Rural generalists and quality of care

In the September 2024 issue of *Canadian Family Physician*, Correia et al look at family physicians who have Certificates of Added Competence (CACs) in care of the elderly.[1] Despite mentioning the roles comprehensive family physicians play in looking after the elderly, they say those who have CACs in care of the elderly "had evidence of additional scope to better support older adults."[1]

Does the evidence really support this? Is there evidence that full-scope rural generalists provide worse care to their patients? The best physicians are often able to see their patients through multiple different lenses, and caring for generations of a family provides a unique and valuable lens. While it is difficult to count the number of rural generalists, there are certainly more of us than there are people with CACs in northwestern Ontario.

As we continue to try to encourage learners to have a broad scope of care, let us celebrate and enumerate those who do just that. And let us look to the evidence before making assumptions about the ability to support our patients.

—*Sarah M. Giles MD CCFP*
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Competing interests
None declared

Reference

1. Correia RH, Frank C, Kirkwood D, Siu HYH, Jones A, Vanstone M, et al. Characteristics of family physicians with additional training or focused practices in caring for older adults. Population-based retrospective cohort study. *Can Fam Physician* 2024;70:559-69.

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Response

We thank Dr Sarah M. Giles for her response[1] to our article, "Characteristics of family physicians with additional training or focused practices in caring for older adults. Population-based retrospective cohort study," published in the September 2024 issue of *Canadian Family Physician*.[2]

In this population-based retrospective cohort study, we examined family physicians who practised in Ontario in 2019 and identified those with Certificates of Added Competence (CACs) in care of the elderly (CAC-COE) or a focused scope of practice in care of the elderly (FSP-COE) billing designation. We described and compared family physicians with and without a CAC-COE or FSP-COE on a number of provider- and practice-level characteristics.

We found family physicians with a CAC-COE or FSP-COE had practice differences, given that more CAC-COE and FSP-COE physicians billed for 1 or more clinical activities for patients aged 65 years or older, conducting complex house call assessments, completing home care applications, and completing long-term care health report forms; more CAC-COE and FSP-COE physicians practised in long-term care; CAC-COE and FSP-COE physicians made more referrals to geriatric medicine and psychiatry for patients aged 65 years or older; CAC-COE and FSP-COE physicians had significantly more encounters with patients aged 65 years or older; the average age of patients (both rostered and unrostered) was higher for CAC-COE and FSP-COE physicians; and greater proportions of CAC-COE and FSP-COE physician practice populations were composed of patients aged 65 years or older.[2]

In response to Dr Giles' concerns, we do not suggest full-scope generalists "provide worse care to their patients."[1] Our findings do not imply that better care is provided by CAC-COE and FSP-COE physicians; rather, they support that these physicians have practice differences that demonstrate increased care of older patients. As stated in our study, "Health human resource planning should consider the contributions of all [family physicians] who care for older adults, and enhancing geriatric competence across the family medicine workforce should be emphasized."[2]

We do not and it was not our objective to comment on the quality of care provided by CAC-COE and FSP-COE physicians versus full-scope generalists (although we do describe it as something that is unknown), including on the basis of rurality. This comparison would have required other methods to compare practice differences and, more importantly, to assess the impacts of having a CAC-COE or FSP-COE on patient outcomes.[3] We agree with Dr Giles that future work is needed to examine the impacts of these practice differences on measures of quality and that core family medicine training should focus on encouraging a broad and comprehensive scope of practice to serve our entire community.

We trust this clarifies our original statement and value this continued discourse.

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Competing interests
None declared

References

1. Giles SM. Rural generalists and quality of care [Letters]. *Can Fam Physician* 2024;70:683.
2. Correia RH, Frank C, Kirkwood D, Siu HYH, Jones A, Vanstone M, et al. Characteristics of family physicians with additional training or focused practices in caring for older adults. Population-based retrospective cohort study. *Can Fam Physician* 2024;70:559-69.
3. Stuart EA, Rubin DB. Best practices in quasi-experimental designs: matching methods for causal inference. In: Osborne J, editor. *Best practices in quantitative methods*. Thousand Oaks, CA: SAGE Publications Inc; 2008. p. 155-76.

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