Ending the generational blame game

Let us move forward with needed primary care change

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Changes in practice patterns and, in particular, declining comprehensiveness among family physicians have been topics of study and concern for decades. While there is no criterion standard definition of *comprehensiveness* when it comes to primary care, its intended meaning usually includes aspects of care in multiple settings, across numerous domains, and for patients at all stages of life. Our recent research shows that declines in visit volume and comprehensiveness of care over the past 25 years are not driven by early-career physicians' practice choices.[1,2] Changes in comprehensiveness have occurred across years in practice, sex or gender, urban or rural practice location, and Canadian or international medical training. On average, the number of service settings and areas dropped most among physicians who are male and who had been in practice 20 years or longer, not among early-career physicians as prevalent narratives sometimes suggest.

Over this same period, primary care became markedly more complex, as guidelines proliferated and as family physicians began seeing more patients with complex and intersecting health and social care needs.[3-6] Family physicians at all career stages are struggling with relentless administrative workloads and inefficient payment and practice models rooted in bygone eras of primary care. While there are many examples of alternative ways of structuring and supporting the work of family physicians,[7-9] the truth is the choices of most family doctors in Canada are constrained by outdated payment and practice models that do not support the current realities of providing comprehensive care. As team-based care evolves, it is possible that comprehensiveness could be bolstered through different contributions of team members, but this has yet to be realized fully across Canada.[10]

Changing demands of family medicine

Declining comprehensiveness across all physician cohorts and strata suggests these changes are driven by health system policy and practice contexts in which all family physicians work, rather than by the adequacy of training or individual-level choices of physicians early in their careers. Health system policy and practice contexts are themselves changing. Family physicians are responding to system needs by taking on roles as hospitalists or practising in specific clinical areas such as mental health, palliative care, and long-term care. Family physicians have stepped up to manage public health emergencies, acquiring the skills needed to care for people who engage in substance use in the context of a toxic drug supply and to rapidly adapt to and manage the ongoing impacts of the COVID-19 pandemic.

With this understanding of the widespread changes in the demands facing family physicians and the lack of corresponding changes in the structures and systems to support providers, it should not be a surprise that declines in comprehensiveness are observed for physicians at all career stages, not just (or even mainly) among those newly entering practice. This reality, however, is inconsistent with the narrative of declining comprehensiveness among early-career physicians. There is a history of pointing to generational change as negatively affecting the direction of family medicine,[11-15] including in articles published in this journal.[11,12] It has also more recently surfaced as part of the rationale for postgraduate training reform. In January 2022, the College of Family Physicians of Canada released the final report of its Outcomes of Training project,[16] in which the College revealed plans to add 1 year of training to existing 2-year family medicine residency programs. The College points to the fact that "family physicians today are not practising as comprehensively as physicians were 10 years ago" and notes a lack of confidence and preparedness among early-career physicians as one of multiple reasons underpinning the need for educational reform.

Systemic change needed

We recognize that there are diverse reasons for the planned extension of residency training, including the changing complexity of family medicine and alignment with the duration of residency programs in other jurisdictions. However, in explaining the rationale and outlining the aim, declining comprehensiveness is a central theme in the College's report. Attributing changes in comprehensiveness to the preparation and choices of early-career physicians places blame on these physicians and, by extension, those who taught (and teach) them. The idea that residents must be trained differently and socialized to provide full-service care anywhere in Canada loads responsibility on individual physicians rather than on the health care systems within which they operate.

The College's report opened with a familiar quotation from Dr Ian McWhinney: "If we [family physicians] are to fill our place, it is crucial that our commitment be unconditional; patients should feel confident that they will never be told 'This is not my field.' "[16]

In the context of education reform, this statement implies that there should be no limits on family physicians' level of commitment to the profession and that a clinical knowledge gap, or at least a confidence gap, currently exists that needs to be corrected.[17,18] This can be interpreted as meaning that those whose commitment or confidence is not unconditional are falling short, and educational reform is needed to enhance social accountability among trainees or to instill in them a greater commitment to the delivery of comprehensive primary care. While there are other arguments for expanding family medicine residency to 3 years, training residents to be more committed and confident in providing comprehensive care within health care systems that do not support comprehensiveness will not address current challenges with respect to accessibility of comprehensive primary care in Canada.[19,20]

We are, of course, not alone in questioning expectations placed on family physicians with respect to delivering comprehensive care. In 2019 Doctors Nova Scotia and the Nova Scotia College of Family Physicians published a position paper in which they clearly distinguish individual physician practice from the full potential scope of family medicine.[21] A 2021 research report published by Doctors Nova Scotia[22] strongly endorsed the importance of collaborative and community-adaptive care:

> The family medicine practice of the future cannot continue to position family physicians as the sole point of support for all matters of health. Comprehensive care must be understood in the context of the social determinants of health, and patient health outcomes as a measure of primary care performance should be understood within the Senn et al. framework, where patient needs impact upon all other facets of the primary care system. Family medicine practices must be equipped to address these needs, family physicians must be remunerated for their work, and Nova Scotia must prioritize health equity by addressing social determinants of health.

Calls for system reforms that change models of practice are also long-standing. For example, in 2015 the Canadian Federation of Medical Students published an update of a 2005 report in which it clearly advocated for new graduates to have opportunities to practise in team-based family medicine models.[23] It also called for "evidence-based government reforms in health human resources planning and primary care job creation that adequately address the known determinants of physician recruitment and retention." In a 2020 BC Family Doctors report, "Reimagining family medicine,"[24] the authors called for humanization of the health care system, including the conditions in which they work:

> We need to humanize the system. Right now, the expectations are that we can do everything, that our time is not our own. That it's okay for us to work ridiculous hours. That we're X-Men. We need to put our own humanity as a first priority. We need to meet our foundational needs. Work reasonable hours. No busy work. Have a team and resources to support our work. Be respected, not exploited. Fair remuneration with reasonable contracts or different payment models.

With family doctors working so hard and feeling undervalued by other medical specialists, governance and regulatory bodies, academic institutions, and even patients, messaging around the rationale for educational reforms and the need for "unconditional" commitment risks dealing them another blow. While the discipline of family medicine may have an unconditional commitment to patients, this must be the shared responsibility of family physicians working within supportive teams and systems, not an individual burden that is boundless and unattainable. The narrative that early-career physicians are lacking knowledge, confidence, and social accountability, and therefore require more training, is inconsistent with existing data, unfair, and harmful. It is time to move past these distracting and inaccurate narratives and instead focus on systemic changes needed to make sure all patients can access comprehensive primary care.

Conclusion

Family physicians, like all physicians, have a responsibility to use their expertise and years of training in ways that meet the needs of patients and communities. For this work, family physicians deserve respect, fair compensation, and healthy, supportive work environments. Primary care is the backbone and heart of our health care system and is currently under enormous strain. Early-career family physicians stepping into their roles—at a time of crisis—are its future. Let us rethink generational blame, listen to what early-career physicians need, and advocate for the system-wide changes that will take care of them as they take care of Canadians.

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Competing interests
None declared

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