Family physicians and health advocacy

Is it really a difficult fit?

Carrie Bernard MD MPH CCFP FCFP Sophie Soklaridis MA PhD Morag Paton MEd
Kenneth Fung MD MSc FRCPC Mark Fefergrad MD MEd FRCPC
Lisa Andermann MPhil MD FRCPC Andrew Johnson Genevieve Ferguson MA
Karl Iglar MD CCFP Cynthia R. Whitehead MD PhD CCFP

Abstract

Objective To examine whether family medicine residents and faculty members appreciate the full spectrum of health advocacy as described in articles published in *Canadian Family Physician* in 2016 and to identify the perceived challenges and enablers of advocating across the entire spectrum.

Design Analysis of a subset of data from a qualitative study using semistructured interviews and focus groups.

Setting University of Toronto in Ontario.

Participants A total of 9 family medicine faculty members and 6 family medicine residents.

Methods A subset of transcripts from a 2015 qualitative study that explored family medicine and psychiatry residents' and faculty members' understanding of the CanMEDS–Family Medicine health advocate role were reviewed, guided by interpretive descriptive methodology.

Main findings Results indicated that family medicine physicians and residents were able to identify the full spectrum of advocacy described in the *Canadian Family Physician* articles and that they valued the role. Further, there was widespread agreement that being a health advocate was linked with their identities as health professionals. The time it takes to be a health advocate was seen as a barrier to being effective in the role, and the work was seen as extremely challenging owing to system constraints. Participants also described a gap in training relating to advocacy at the system level as a challenge.

Conclusion Team-based care was seen as one of the most important enablers for becoming involved in the full spectrum of advocacy, as was time for personal reflection.

Editor's key points

- In 2016, *Canadian Family Physician* published 4 articles describing the need for family physicians to practise social accountability across the individual (micro), community (meso), and system (macro) levels. Although the authors encouraged family physicians to consider how they could become involved at all levels of this spectrum, they acknowledged that many physicians might feel most competent at the micro level and might find the higher levels to be a difficult fit.
- This study aimed to explore how family medicine residents and faculty members understand the breadth of the CanMEDS–Family Medicine health advocate role. The authors found that family physicians recognize the full spectrum of social accountability and feel that being an advocate is an important part of their clinical role.
- Time constraints and gaps in training are perceived barriers to advocating across the full spectrum, and participants emphasized that the risk of burnout was a concern. Team-based care might be the most important enabler for becoming involved in the full spectrum of advocacy and for helping to prevent burnout.

Points de repère du rédacteur

- En 2016, *Le Médecin de famille canadien* publiait 4 articles décrivant la nécessité pour les médecins de famille de pratiquer la responsabilité sociale à tous les niveaux, que ce soit sur les plans individuel (micro), communautaire (méso) ou systémique (macro). Même si les auteurs encourageaient les médecins de famille à envisager comment ils pourraient s'impliquer à tous les échelons de ce spectre, ils reconnaissaient que de nombreux médecins se sentaient plus compétents au niveau micro et pouvaient trouver plus difficile d'agir aux échelons plus élevés.
- Cette étude visait à explorer la façon dont les résidents et les membres du corps professoral en médecine familiale comprennent l'envergure du rôle de promoteur de la santé de CanMEDS-Médecine familiale. Les auteurs ont constaté que les médecins de famille reconnaissent toute l'ampleur de la responsabilité sociale et estiment que la promotion de la santé constitue une partie importante de leur rôle clinique.
- Ils perçoivent les contraintes de temps et les lacunes dans la formation comme des obstacles à la promotion de la santé dans l'ensemble du spectre, et les participants ont fait valoir que les risques d'épuisement professionnel étaient une source de préoccupation. Les soins en équipe pourraient être un facilitateur important d'une implication dans l'ensemble du spectre de la promotion de la santé et dans la prévention de l'épuisement professionnel.

Les médecins de famille et la promotion de la santé

Est-ce vraiment difficile à concilier?

Carrie Bernard MD MPH CCFP FCFP Sophie Soklaridis MA PhD
Morag Paton MEd Kenneth Fung MD MSc FRCPC Mark Fefergrad MD MEd FRCPC
Lisa Andermann MPhil MD FRCPC Andrew Johnson Genevieve Ferguson MA
Karl Iglar MD CCFP Cynthia R. Whitehead MD PhD CCFP

Résumé

Objectif Examiner si les résidents et les membres du corps professoral en médecine familiale apprécient le spectre complet de la promotion de la santé comme l'ont décrit les articles publiés dans *Le Médecin de famille canadien* en 2016, et cerner les perceptions quant aux obstacles et aux facilitateurs associés à la promotion de la santé dans l'ensemble du spectre.

Type d'étude Analyse d'un sous-ensemble de données tirées d'une étude qualitative au moyen d'entrevues semi-structurées et de groupes témoins.

Contexte Université de Toronto, en Ontario.

Participants Neuf membres du corps professoral et 6 résidents en médecine familiale.

Méthodes Un sous-ensemble de transcriptions provenant d'une étude qualitative en 2015 qui explorait la compréhension du rôle de promoteur de la santé de CanMEDS-Médecine familiale par des résidents et des membres du corps professoral en médecine familiale et en psychiatrie, suivant une méthodologie descriptive interprétative.

Principaux résultats Les résultats ont indiqué que les médecins et les résidents en médecine familiale étaient capables de cerner le spectre complet de la promotion de la santé comme l'ont décrit les articles du *Médecin de famille canadien,* et qu'ils valorisaient ce rôle. De plus, ils s'entendaient largement pour dire que la promotion de la santé était liée à leur identité en tant que professionnels de la santé. Le temps nécessaire pour promouvoir la santé était considéré comme un obstacle à l'efficacité dans l'exercice de ce rôle, et ce travail était considéré comme étant extrêmement difficile, compte tenu des contraintes de temps. Les participants ont aussi indiqué que les lacunes dans la formation concernant la promotion de la santé au niveau systémique représentaient un problème.

Conclusion Les soins en équipe étaient considérés comme l'un des plus importants facilitateurs de l'implication dans l'ensemble du spectre de la promotion de la santé, de même que le temps nécessaire à des réflexions personnelles.

As family medicine begins to embrace the idea of teams of professionals working together to provide comprehensive, coordinated, continuing care to their patients through the Patient's Medical Home, there might be greater opportunity for all family physicians to be a part of social advocacy across all levels of the spectrum.

In 2016, *Canadian Family Physician (CFP)* published 4 articles describing the need for family physicians to practise social accountability across the individual (micro), community (meso), and system (macro) levels.[1-4] In the articles the authors described a spectrum of advocacy activities that meet the goals of social accountability and they provided examples of how individual family physicians could become involved at each level of the spectrum. The series is positioned as a "call to action and a raising of awareness of our responsibility to our patients, communities, and society as a whole."[1] The authors' call to action is bold and decisive, having the potential to harness the collective power of family physicians across the country to effect social change. Yet, the call might seem intimidating and invites the question, is this asking too much of each one of us?

When discussing social accountability at the macro level, Meili et al note that efforts to embrace this broader articulated role for the family physician might, "at first glance, seem a difficult fit with the traditional role of physicians."[3] This notion of "fit" also arises at the meso level, as Woollard et al point out that family physicians tend to feel most comfortable and competent at the micro level, where they attend most closely to the doctor-patient relationship.[4] Although the authors explain that looking upstream at the full spectrum of need can cause "an overwhelming mix of frustration, helplessness, and guilt,"[4] they encourage family physicians to move beyond their offices and to consider escalating their advocacy to the other levels.

If family physicians are to meet this call to action to practise social accountability across the full spectrum, they need to value advocating across the micro, meso, and macro levels and to feel competent to do so. Otherwise, the "fit" will remain elusive and uncomfortable, especially at the community and system levels.

Data that directly address this issue of social accountability and "fit" exist within a larger qualitative study[5] exploring family medicine and psychiatry residents' and faculty members' understanding of the CanMEDS–Family Medicine (CanMEDS-FM) health advocate (HA) role (**Box 1**).[6] By taking a deeper dive into a subset of the family medicine data that specifically address social accountability across the macro, meso, and micro levels, we help to shed light on the barriers to and enablers of this call to action.

Box 1. 2017 Definition of the health advocate role in CanMEDS–Family Medicine

As health advocates, family physicians work in partnership with patients and communities, contributing their expertise and influence to improve health through an understanding of needs, as agents of change, and the mobilization of resources.[6]

Methods

While the original study used a grounded theory approach[7] (see the original paper[5] for a full description of the methods), the current inquiry into the subset of family medicine transcripts was guided by interpretive descriptive methodology.[8] This methodology aims to develop "a coherent conceptual description that taps thematic patterns."[9] Here we analyze only family medicine transcripts, guided by the following questions:

- Do family medicine residents and faculty members appreciate and value the full spectrum of health advocacy described in the *CFP* articles?
- What are the perceived challenges to and enablers of advocating across the entire spectrum?

Original data collection

For the initial study, faculty and resident participants were identified through snowball, convenience, and purposeful sampling techniques[10] in the departments of family medicine and psychiatry at the University of Toronto.

A total of 9 faculty members from family medicine and 10 from psychiatry were invited to participate based on their involvement in the planning or implementation of curricula related to the HA role at this urban Canadian university. A research assistant (G.F.) conducted semistructured interviews using an interview guide and asked 6 questions that explored the participants' experiences with health advocacy, as well as the challenges and opportunities related to teaching the HA role within postgraduate medical education. These interviews lasted between 30 and 60 minutes.

Psychiatry and family medicine residents were invited to participate through e-mail messages from resident leaders in each department and from the teaching hospitals. The same research assistant conducted 1 focus group of 6 family medicine residents (6 residents attended and completed consent forms; 5 appear in the transcripts) and 3 focus groups with a total of 12 psychiatry residents. The 1-hour focus group explored how residents made sense of the HA curriculum and their experiences as HA learners. The total number of participants in the larger study was 37 (10 psychiatry faculty members, 12 psychiatry residents, 9 family medicine faculty members, 6 family medicine residents).

The interviews and focus group were professionally transcribed. No incentives were provided. The study received research ethics board approval from the University of Toronto and the Centre for Addiction and Mental Health. Transcripts were originally analyzed

using an iterative and constant comparison method, and thematic codes and categories emerged[11] (additional details are available in the original paper[5]).

Re-analysis

The family medicine transcripts (6 residents and 9 faculty members) were re-analyzed independently by 2 researchers (C.B., M.P.) for thematic categories relating to the 2 questions described above. All themes were reviewed with the entire research team at 2 subsequent meetings and were refined through consensus. The diverse backgrounds of the researchers informed the original and subsequent analysis and ensured that no single perspective dominated.[12]

Findings

Value and spectrum of health advocacy

Our findings indicate that family medicine physicians and residents were able to identify the spectrum of social accountability (micro, meso, and macro levels) articulated in the *CFP* series, although they did not always describe the levels using the same terms. Micro-level advocacy was described as "what you would do daily for the patient" (FM resident 3) or as "small advocacy acts." (FM faculty 4) Examples of this work included connecting individual patients with resources, providing home visits, expediting appointments, or filling out forms for receiving social assistance. Advocacy at the meso level was commonly described as community-focused actions. Examples included advocating for resources to address the community needs, using academic positions to address social determinants of health for various communities, and teaching others how to become engaged in advocacy—such as teaching "everything from how to organize a campaign around an issue, how to write an op-ed, how to organize a rally, etc." (FM faculty 16) Macro-level forms of advocacy were described as systemic or global interventions. Examples included engagement with national bodies in the political arena, "running for political office with the intention of trying to make political changes for people's health," and using the "power of the white coat and stethoscope to intervene" (FM faculty 19) against potentially hurtful policy directives.

While physicians did not always define advocacy as a series of escalating interventions, it was clear that they all valued the role. Although there was a range of responses when the physicians were asked to define the CanMEDS-FM HA role, there was a clear understanding that health advocacy is an intrinsic part of being a family doctor. One physician said that it is "absolutely intimately core to the profession," (FM faculty 16) and another said that it is "basically everything we do in family medicine." (FM faculty 1) When asked if being an HA was linked with their identity as health professionals, there was widespread agreement.

Challenges and enablers to advocating across the spectrum

Although participants clearly valued the entire spectrum of advocacy, they also described considerable barriers to these activities. Time was seen as a main barrier, as the work was described as happening "outside your traditional work day" (FM faculty 19) and going "above and beyond." (FM resident 5) Advocacy work was also seen as challenging, coming at a personal cost because "the system is not well set up for it, there are no straight lines, and it is rooted in pain." (FM faculty 17)

Many participants commented on how difficult it was to ensure that they did not overstep when speaking "for" a patient: "You walk a very fine line in between speaking with people and speaking for people and kind of how to navigate that." (FM faculty 16)

Participants also struggled with balancing the needs of the community with the needs of individuals (eg, "how much do I go 'collective' when I have all these patients who actually need me?" [FM faculty 17]). These challenges were linked to a fear of burnout. Participants described a need for personal boundaries, as "some people advocate to the point of burning themselves out." (FM faculty 11)

In terms of enablers to advocating across the spectrum, multiple resident participants referenced the idea of "sustainability" when discussing advocacy work as a means of guiding their future practice. Faculty participants saw patient-centredness and personal reflection as ways to maintain boundaries and reduce stress: "You need to have a patient-centred approach. If the patient wants it, it's not just you trying to advocate for them without them wanting this in the first place." (FM faculty 13)

Another faculty member said, "A career in medicine is all about reflection. Especially in family medicine: you pull back; you're exhausted; you change your schedule; you change your way of being; you surround yourself with others." (FM faculty 17) Participants recognized that the challenges of practising advocacy must be met with enablers in order to have a sustainable career.

Almost all participants described team-based care as one of the most important enablers for becoming involved in the full spectrum of advocacy. Team-based care was seen as important because it engaged others with complementary training and skills: "You feel that you're not alone in the issue in that you also have a team, whether you have social workers or a family health team or whether you have access to people in the community that can help your patients." (FM faculty 1) Working in teams was also seen as a way to prevent burnout by providing space for reflection and support: "There's no doubt in my mind I would have a much harder time doing what I'm doing with my patients if I were a solo practitioner or were with a group that doesn't really resonate with all these values." (FM faculty 17)

Discussion

Our study provides compelling evidence that both confirms the multi-leveled nature of health advocacy and attests to the embodiment of health advocacy within family physicians. It also confirms Woollard and colleagues' suspicion that advocating across levels can generate "an intimidating list of calls upon our all-too-precious time."[4] The physicians in our study clearly valued their role as advocate, but many feared that burnout could be a natural consequence of engaging too deeply.

Those who felt most comfortable with the advocacy role were able to shed light on activities, settings, and structures that enabled them to advocate most effectively. Specifically, they described the need for team-based, patient-centred care, along with adequate time for reflection, sharing among colleagues, and support. When Hubinette and colleagues interviewed physicians who were seen as being effective HAs, those physicians described health advocacy as a collective activity.[13] As Hubinette et al point out, advocacy teaching in family medicine education has traditionally been represented as an *individual* activity of physicians on behalf of patients and communities, particularly in the 2009 CanMEDS-FM framework.[14,15] Perhaps it is this representation of advocacy that makes it seem to be a "difficult fit" for some, as they struggle to see themselves as competent across the full spectrum and perhaps it is time for the vision of physician-as-advocate to be firmly situated within the team.

Indeed, the updated definition of *health advocate* as of 2017 in CanMEDS-FM has been amended: "As Health Advocates, family physicians work in partnership with patients and communities, contributing their expertise."[6] Perhaps this notion of partnership should be extended outside the immediate health team, including interdisciplinary teams and other appropriate partners (eg, legal, financial, education). This very type of partnership has been described as a way of building primary care capacity in addressing some of the issues on the "intimidating list" by Pinto and Bloch.[16] They provide a framework to take the practitioner from "downstream data to upstream advocacy," which involves building relationships with partners in other sectors. Their experience aligns with our findings and with Hubinette and colleagues' assertion that "health advocacy is a team sport."[13]

The image of family physicians as individuals needing to fulfil all roles for all patients is becoming less attainable as care becomes more complex[17,18] and many family doctors limit their scopes of practice to maintain a sense of competence.[19,20] Although family physicians have always recognized the important role of specialty colleagues in caring for all of their patients' needs, the importance of expanding the primary care team beyond the solo or group practitioner is fairly new territory.

The College of Family Physicians of Canada has presented a vision for the future of family practice in Canada called the *Patient's Medical Home*.[21] This vision recognizes the need for family physicians to work with health care teams to provide comprehensive, coordinated, and continuing care to their patients. These team members need not be physically co-located but are part of a central team who are in close communication.

Our findings suggest that ensuring that all family physicians have the opportunity to work within such teams would make the "fit" of social accountability seem more manageable. It would allow for those with special skills to work to their full capacity, while helping other professionals gain expertise along the way.

Limitations

Our study engaged physicians who are teaching in academic health science centres and community practices affiliated with an educational institution, and their responses might differ from those of physicians who serve other populations. The participants were recruited to reflect on the HA role, so there could potentially be a self-selection bias. The original study used a grounded theory thematic analysis. Although the faculty and residents came from different departments, the aim of that study was not to look at differences between these departments, and saturation was considered as a whole. We appreciate that there might be concerns relating to saturation in the 1 family medicine focus group; however, this current paper is a guided inquiry using interpretive descriptive methodology. We did not look for saturation specifically.

Further, interviews took place before publication of CanMEDS-FM 2017. It is possible not all family physicians interviewed had seen the framework, conceptualized what they engage in as health advocacy, or described health advocacy as intrinsic to their profession. Responses might also have been affected by social desirability.

Conclusion

Our findings suggest that family physicians and residents do have the awareness, capacity, and passion to advocate for their patients and communities at multiple levels across the spectrum. Although advocating can sometimes put clinicians at risk of burnout, person-centred care and reflective practice are crucial enabling principles. Further, collaboration among family physicians, with other specialties and health professionals and with communities at large, is key to sustainability and success beyond the individual (micro) level.

As we increasingly embrace a team-based approach within primary care, the ways in which teams can facilitate advocating across the full spectrum should be investigated. Further, as many family medicine residents now have the opportunity to train in teams, the effect of team-based learning on attitudes toward advocacy would be an important area of inquiry.

Given the sometimes political nature of advocacy and varying levels of comfort that individuals have across

the spectrum, it might also be important to gain a better understanding of the potential tension between team functioning and the differing values, experiences, identities, and views of the individuals within teams. As practitioners and scholars we need to better understand how teams can come together to fulfil the full spectrum of advocacy in family medicine while valuing the uniqueness of individual members.

In the interim, while time, resources, boundaries, or even fear of push back might be realistic obstacles, the profession of family medicine as a whole is poised to answer the "call" *fittingly* through collective team-based action.

Dr Bernard is Assistant Professor and Associate Program Director of Curriculum and Remediation for the postgraduate program in the Department of Family and Community Medicine at the University of Toronto in Ontario and Assistant Clinical Professor in the Department of Family Medicine at McMaster University in Hamilton, Ont. **Dr Soklaridis** is Independent Scientist and Interim Director of Education Research at the Centre for Addiction and Mental Health in Toronto and Assistant Professor in the Department of Psychiatry at the University of Toronto. **Ms Paton** is a doctoral candidate in the Ontario Institute for Studies in Education at the University of Toronto and Education Research Coordinator for Continuing Professional Development in the Faculty of Medicine at the University of Toronto. **Dr Fung** is Clinical Director for the Asian Initiative in Mental Health and Associate Professor in the Equity, Gender, and Population Division of the Department of Psychiatry at the University of Toronto. **Dr Fefergrad** is Assistant Professor and Program Director of Postgraduate Education in the Department of Psychiatry at the University of Toronto. **Dr Andermann** is Associate Professor in the Equity, Gender, and Population Division of the Department of Psychiatry at the University of Toronto. **Mr Johnson** is Manager of Client and Family Education and CAMH Publications Education at the Centre for Addiction and Mental Health. **Ms Ferguson** was a research coordinator for this project through the Centre for Addiction and Mental Health. **Dr Iglar** is Associate Professor in the Department of Family and Community Medicine at the University of Toronto. **Dr Whitehead** is Associate Professor in the Department of Family and Community Medicine at the University of Toronto, Director and Scientist at the Wilson Centre for Research and Education, Vice President of Education at Women's College Hospital, and the BMO Financial Group Chair in Health Professions Research at University Health Network.

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Contributors

Drs Bernard, Soklaridis, Fung, Fefergrad, Iglar, and **Andermann,** along with **Ms Paton** and **Ms Ferguson,** collaborated on the concepts relating to the study. **Dr Bernard, Soklaridis, Fung, Fefergrad,** and **Andermann,** along with **Ms Paton, Ms Ferguson,** and **Mr Johnson,** were involved in the analysis of the findings. **Dr Whitehead** was involved in all aspects of the project. All authors were involved in the drafting and revising of the article, and all authors reviewed and approved the final version.

Competing interests

None declared

Correspondence

Dr Carrie Bernard; e-mail **carrie.bernard@utoronto.ca**

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