Physician resource planners must understand that we need even greater numbers of family medicine residency positions if we are going to produce enough doctors to meet all these needs.

Regardless of the eventual pattern of practice of family medicine graduates, the CFPC Board has endorsed the fact that all family medicine residents must complete training and demonstrate their competence in a broad range of core family practice knowledge and skills. The CFPC recommends that a core curriculum include elements such as those listed by the PCCCAR (see section 2.2). Areas such as intrapartum obstetrics, emergency medicine, palliative care, mental health, and care of the elderly, should be part of the core 2-year program for all trainees and also offered as a

defined number of third-year positions for those seeking added skills in these areas. Newer integrated approaches to practice involving specialists, nurses, and other health professionals are also recommended as models for family medicine residency training.

2.5.3 Certification, Fellowship and lifelong learning

Commitment to a defined program of lifelong learning is the essence of being a CFPC member. Indeed, most family physicians in Canada are committed to and enjoy participating in CME/CPD as part of their professional responsibility. It is a core requirement for being granted and for maintaining membership (MCFP), Certification (CCFP), and Fellowship (FCFP) in the CFPC. The CFPC's mandate includes establishing accreditation standards and carrying out accreditation of CME/CPD programs for family physicians in Canada. As of October 2004, CFPC's total membership included just over 17 000 of Canada's 28 000 physicians practising as family doctors in Canada.⁸⁴ Of the 17 000, 14 552 physicians in Canada hold valid CCFP or FCFP designations.

The CFPC has the authority to conduct examinations and confer Certification in Family Medicine and also Certification of Special Competence in Emergency Medicine to physicians who demonstrate knowledge and skills in this area.

Although the requirements for Certification in Family Medicine and the rigour of the Certification Examinations easily match the standards and requirements for Certification in RCPSC specialties, up to now, holding CCFP has not carried with it a similar value or prestige with many of our medical schools, regulatory bodies, hospitals, fee negotiators, or other publics. This has been the case, despite the fact that, since 1992-1993, the Federation of Medical Regulatory Authorities of Canada agreed that, to have a full portable license to practice, new graduates would have to have successfully completed the Licentiate of the Medical Council of Canada (LMCC) examinations and to have attained Certification from either the RCPSC (specialists) or the CFPC (family doctors).

The past several years have seen many family physicians, medical students, medical school leaders, and others recommending that we more strongly promote the meaning and value of Certification in Family Medicine. Just as our sister Colleges in Canada and elsewhere who years back faced this same challenge did, the CFPC will explore options for recognizing Certificants as they deserve and for recognizing the many outstanding family doctors who were in practice for many years before Certification became firmly ensconced in Canada (1992-1993) and who, therefore, have never achieved CCFP status. Although our College has maintained a practice-eligible path to Certification for those who never had residency training, preparing for and passing the examinations are often impractical and unattainable for older physicians. The CFPC will seek a solution to this challenge in the near future, a solution that will help augment the image and value of the discipline of family medicine and the thousands of certified and non-certified, but excellent, family physicians committed to both their patients and lifelong learning.

With the constant explosion of new knowledge, the universe of CME/CPD is expanding rapidly. The CFPC is one of the medical organizations playing a lead role in the development and evolution of CME/CPD standards both in Canada and internationally. Research in CME/CPD is essential to help determine the best learning strategies and their effect on physicians' competence

⁸⁴ While the CMA Masterfile indicates there are 31 503 such physicians, which includes all physicians who are not certified as RCPSC specialists, CFPC estimates about 28 000 are in active practice.

and performance in practice. The next few years will see the CFPC increase its role in carrying out these types of studies.

Emerging evidence already supports the value of practice-focused, evidence-based, reflective learning, which is the basis of the CFPC's Mainpro-C program, including the "linking learning to practice" programs. In the past year, CFPC's Board approved bringing Fellowship (FCFP) into the important pathway of lifelong learning, with Mainpro-C requirements central to earning and maintenance of Fellowship. The special designations awarded by our College (MCFP, CCFP, FCFP) will now signify that the family physicians who hold them have reached another plateau in their commitment to lifelong learning.

Medical regulatory bodies, health authorities, and hospitals in Canada and around the world are now considering increasing the requirements for renewal of licenses and privileges. Physicians are being asked to provide evidence of carrying out high-quality practice (audits) and of their ongoing commitment to lifelong learning. The CFPC is prepared to be the voice of family medicine in these deliberations, ensuring that standards and requirements being developed for revalidation of licenses and privileges for family physicians are appropriate and offering our CME/CPD experience and programs as equivalents that should be fully recognized by these other bodies. We hope this will help reduce anxiety, duplication of effort, and costs for our family physician members.

2.5.4 Strategies for transferring new evidence-based knowledge into practice

Family physicians are the entry point to medical care for most Canadians and are also on the front line for ensuring new discoveries become part of patient care. Research often results in knowledge that greatly affects how diseases are prevented and treated, what services are delivered, and how these services are delivered (eg, vaccines, diagnostics, screening methods, and pharmaceuticals). Added to this are the enormous opportunities arising from developments in minimally invasive and robotic interventions and in ICT. With each new advance in medical science, the science of family medicine grows and matures, and ultimately, patients benefit. Without family physicians, patients' ability to understand new approaches and advances in medicine is severely impeded. Without family physicians to triage and determine whether, when, and how new technologies should be used, costs in the health care system could become unmanageable.

One of the most exciting emerging fields in medicine is genomics. As Dr Henry Friesen, Head of Genomics Canada and a CFPC honorary member, has reminded us, discoveries in the field of genomics will have a huge effect on delivery of health care and require family physicians to play a critical role in helping patients understand the world unfolding before them. Genetic information is already being used to screen those in families affected by heritable diseases (eg, Huntington's disease and breast and colon cancer). Within the next decade, it is highly likely that genetic information will be used to help prevent illness, to fine-tune diagnoses, and to tailor treatments to individuals. One area where genetics research might soon be applied on a regular basis is in "pharmacogenomics," where family history and genetic profiling could help determine which drugs will help or harm which patients. Family physicians' unique knowledge of patients and their family histories will play a key role. Dr Francis Collins, Director of the National (US) Institute of Health's Human Genome Research Institute, has said, "Translation of genomic advances into

improved clinical outcomes can only occur if family physicians are well informed.”⁸⁵ Advances in this area of science are enormous and must be incorporated into family physicians’ practice. It is crucial that family doctors, including today’s students and residents, who will be the family physicians of tomorrow, understand that it is in their practices with their patients that many of the most exciting discoveries in medical science will be brought to life.

The intensified focus on patient safety in Canada as well as the United States, United Kingdom, and Australia, will also lead to changes in practice. We hope this will unfold in a climate focused on system rather than on individual responsibility and on improving quality of care and outcomes rather than searching out blame or concentrating on litigation. The 2003 First Ministers’ Accord on Health Care Renewal committed the Health Ministers to take leadership in implementing the recommendations of the new National Steering Committee on Patient Safety,⁸⁶ including establishment of the Canadian Patient Safety Institute (CPSI). This work will likely lead to implementation of new practices, technologies, and programs across the health care system and will definitely require ongoing leadership from organized family medicine and educating family physicians, specialists, and other health professionals in Canada. If this initiative unfolds as it appears it will, family doctors will play a critical role in providing and using the information that will help their patients navigate through the health care system with less chance of adverse outcomes.

Section 2.2.3 highlighted the key role in public health that family physicians must play as we head into the future. Knowledge gained from surveillance, research, and new advances related to ever-changing and some as-yet-unknown public health challenges must be readily available to family physicians so they can incorporate it into their practices and share it with their patients. The field of public and population health is emerging as one of the most vitally important areas in medicine. The opportunity and need for family doctors to play a part in regional and national surveillance, prevention, and treatment networks is immense.

New developments in the delivery of health services (new models of care, PCR strategies) were described in section 2.4. These initiatives provide “living laboratories” for testing new approaches and evaluating their effect on dimensions such as health outcomes, patient and provider satisfaction, and cost-effectiveness. Family doctors will be front and center as both researchers and subjects of these ongoing studies. Reaping the full value of knowledge gained from these initiatives requires strategies for communicating the knowledge and encouraging adoption and implementation into practice those approaches proven most effective.

The CFPC is positioned and willing to play a lead role in transfer of knowledge, establishment of standards, and ongoing research essential to the future of family practice and primary care in communities across Canada. Family physicians’ advanced knowledge and skills, combined with their ongoing relationships with their patients, will place them in the forefront of this laboratory studying Canada’s health care system of the 21st century.

⁸⁵ Francis Collins in a keynote address to a joint meeting of WONCA and the American Academy of Family Physicians, Oct 14, 2004, and quoted in the AAFP’s *F P Report*, Oct 15, 2004.

⁸⁶ Building a Safer System, September 2002: National Steering Committee on Patient Safety.

3 RECOMMENDATIONS: PROMOTING ACCESS TO CARE FOR CANADIANS

“Access to timely care across Canada is our biggest concern and a national priority.”⁸⁷ Access includes several dimensions. One of the most critical at this time is the need for more health human resources. Given their importance, recommendations related to human resources are covered in a separate section (section 4) devoted to family physician supply. Section 3 includes recommendations on other important dimensions of access, such as tracking wait times, organizing and supporting delivery of the full continuum of medical care, and addressing the needs of underserved populations.

3.1 Measure wait times from patients’ perspective (ie, when symptoms are first experienced)

- 3.1.1 Wait time studies and guidelines should be patient centred.
- 3.1.2 Wait times should be defined from when patients experience a problem and attempt to seek care through being seen by family physicians, through specialist consultation and specialty interventions, until definitive care is carried out.
- 3.1.3 Wait time standards, benchmarks, and targets should be established for conditions beyond the five areas identified in the September 2004 First Ministers’ Accord.
- 3.1.4 Guidelines should be developed in Canada to help patients better understand wait times that are acceptable and safe for their medical problems.
- 3.1.5 Policies addressing the accountability of all players in the system, including governments, should be in place to assure Canadians that their serious medical problems will be attended to within acceptable and safe periods.

3.2 Provide support for delivery of personal, comprehensive, continuing care in many settings

- 3.2.1 Every Canadian should have the opportunity to have a family physician of his or her own.
- 3.2.2 Personal, comprehensive, continuing care provided by family physicians practising in or linked to groups, networks, or teams should be the cornerstone of family practice.
- 3.2.3 Definitions of “comprehensive” and “continuity” in family medicine should evolve to include the roles of individual family physicians, groups and teams of family doctors and other health professionals, and information with patients at the centre.
- 3.2.4 The PCCCAR list of primary care mandatory functions should serve as a guide for defining the core services provided by family practice (see section 2.2 for list).
- 3.2.5 Individual family physicians may, but should not be expected to, provide full core family practice services on their own. Those in solo or small-group practices should be encouraged and supported to work with other family physicians when and where possible to help provide services and to share after-hours coverage.
- 3.2.6 Family physicians and family practice groups, networks, and teams that offer personal,

⁸⁷ “A 10-year plan to strengthen health care.” Office of the Prime Minister. News release, Sept 16, 2004

comprehensive, continuing care and full family practice services to their patients are highly valued by Canadians and should receive strong support from the health care system, including remuneration incentives for provision of these services.

- 3.2.7 Family practice groups, networks, and teams being introduced across Canada should:
- encourage and support participation by physicians, patients, and other health professionals through voluntary rather than mandated approaches;
 - identify family physicians as the entry point to medical care and main providers and coordinators of medical care for each patient;
 - offer personal, comprehensive, continuing care for patients and families throughout their lives;
 - deliver the spectrum of primary health care services to patients through interdisciplinary integrated care teams;
 - ensure response to the needs of patients with full primary care and family medicine services 24 hours a day, 7 days a week, 365 days a year;
 - be supported to incorporate information technology systems, including electronic health records, as part of each practice; and
 - encourage and support all health professionals in the team in their CME/CPD.
- 3.2.8 To help ensure patients' access to core primary care and family medicine services and other medical services needed in particular communities, family physicians with added skills or focused practices should be included as part of family practice groups, networks, and teams.
- 3.2.9 Remunerative incentives should be introduced in every province and territory for provision of comprehensive care by family physicians and family practice groups, networks and teams.
- 3.2.10 Secure and reliable access to electronic health records and communication links between family physicians, specialists, other health care providers, pharmacies, hospitals, laboratories, and other diagnostic services must continue to be developed.
- 3.2.11 Family physicians and practice groups, networks, and teams should be funded to include electronic information and communication systems, nurses and nurse practitioners, and other appropriate health professionals as required in their practices.
- 3.2.12 The International Classification of Primary Care (ICPC-2) should be adopted in Canada as the standard for classification and coding of data for family practice and primary care.

Family physicians in hospitals

- 3.2.13 The role of family doctors in all hospitals should be encouraged and strongly supported.
- 3.2.14 All hospitals should:
- understand and recognize the importance of the role of family doctors as the link between the community and the hospital;
 - support the highly valued role family physicians play in caring for their patients, including their role when their patients are hospitalized;

- implement appropriate privileging criteria for family physicians; and
 - provide family physicians with timely notification of their patients' hospital admissions, progress, and discharge.
- 3.2.15 Family physicians should organize themselves into networks or groups to share the responsibilities and workload of managing hospital patients.
- 3.2.16 Family physicians who choose to work as hospitalists should be encouraged to maintain practices in the community and to work as hospitalists as part of their overall professional commitment.
- 3.2.17 Appropriate remuneration incentives for all hospital responsibilities should be available to family physicians to support their ongoing involvement in inpatient hospital care.
- 3.2.18 Hospital accreditation standards should include the requirement for every hospital to have appropriate privileges and opportunities for meaningful patient care and other hospital roles for family physicians who practise in the community served by that hospital.

Family physicians in home care

- 3.2.19 Family physicians should be recognized as key players on teams providing home care services.
- 3.2.20 Family physicians should be responsible for overseeing and monitoring the medical aspects of home care for their patients.
- 3.2.21 Inadequate remuneration, administrative workload, and lack of system support to integrate family physicians into care teams need to be removed as barriers to family physicians' involvement in home care.
- 3.2.22 Communication among health professionals and caregivers involved in providing home care services must include patients' family physicians.
- 3.2.23 Home care programs should include insured coverage of prescription medications and other acute medical services, treatments, and devices that are required to avoid or substitute for hospital care.

3.3 Integrate and support family physicians in public health and health promotion strategies

- 3.3.1 Family physicians should be recognized and provided with the education and practice support needed to enable them to be an integral part of Canada's public health system.
- 3.3.2 Governments, public health systems, medical schools, and professional colleges should support undergraduate and postgraduate education, training, and CME/CPD for family physicians in areas related to their potential public health roles.
- 3.3.3 Public health officials and hospitals should communicate and collaborate with family physicians to manage population-based public health crises and emergencies.

- 3.3.4 Community family practices must be provided with the resources, including funding, support staff, information and materials (supplies), needed to carry out their role in community public health crises and emergencies.
- 3.3.5 Electronic records to aid surveillance, monitoring, reporting, research, and quality control should be developed and implemented to link networks of community-based family physicians to public health officials.

3.4 Support strategies to promote access to care for underserved populations

- 3.4.1 Medical schools should modify admission criteria to encourage more successful applicants from Aboriginal, rural, remote, and other underserved communities.
- 3.4.2 Governments, medical schools, and health professional organizations, including the CFPC, should support implementation of the federal/provincial/territorial Aboriginal Health Human Resources Initiative announced in September 2004.
- 3.4.3 Medical schools and departments of family medicine should ensure the education and training of sufficient numbers of family doctors to provide care to Aboriginal people, with a special focus on training family doctors who come from Aboriginal families and communities.
- 3.4.4 Medical schools and departments of family medicine should provide better role models for medical students and residents of physicians and practices serving remote, rural, inner-city, elderly, Aboriginal, and other underserved populations.
- 3.4.5 Undergraduate, postgraduate, and continuing education programs should help increase the awareness and sensitivity of trainees and physicians of their own biases in order to provide more appropriate care to diverse populations.
- 3.4.6 The recommendations of the Working Group on Postgraduate Education for Rural Family Practice⁸⁸ should continue to be used to guide rural family medicine residency training programs across Canada.
- 3.4.7 Care of the elderly should continue to be a focus within the core 2-year family medicine curriculum for all residents and to be offered as a third-year opportunity for a defined number of physicians seeking added-skills training in this area.
- 3.4.8 Health professional organizations, including the CFPC, should encourage and support the education and practice needs of family physicians who themselves come from diverse and underserved populations.

3.5 Optimize access to specialty care

- 3.5.1 Primary care reform and renewal initiatives and strategies must include a focus on improving access for family physicians and their patients to specialists and specialty care.
- 3.5.2 Family physicians and specialists must work together to achieve optimal models of

⁸⁸ *Postgraduate Education for Rural Family Practice: Vision and Recommendations for the New Millennium*. Report of the Working Group on Postgraduate Education for Rural Family Practice, approved by the CFPC Board, May 12, 1999

medical care for all Canadians, ensuring a seamless referral and consultation process for patients in all communities.

- 3.5.3 Shared-care models involving family physicians and specialists, such as those being developed in the areas of mental health and chronic disease management, should be introduced in a broad cross-section of clinical areas.
- 3.5.4 A collaborative initiative led by the CFPC and the RCPSC should address the roles and relationships of family physicians (including family physicians with added skills and focused practices) and specialists in Canada.
- 3.5.5 The roles and relationships of family physicians and specialists should be role modeled as early as possible in undergraduate medical school curriculums so medical students will have appropriate exposure to both family physicians and specialists.
- 3.5.6 The roles and relationships of family physicians and specialists should be role modeled in both family medicine and specialty postgraduate programs so all residents will have exposure to both family physicians and specialists.
- 3.5.7 Integrated educational models involving family physicians, specialists, nurses, and other health care professionals should be supported at undergraduate and postgraduate levels in our medical schools.

4 RECOMMENDATIONS: ENSURING A SUSTAINABLE SUPPLY OF FAMILY PHYSICIANS AND OTHER HEALTH PROFESSIONALS

4.1 Plan for sufficient, sustainable family physician resources

- 4.1.1 To ensure a sustainable supply of health human resources, including family physicians, a national health human resource infrastructure should be established and be responsible for collecting data, monitoring, conducting research, reporting, and making recommendations related to Canada's ongoing health human resources needs.
- 4.1.2 Physician resource planning must ensure that there are adequate numbers of family physicians to provide both personal, comprehensive, continuing care and defined added-skills services for Canadians.
- 4.1.3 Health planners, in collaboration with our medical organizations, must define what is considered to be an appropriate, sustainable mix of Canadian and international medical graduates (IMGs) needed to meet the ongoing needs of Canadians, and plan medical school entry, residency training, and recruitment and retention programs accordingly.
- 4.1.4 Family physician resource planning must pay particular attention to the changing demographics (eg, age, sex) and practice patterns (eg, hours worked, scope of practice) of the medical profession.
- 4.1.5 The need for family physicians to have careers with reasonable working hours so they can balance their personal life needs (childbearing and rearing and caring for aging parents, themselves, and their families) with their professional responsibilities must become a priority in physician resource planning.

4.2 Fund sufficient medical school and postgraduate training positions

- 4.2.1 Ensure the number of medical school entry positions is appropriate to sustain Canada's contribution to our future physician supply. The changing demographics of Canada's physicians must be a prime consideration in planning future physician resources.
- 4.2.2 There should be 2500 medical school entry positions in Canada by 2008.
- 4.2.3 To allow for postgraduate training of both Canadian graduates and IMGs and accommodate re-entry positions, there must be 120 PGY-1 positions in Canadian medical schools for every 100 Canadian medical school graduates.⁸⁹
- 4.2.4 To meet their social responsibility to produce the numbers and proportions of both family physicians and specialists needed by Canadians,⁹⁰ medical schools must allocate a minimum of 45% of all PGY-1 positions across Canada to family medicine and encourage and support students to select these positions for residency training.
- 4.2.5 To meet the needs of Canadians in both rural and urban communities, there must be appropriate support and funding for the right number of 2-year family medicine and added and special skills third-year training positions.
- 4.2.6 The number of PGY-1 family medicine residency positions across Canada might need to be further increased to ensure graduation of appropriate numbers of both comprehensive, continuing care family doctors and family physicians who will be involved in added-skills and focused practices.

4.3 Provide adequate support for assessment and training of international medical graduates

- 4.3.1 An appropriate balance of Canadian graduates and IMGs (see 4.2.1) should be encouraged and supported as an ongoing part of Canada's physician resource planning.
- 4.3.2 To ensure high-quality safe care for all Canadians, all Canadian graduates and IMGs should be required to meet the same standards for licensure and certification.
- 4.3.3 All IMGs should be offered increased opportunities for assessment and, where needed, additional training to help them meet the standards required for licensure and Certification in Canada. Increased funding and resources will be needed to support both the IMGs and the physicians and programs carrying out assessment and training.
- 4.3.4 The CFPC should continue to work with IMGs to explore ways that the College can:
- be a home for IMGs, including those already in practice and those participating in assessment or training program;
 - advocate with and for IMGs for their issues of concern; and
 - facilitate the pathway for IMGs to achieve Certification in the CCFP.

⁸⁹ CFPC supports these recommendations of the CMF.

⁹⁰ *Social Accountability: A Vision for Medical Schools* (Health Canada: 2001) names medical schools as playing the key role in producing a well trained and appropriate mix of generalists and specialists. Since the early 1990s, Canada has been committed to a physician practice population that is 50% family physicians and 50% specialists. To maintain this will require at least 45% of all medical school graduates to enter family practice.

- 4.3.5 Canadian citizens who successfully complete their undergraduate training in accredited medical schools in other countries should not have unreasonable obstacles to accessing residency training or practice opportunities in Canada.

4.4 Eliminate impediments to choice of family practice as a medical career

4.4.1 Medical school tuition fees and remuneration disparity

- 4.4.1.1 To encourage and support students from all backgrounds to consider becoming physicians in Canada, medical school tuition fees must be kept at reasonable and affordable levels and medical students should be offered increased financial support programs.
- 4.4.1.2 To attract graduating medical students, many of whom are facing heavy debt loads, to family practice and to support family physicians already in practice, the growing income gap between family physicians and specialists must be addressed.
- 4.4.1.3 Encouragement, including remunerative incentives, must be given to family physicians and family practices providing comprehensive, continuing care family practice services to their patients.
- 4.4.1.4 Remunerative incentives must be provided to family physicians offering the following needed services: hospital inpatient care, emergency department services, palliative care, mental health services, elderly care, obstetric care, and surgical and anesthesia services in smaller communities.

4.4.2 Medical school admission policies

- 4.4.2.1 Medical school admission policies must ensure that the attributes prioritized in the selection of medical students should be balanced appropriately between those associated with producing future rural or urban family physicians and those associated with producing RCPSC specialists (see also 4.4.1.1 tuition fees).

4.4.3 Early career decision-making and flexibility in choice of residency program

- 4.4.3.1 To address the issues of early career decision-making and flexibility in residency training, a range of issues must be considered, including medical school admission policies (see 4.4.2), undergraduate curriculums, medical student counseling, timing of the CCaRMS match, flexibility of transfer during residency (including both recognition and credit for training already completed and funding to support resident transfers⁹¹), re-entry opportunities, and careers supports.
- 4.4.3.2 The CFPC and the RCPSC should continue to explore ways to recognize and give increased credit to residents who have completed training in one another's postgraduate programs and are seeking transfer.
- 4.4.3.3 Recognition and credit given to residents toward completion of family medicine residency should be based on meeting educational and experiential objectives and not

⁹¹ An example is the Quebec training card system where funding follows residents to the end of residency even if they transfer from a shorter to a longer program.

just on time spent in particular training programs.

4.4.4 Perception of family medicine in undergraduate and postgraduate training

- 4.4.4.1 Family medicine must be identified as a distinct and respected discipline equal to all specialties in Canadian medical schools.
- 4.4.4.2 Family medicine and family physicians should play a leading role in undergraduate and postgraduate teaching related to general medicine. At the postgraduate level, this should include more involvement in teaching and training RCPSC specialty residents.
- 4.4.4.3 Negative messaging to medical students about careers in family medicine or any other discipline is inappropriate and unethical and must be strongly discouraged by all medical schools and professional organizations.
- 4.4.4.4 All teaching modules, case scenarios, and other methods used in the undergraduate curriculums of our medical schools must be reviewed, and when necessary, rewritten to ensure that they are not denigrating the role of family physicians or any other health professionals.
- 4.4.4.5 The Medical Council of Canada (MCC) should provide:
- medical students with study guidelines and objectives for family medicine in preparation for their MCC Part 1 examination, and
 - medical schools with reports on each student’s performance in family medicine as part of his or her results of the MCC Part 1 examination.
- 4.4.4.6 Every medical student should have his or her own family physician to provide ongoing health care and potentially serve as a role model for family medicine.

5 RECOMMENDATIONS: EDUCATING AND TRAINING OUR FAMILY PHYSICIANS

The previous section set out recommendations to ensure an appropriate supply of family physicians, including recommendations related to medical education and training. This section focuses on additional medical school undergraduate and postgraduate curriculums and faculty development issues.

5.1 Ensure an appropriate role for family medicine in undergraduate medical education⁹²

- 5.1.1 A National Task Force on the role of family medicine in undergraduate curriculums should be established to study and recommend changes to these curriculums that will ensure an increased role for family medicine and family physicians.
- 5.1.2 The undergraduate curriculum review should consider the recommendations of the CFPC’s Working Group on Undergraduate Education, including:
- integration and incorporation of the CanMeds role in defining the roles of

⁹² Recommendations in this section are primarily drawn from the report of the CFPC Working Group on Undergraduate Education, with additional recommendations based on follow-up discussion within the CFPC.

specialists and the Four Principles of Family Medicine that guide family physicians' practice;

- an experience in family medicine in the first year and each year of the curriculum thereafter;
- a longitudinal experience in family medicine during the preclerkship years; and
- a clerkship in family medicine that:
 - is based on a national vision,
 - follows core objectives set nationally, and
 - provides for community-based experiences (both rural and urban community-based sites should be considered).

5.1.3 Departments of family medicine at each medical school should play a central role in defining and teaching the knowledge, skills, attitudes, and values graduating medical students should have in the following areas.

- Front-line diagnosis, treatment, and management of illness and injury for patients of all ages
- Integration and application of basic medical knowledge to patient care
- Integration and application of clinical science knowledge in the context of the whole patient
- Clinical reasoning skills that integrate evidence with patient values
- Acknowledgment of the centrality of the doctor-patient relationship
- The context of illness, particularly the role of family and the community
- Health promotion and illness prevention
- Continuity of care
- Health care team development and leadership skills
- Communication skills
- Role of healing
- Attributes of professionalism
- Outpatient and ambulatory learning environments

5.1.4 The CFPC should work with accreditors of medical schools (Committee on Accreditation of Canadian Medical Schools and Liaison Committee on Medical Education) and hospitals and health care facilities (Canadian Council on Health Services Accreditation) to ensure accreditation standards include:

- the need for family medicine experiences throughout the curriculum to ensure that core competencies have been attained,
- the availability of community-based experiences,
- adequate support for undergraduate teachers,
- the requirement that family medicine faculty serve on key curriculum committees, and
- the requirement that all hospitals used as sites for medical student and resident training include meaningful patient care and other roles for family physicians.

5.2 Reinforce a standardized core curriculum for urban and rural postgraduate training in family medicine

- 5.2.1 The accreditation standards of all family medicine postgraduate programs across Canada should be reviewed to ensure a standardized “core” curriculum.
- 5.2.2 The PCCCAR list of mandatory functions (see section 2.2) should serve as a guide to defining the core family medicine residency curriculum.
- 5.2.3 Maternity care (including intrapartum obstetrics), emergency medicine, palliative care, mental health care, and care of the elderly should be part of the core curriculum of each family medicine residency program for all residents and should also be offered among the third-year added skills programs for a defined numbers of trainees.
- 5.2.4 All family medicine residents should be assured of having appropriate opportunities to access family medicine residency experiences in each of the areas defined as part of the core curriculum.
- 5.2.5 Rural family medicine residency programs should follow curriculum guidelines recommended by the Working Group on Postgraduate Education for Rural Practice.⁹³ All family medicine residents should have an opportunity to select training experiences in rural practices and communities as part of their 2-year family medicine programs.
- 5.2.6 Enhanced standardized in-training evaluation of performance, including evaluation of a defined menu of procedural skills, should be carried out for all residents .
- 5.2.7 Two-year family medicine residency training programs, with appropriate numbers of positions to accommodate added and special skills training for some graduates within or beyond the 2 years, should, for the time being, remain the training model for preparing family physicians to meet the needs of the people of Canada.
- 5.2.8 Three-year family medicine residency programs, such as those being pilot tested in Quebec, should be further studied and explored.
- 5.2.9 Only family medicine-friendly hospitals and health care facilities with family physicians actively involved in patient care should be considered as sites for family medicine residency training.
- 5.2.10 Integrated practice models involving family physicians, other specialists, and other health care professionals should be introduced into Canadian medical school undergraduate and postgraduate training.
- 5.2.11 Specialty residents should be required to complete a minimum of 2 months in a family medicine setting as part of their postgraduate training requirement.

5.3 Strengthen support for departments of family medicine in medical schools

- 5.3.1 Departments of family medicine must have the support and resources to recruit and retain family medicine preceptors, teachers, and researchers in both their university-based academic units and community settings to provide both undergraduate and

⁹³*Postgraduate Education for Rural Family Practice: Vision and Recommendations for the New Millennium*. Report of the Working Group on Postgraduate Education for Rural Family Practice, approved by the CFPC Board, May 12, 1999

postgraduate teaching and role modeling.

5.3.2 Each department of family medicine should undertake to:

- define criteria for selection of undergraduate teachers in family medicine;
- participate in the design and presentation of faculty development programs for undergraduate teachers in family medicine;
- work with the dean's office to develop innovative and effective programs to assist in recruitment and retention of community-based teachers in family medicine,
- ensure that adequate support is available for undergraduate family medicine teachers, and
- encourage research, presentations, and publications by undergraduate family medicine faculty members and students.

5.3.3 Medical schools should encourage and support family physician teachers and researchers for faculty appointments, promotions, and increased responsibilities in undergraduate and postgraduate teaching and research.

5.3.4 Family medicine faculty should be provided with increased remuneration and other resources to support the growing demands on them as teachers of increased numbers of Canadian medical students, IMGs, residents in added-skills programs, other health professionals, and physicians in re-entry training programs.

6 RECOMMENDATIONS: PROMOTING INNOVATION AND QUALITY IN FAMILY MEDICINE

This set of recommendations focuses on what is needed to discover and incorporate new knowledge about medicine and health service delivery into day-to-day family practice. They focus on defining the increased importance of family doctors as skilled physicians, teachers, and researchers involved in continuing relationships with patients who are, therefore, the health professionals best-positioned to help patients understand and access new medical breakthroughs and emerging technologies. The growing need to combine the art and science of medicine will see family doctors in the forefront of Canada's future health care system.

6.1 Support innovation and quality in the discipline through family medicine research

6.1.1 The discipline of family medicine must be strongly supported by family medicine research. Family medicine research must be provided with the funding and other resources needed to:

- help build its research capacity; and
- support family medicine researchers from novices to the most experienced to lead and participate in research in areas including population health, health service delivery, and community-based care, all of which have been traditionally undersupported.

6.1.2 Family medicine departments should work toward developing an accredited third-year

family medicine residency program in enhanced skills training in family medicine research.

6.1.3 The Canadian Institutes of Health Research (CIHR) should support:

- research training fellowships in family medicine,
- a family physician scientist program, and
- a CIHR special advisor on family medicine research.

6.1.4 The CFPC should advocate at a national level for greater visibility and opportunities for family medicine researchers and research with national grant panels and granting agencies, play a coordinating role in disseminating information about research opportunities, and facilitate networking among family medicine researchers and the Canadian health research community.

6.2 Facilitate transfer of knowledge and incorporation of new skills and practices among family physicians

6.2.1 Strategies must be developed to facilitate adoption and incorporation into practice of evidence-based innovation, initiatives, and new discoveries in medicine.

6.2.2 Such strategies must:

- recognize the effects on those who will be most affected by it,
- be developed in partnership with those most affected,
- offer choice, and
- provide support to successfully manage the transition.

6.2.3 The discipline of family medicine and family physicians should play a lead role in helping patients understand and access emerging technologies and advances in medicine, such as genomics, robotics, minimally invasive interventions, innovations in public and population health, and use of e-health records and information.

6.2.4 Family physicians should play a lead role in introducing and using electronic health records in the Canadian health care system.

6.2.5 Family physicians should continue to support the unfolding patient safety activity in Canada, providing and using information to help patients navigate the Canadian health care system with fewer adverse outcomes.

6.2.6 Family physicians should be appointed to leadership roles on the board and committees of the Canadian Patient Safety Institute.

6.2.7 The patient safety program should focus on both institutional and community care.

6.2.8 Patient safety activities must be introduced in an environment that shifts from a culture of blame to one of constructive feedback and continuous quality improvement, and from focus on individuals to the system as a whole.

6.3 Support commitment to lifelong learning through enhanced continuing medical education and continuing professional development, certification, and Fellowship programs

- 6.3.1 Family physicians should maintain a lifelong commitment to continuing medical education and continuing professional development (CME/CPD).
- 6.3.2 The CFPC should continue its role as a national and international leader in CME and in establishing accreditation standards for family physicians' CME/CPD programs.
- 6.3.3 The CFPC should carry out and publish research related to the effectiveness of various CME/CPD strategies, including the effect of CME/CPD on competence and performance in practice.
- 6.3.4 The CFPC should continue to work with others in development of CME/CPD programs, including collaboration with provincial and territorial regulatory and licensing authorities as they develop requirements for CME/CPD as part of their physician assessment and maintenance or revalidation of licensure programs.
- 6.3.5 Family physicians who meet the CFPC's CME/CPD requirements should be recognized by the regulatory and licensing authorities as having met their CME/CPD requirements.
- 6.3.6 The CFPC's CME/CPD programs should be accessible to all family physicians in Canada in order for them to address their learning needs, including needs identified for them through the assessment programs of provincial and territorial regulatory and licensing authorities.
- 6.3.7 Mainpro, the CFPC's CME/CPD program, should continue to evolve to ensure that it meets the changing needs of family physicians across Canada, including those with focused practices.
- 6.3.8 Mainpro-C, which is focused on practice-related, evidence-based reflective learning, should continue to be promoted as a model learning strategy for family doctors and as a core requirement for earning, being awarded, and maintaining Fellowship in Family Medicine in Canada.
- 6.3.9 Mainpro should be introduced to family medicine residents during postgraduate training.
- 6.3.10 E-learning opportunities should be increased for all family physicians and accredited as part of CFPC's Mainpro program.

7 RECOMMENDATIONS: UNDERSTANDING AND PROMOTING THE VALUE OF FAMILY PHYSICIANS

The recommendations made thus far address the inherent value of family physicians and the discipline of family medicine for patients, family doctors, other physicians and health professionals, medical schools, other health and medical organizations, governments, policy-makers, funding bodies, and society at large. To achieve the desired end—sustainable access to high quality, person-centered, comprehensive, continuing care by family physicians as a key part of the foundation of Canada's health care system—this value must be communicated more explicitly.

7.1 Raise awareness of the role and value of family physicians with all publics

- 7.1.1 What family doctors and family practices do and what the discipline of family medicine teaches and researches need to be better communicated to all publics in Canada.
- 7.1.2 Governments, health planners, medical schools, and other health professional organizations should be made aware of studies that confirm how highly the people of Canada value the role of family doctors.
- 7.1.3 There should be dialogue with medical schools, health planners, patients, and our RCPSC specialist colleagues to reinforce the importance and value of having strong teams of both family physicians and specialists across Canada so that they can not only work together cohesively but also can focus their time and energy appropriately on their areas of expertise. All of this is in patients' best interests.
- 7.1.4 The CFPC's Principles of Family Medicine (including the centrality of the patient-doctor relationship) should be promoted and better understood by family physicians, medical students, medical educators, other health professionals, and all other publics in Canada.
- 7.1.5 The special skills and competencies in the discipline of family medicine that members, Certificants, and Fellows of the CFPC have demonstrated should be promoted so that they will be better understood and more highly valued by medical schools, fee negotiators, governments, other health care professionals, and the public across Canada.
- 7.1.6 Special designations in family medicine, such as Certification (CCFP) and Fellowship (FCFP) in the CFPC, should be recognized and more highly valued by all publics in Canada. These designations reflect demonstration by their holders of special competence in, and ongoing commitment to, the discipline of family medicine and are achieved and awarded according to criteria similar to certification and fellowship in other disciplines in Canada and around the world. Communication and promotion strategies needed to achieve this must be further explored.

8 CONCLUSION

Family Medicine in Canada—Vision for the Future outlines the major contributions made by family physicians in Canada and reminds us how highly Canadians value the care of their family doctors. It emphasizes how our system has ignored the value of its family physicians for far too long. This has resulted in a family doctor workforce no longer able to provide the kind of care and services it wants to and was trained to provide. This paper focuses on the obvious link between the family doctor shortage and the severe access-to-care and wait-time crises unfolding for the people of Canada. It highlights the challenge of trying to rejuvenate what should be one of the most rewarding and joyful careers so that family doctors will once again feel that their role is meaningful and appreciated, and greater numbers of medical school graduates will once again select family medicine as their preferred medical specialty.

The future of health care in Canada can and should include family doctors filling traditional roles as front-line providers of personal, comprehensive, continuing care for millions of Canadians. This includes playing a key role in meeting the health care needs of underserved populations, such as the elderly and those in remote or Aboriginal communities. It should also see family physicians

playing lead roles in renewed and well supported models of practice delivering medical and health care services to our population through strategies involving all health professionals—family doctors, specialists, nurses, and others. It also envisions family physicians as skilled and knowledgeable medical leaders bringing the innovations of medical science to patients, playing a key role in ensuring that emerging technologies and scientific breakthroughs are properly researched, taught, and then implemented. It will be those highly trained family physicians who have ongoing and trusting relationships with their patients who are most likely to make this happen. Public health, patient safety, genomics, minimally invasive interventions, and e-health records and information are but a few of the areas that will depend on family medicine and family doctors for their success.

The recommendations in this Vision paper are aimed at trying to find solutions to improve access to care for all Canadians and restore family medicine and family doctors to their appropriate place in our health care system, a place Canadians see as highly valued and indispensable. This will not happen, however, without greatly increased understanding and support from many other key players in the Canadian health and medical educational systems. The CFPC and its family physician members look forward to working with governments, medical schools, hospitals, specialists, other health professionals, and citizens from coast to coast to coast to find the answers needed to create a secure future for family medicine, family physicians, and the millions of Canadians who are their patients.

APPENDIX: ACRONYMS USED IN THIS PAPER

AAFP	American Academy of Family Physicians
CACMS/LCME	Committee on Accreditation of Canadian Medical Schools
CaRMS	Canadian Residency Matching Service
CCFP	Certification in the College of Family Physicians of Canada
CCHSA	Canadian Council on Health Services Accreditation
CFMS	Canadian Federation of Medical Students
CFPC	College of Family Physicians of Canada
CIHR	Canadian Institutes of Health Research
CMA	Canadian Medical Association
CME/CPD	Continuing medical education and continuing professional development
CMF	Canadian Medical Forum
CPSI	Canadian Patient Safety Institute
FCFP	Fellowship in the College of Family Physicians of Canada
FP	Family physician
HHR	Health human resource
ICPC-2	International Classification of Primary Care
ICT	Information and communications technology
IMG	International medical graduate
LCME	Liaison Committee on Medical Education
LMCC	Licentiate of the Medical Council of Canada
MCC	Medical Council of Canada
MCFP	Member, College of Family Physicians of Canada
NFPWS	National Family Physician Workforce Survey
NPS	National Physician Survey
PCCCAR	Provincial Coordinating Committee on Community and Academic Health Science Centre Relations
PCR	Primary care reform/renewal
PGY-1	Postgraduate Year 1 (first year of residency program)
R3	Third year of added/special skills training in following 2-year family medicine residency program
RCPSC	Royal College of Physicians and Surgeons of Canada, or “Royal College”
SRPC	Society of Rural Physicians of Canada
WHO	World Health Organization
WONCA	World Organization of Family Doctors

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