

ROBUST PRIMARY
CARE BUILT ON THE
EXPERTISE OF THE
FAMILY PHYSICIAN



01/2017
POSITION
STATEMENT

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Collège des médecins du Québec
Suite 3500
1250, René-Lévesque Boulevard West
Montreal (Quebec) H3B 0G2
Telephone: 514 933-4441 or
1 888 MÉDECIN
Fax: 514 933-3112
Website: www.cmq.org
Email: info@cmq.org

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Odette Lord

Translation

Barbara Pattison, C.Tr.

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Notes:

In this publication, the masculine gender is used without prejudice and solely to facilitate reading.

In addition, to simplify the text, the term “health” is used to refer more broadly to “health and social services”.

— Members of the working group responsible for updating the position statement on the role of the family physician

DR. JEAN-PIERRE BOUCHER

Family Physician
Chair of the working group

DR. JULIE LAJEUNESSE

Family Physician
Vice-chair of the working group

DR. JEAN-BERNARD TRUDEAU

Family Physician
Assistant Secretary
Collège des médecins du Québec
Secretary of the working group

DR. ARMAND AALAMIAN

Family Physician
Associate Dean of Postgraduate Medical
Education and Professional Affairs
McGill University

DR. DOMINIQUE DESCHÊNES

Family physician designated by
the Collège québécois des médecins
de famille

DR. MARC GIRARD

Specialist physician in neurology
designated by the Fédération
des médecins spécialistes du Québec

DR. BERNARD MILLETTE

Family Physician
Medical Advisor to the Executive Office
of the Collège des médecins du Québec

MR. PIERRE PARENT

Public representative

DR. CLAUDE RIVARD

Family physician designated by the
Fédération des médecins omnipraticiens
du Québec

— Members of the working group responsible for updating the position statement on the role of the family physician

PEOPLE AND ORGANIZATIONS THE WORKING GROUP MET WITH AND/OR THAT SUBMITTED A DOCUMENT

People/organizations met with:

- › Dr. Marie-Dominique Beaulieu, Family Physician, Researcher and Full Professor, Department of Family Medicine and Emergency Medicine, Faculty of Medicine, Université de Montréal
- › Mr. Pierre Blain, Chief Executive Officer, Regroupement provincial des comités des usagers
- › Mr. Georges-Émile Bourgault and Mr. Michel Caron, Ordre des pharmaciens du Québec
- › Dr. Marie-Josée Chouinard, Psychiatrist, Dr. Suzie Benoît, Family Physician, and Ms. Hélène Brouillet, Psychologist, Mental Health and Addiction Programs, CISSS de la Montérégie-Est
- › Dr. Maxine Dumas Pilon, President, Collège québécois des médecins de famille
- › Dr. Diane Francoeur, President, Fédération des médecins spécialistes du Québec
- › Dr. Louis Godin, President, Fédération des médecins omnipraticiens du Québec
- › Dr. Antoine Groulx, Family Physician, Director of the Organization of Integrated Primary Care Services, Ministère de la Santé et des Services sociaux
- › Dr. Yun Jen, President, Québec Medical Association
- › Dr. Yves Langlois, Family Physician, and Dr. Mauril Gaudreault, Family Physician, Steering Committee on Shareable Medical Activities, Collège des médecins du Québec
- › Dr. Paule Lebel, Specialist Physician in Public Health and Preventive Medicine, Co-director of the Direction collaboration et partenariat patient, Associate Professor, Faculty of Medicine, Université de Montréal
- › Dr. Jean Pelletier and Dr. Luce Pélissier-Simard, representatives of the directors of Quebec's four departments of family medicine / emergency medicine and Quebec's four family medicine residency programs
- › Dr. Claude Rivard, Family Physician, and Ms. Julie Côté, Manager, Clinique familiale des Hauts-Bois
- › Dr. Andréanne Roy and Dr. Philippe Karazivan, researchers at the Université de Sherbrooke and the Université de Montréal, respectively, who have conducted studies on issues relating to the practice of young family physicians
- › Dr. Guy Bertin Tcheumi, Dr. René Wittmer and Ms. Geneviève Coiteux, representatives of the Fédération des médecins résidents du Québec

— Members of the working group responsible for updating the position statement on the role of the family physician

- › Students: Chanel Béland, Université de Montréal; Samuel Caron, Université Laval; Roselyne Choinière, Université de Sherbrooke; Annick Gauthier, McGill University, representatives of Family Medicine Interest Groups
- › Mr. Robert Salois, Health and Welfare Commissioner of Quebec, and Dr. Véronique Déry, Specialist Physician in Public Health and Preventive Medicine, Deputy Commissioner of Health and Welfare Analysis and Policies
- › Ms. Lucie Tremblay, President, and Ms. Geneviève Ménard, Consulting Director, Department of External Affairs, Ordre des infirmières et des infirmiers du Québec
- › Ordre professionnel de la physiothérapie du Québec
- › Ordre professionnel des diététistes du Québec
- › Ordre professionnel des inhalothérapeutes du Québec

People/organizations that submitted a document:

- › Ordre des ergothérapeutes du Québec
- › Ordre des psychologues du Québec
- › Ordre des travailleurs sociaux et des thérapeutes conjugaux et familiaux du Québec

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Chapter 1/ The context of the working group's mandate regarding the role of the family physician

The mission of the Collège des médecins du Québec (the Collège) is to ensure that Quebec's citizens can count on quality medicine at the service of the public.

In 2005, the Collège published a position statement on the role of the family physician.¹ In fall 2014, in a context of evolving interprofessional practices, the Collège developed a framework to assess requests for the sharing of medical activities. This framework made it necessary to revise the 2005 statement on the role of the family physician.

Following this decision and without any causal relationship, in 2015 the health and social services sector in Quebec was the subject of a period of intense debate with the tabling of a number of bills to transform medical practice. In this context, family medicine will face increasing challenges, which confirms the need to revise the Collège's position statement on the role of the family physician.

¹ Collège des médecins du Québec (2005). *Le médecin de famille : un rôle essentiel à moderniser* (available in French only).

Chapter 2/ Statements fundamental to robust primary care² built on the expertise of the family physician

The Collège now affirms that the following statements, as a prelude to this position statement, are fundamental to robust primary care built on the expertise of the family physician. These statements are both the foundation and the cement of the recommendations that follow.

STATEMENT NO. 1³

As numerous studies and much research and evidence show, a strong, high-performance, accessible and viable public health and social services system must be founded on robust primary care and services where the family physician plays a vital role. To ensure quality, effectiveness, efficiency and robustness, resources and funding must be allocated accordingly.

STATEMENT NO. 2

Physicians (*all specialties combined*) share a collective social responsibility to meet the health care needs of the community they practice in and must adapt their practice to local needs (e.g., timely access to acute care and patient follow-up), subject to the resources available. Consequently, close, effective “family physician – specialist physician” collaboration that ensures easy, direct access is imperative.

² The term “primary care” refers to primary health care and social services directly accessible to citizens. More specialized care, referred to as secondary and tertiary care, is usually accessible following a primary care intervention.

³ See the end of the position statement for the complete list of statements and recommendations.

STATEMENT NO. 3

Quebec's citizens must, if they so wish, be able to register with a family physician and be seen in a timely manner by him or by a professional on his team.

STATEMENT NO. 4

The family physician's primary mission is to accept responsibility for the long-term follow-up of patients in primary care (e.g., health promotion, treatment of acute ailments, follow-up of chronic diseases).

STATEMENT NO. 5

The great versatility of many family physicians in Quebec, who provide both patient follow-up and secondary care, is an added value.

STATEMENT NO. 6

The family physician's training, both in biological sciences and human sciences, as well as his versatile primary care practice make him a key care provider, the integrative leader and *conductor* of the primary care team. He is the health professional who, by sharing and integrating information from other health care team members, is best qualified to create a complete picture of the patient's health with each patient, coordinate their care plans and, if necessary, help them navigate the health and social services system.

STATEMENT NO. 7

Concrete action must be taken to increase recognition of the value of family medicine in society given its importance for robust primary care. Any remarks that run contrary to this recognition of the value of family medicine, irrespective of the context (teaching, training, practice), must be swiftly denounced and steps taken immediately to put an end to them.

Chapter 3/ The health needs and expectations of Quebec's citizens

The consultation conducted by the Collège and the scientific literature identified a number of expectations, observations and needs that are considered a priority with respect to family medicine.

ACCESS TO HEALTH CARE AND SERVICES: A CRY FROM THE HEART!

Quebecers are strongly attached to their public health care and social services system. However, they are highly critical, and rightly so, of problems of timely access, both to health professionals (especially family physicians and specialist physicians) and to diagnostic and therapeutic services.

Paradoxically, Quebec's citizens are able to access, with few or no barriers, specialist consultants and tests and treatments if they are hospitalized and when they consult at an emergency room. The situation is very different if they go to an ambulatory care clinic, in particular if they consult a family physician. Then they face wait times or often have to pay to obtain some tests or treatments more quickly.

In practice, despite the improvements of recent years, access within ambulatory services to specialist physicians and technical platforms is still a major problem for family physicians and patients. That's why it is important to once again stress what is expected of specialist physicians so that they focus their level of management on the clientele that requires their particular expertise while making themselves available to support the family physician in his clinical work.

A COMPREHENSIVE APPROACH TO INDIVIDUAL, FAMILY AND COMMUNITY HEALTH

Societies invest enormous sums in their health care systems. Yet the scientific literature shows that other determinants (e.g., education and income, healthy lifestyle, social support, environment) have a greater impact on reducing mortality, morbidity and costs for a society and must therefore be taken into account to ensure citizens' health and welfare. All these determinants confirm the importance of combining disease prevention and health promotion interventions with curative approaches while also taking into account the connection between thoughts, emotions and individual physiological processes. By adopting a biopsychosocial model, a systemic and comprehensive approach can be taken to the assessment and understanding of a person's health.

TO BE LISTENED TO WITH EMPATHY AND RESPECT

Quebecers want to be treated effectively, with respect and humanity. When it comes to their health, people want to see a family physician or a team of professionals who work with him, whom they know and who know them and who will take the time to listen to them with compassion and with respect for their experience, their values and their ideas.

COORDINATED HEALTH CARE AND SERVICES

Multiple biopsychosocial factors can account for a condition or a disease and facilitate or hinder its resolution or mitigation. This means that professionals from different fields of practice may have to be called on to assess a patient's health problems. This multiplication of care providers and interventions may lead to confusion, duplication of efforts and contradictions. In this context, interprofessional collaboration in partnership with the patient and his family poses, for the family physician, the challenge of coordinating health care in order to integrate all the information that will enable him to establish a differential diagnosis and, ultimately, a diagnosis. Sharing tasks between the different health and social services providers becomes a major coordination issue that requires the goodwill of all involved so that they listen to each other's comments and suggestions and also those of patients and their families. Furthermore, every citizen also bears some responsibility for his health and self-management of his care, to the extent possible.

Chapter 4/ The challenges facing primary health care and services in Quebec

A number of challenges and issues call for vigorous and courageous action on the part of all stakeholders (care providers, administrators, politicians, educators, researchers) in partnership with citizens.

FROM 2005 TO 2015: SIMILAR ISSUES FOR FAMILY MEDICINE AND PRIMARY CARE

Several people and organizations the working group met with reported finding, in the 2005 statement, issues similar to those we are facing today. They noted that a number of recommendations have not been followed up on and have yet to be implemented.

Although the 2005 document remains current with respect to its definition of the role of the family physician, the statement needs to be updated in order to make new recommendations, including oversight measures to ensure they are implemented.

A CHANGING AND DEMANDING ENVIRONMENT

Here is a reminder of some of the issues facing Quebec and which are putting tremendous pressure on the funding and operation of the current and future health system:

- › An increasing number of patients with more complex care needs (e.g., rise in chronic diseases, increased identification of mental health problems, rise in multimorbidity, ageing of the population).
- › The pressure of innovations (e.g., medications, interventions, technologies) and the challenge associated with their cost, selection and use.

- › A changing social context (e.g., public access to multiple sources of information, multimedia, high citizen expectations, increasing value given to quality of life, dilemma of end-of-life care).
- › An ongoing global economic crisis that is eating away at government revenues and reducing citizens' purchasing power.
- › The fact that many people wish to stay in their homes for as long as possible (e.g., home care for older adults with impaired mobility, palliative care at the end of life, outpatient treatment of some acute and chronic diseases).
- › The need to adapt due to societal changes affecting access to information and methods of communication (e.g., Web 2.0, social media, use of the Internet to make appointments, online records accessible to patients and care providers, teleconsultation).

CHANGING PERSONAL VALUES AND CHOICES

The younger generations of physicians, who are avid technology users and very present on social networks, are changing society's values. Like many other citizens, they place more value on a better work-life balance. The new generation of physicians also sees the vocation of medicine differently and is looking for a stimulating practice that will allow them to maintain this balance. This situation clearly gives rise to intergenerational challenges.

EFFORTS TO OBTAIN MORE FUNDING FOR PRIMARY CARE MUST BE CONTINUED

While in agreement with evidence in favour of the reorientation of the health system from the acute care hospital to a community-based, people-centred network (redistribution of resources and funding to primary care, including infrastructure and operation), Quebec has not completed the required shift. Despite the growing ambulatory network, greater use of local community services centre (centre local de services communautaires – CLSC) services and the increasing involvement of various types of professionals in home care, it is clear that efforts must be continued and that they are not being felt significantly in family physicians' day-to-day clinical practice. With respect to this last statement, one should remember that physicians with an office-based practice, except for those who do not participate in the public health insurance plan (a marginal phenomenon⁴), are remunerated by the government. The public does not always understand this, with the result that family physicians' offices are

⁴ In December 2015, according to RAMQ figures, nearly 270 general practitioners / family physicians out of a total of more than 9,000 family physicians in Quebec did not participate. <http://www.ramq.gouv.qc.ca/SiteCollectionDocuments/professionnels/facturation/desengages.pdf>

associated with the private network. It is important to correct this mistaken assumption so as not to jeopardize support for family physicians and the development of robust primary care that is able to meet the population's health needs effectively and efficiently.

KNOWN, RECOGNIZED AND PROVEN SOLUTIONS IN SUPPORT OF FAMILY MEDICINE

In Quebec, to effectively support family medicine in order to build robust primary care capable of overcoming the challenges and issues facing the health and social services system, a number of key conditions must be met:

- 1/ Recognition and appreciation of the value of the family physician's expertise in his central role as integrative leader (*conductor*) of the primary care team.
- 2/ Close collaboration between family physicians, specialist physicians and other health and social services providers in partnership with patients and their families.
- 3/ The implementation of organizational models for primary health care and services that are high quality, accessible, effective, efficient, interoperable and ensure timely access to specialist physicians, technical platforms and specialist consultations.
- 4/ A selection process that focuses on the desirable qualities of future family physicians followed by solid training, the assistance of a dynamic primary health care research sector and support for new graduates entering practice.

Chapter 5/ The family physician in Quebec: roles and issues

The central role of integrative leader (integration of information from different sources about patient health) that the family physician must play in primary care as *conductor* of the health care team was recognized by all the people and the organizations the Collège's working group met with.

ROLE - THE FAMILY PHYSICIAN'S CENTRAL MANDATE

As mentioned in the 2005 statement as well as in international literature and by professional associations in Quebec and Canada, the family physician's primary role, central to his practice, is to accept responsibility for the lifelong follow-up⁵ of the patients who choose him. This role involves helping patients to maintain and improve their overall health, preventing disease, assessing and treating their episodic ailments and illnesses and providing follow-up for their chronic health problems while respecting their values and preferences.

ROLE - THE FAMILY PHYSICIAN'S CORE COMPETENCIES AND TASKS

The extensive media coverage of difficulties with access to care casts a shadow over the professionalism, commitment and quality of the interventions of the vast majority of family physicians in Quebec. It is sometimes hard for the public and even for other health professionals to understand the particular nature of the family physician's work and the added value of his interventions. Some key aspects of the particular nature of his work are as follows:

- › The family physician is an expert in managing common problems, detecting latent, acute and chronic problems, and identifying less common but potentially dangerous though treatable diseases. Identifying health problems, diagnosing diseases and determining an investigation and treatment plan are the foundations of his professional competencies.

⁵ Although the term *management* is often used in medicine, it reflects a paternalistic attitude that we would like to move away from by instead emphasizing a positive message that conveys the physician's commitment and responsibility towards the patient. Therefore, its use should be avoided, for, except in the event of a highly debilitating health problem, the physician advises the patient and does not decide for him as the term *management* might suggest. We have decided to use the expression "accept responsibility for follow-up" to reflect a contemporary vision in partnership with the patient.

- › The prevalence, in primary care, of concomitant biopsychosocial situations often leads to ambiguity and uncertainty with respect to the identification, assessment and prioritization of problems and their potential solutions. This adds to the complexity and is a specific characteristic of the practice of family medicine. The development of medical specialties and the expansion of other health and social services professions confirm the importance of and the need for the family physician's *integrative* functions.
- › A versatile professional, the family physician develops, over the years and in the course of many meetings, a long-term relationship with patients that builds trust and strengthens the therapeutic bond. The challenge for the family physician is not only to treat diabetes, or Mrs. Tremblay's diabetes (fictitious name) but, most importantly, to accept responsibility for providing comprehensive, lifelong follow-up to Mrs. Tremblay in order to maintain her health and well-being.
- › A professional who works closely with people, the family physician adapts his practice to his community's needs. Thus, while providing long-term follow-up for his clientele, he also contributes collectively, with his colleagues and the local network, to the delivery of general medical care in the emergency room, hospital, residential and long-term care centre (centre d'hébergement et de soins de longue durée – CHSLD) and in the patient's home.

ROLE - THE SOURCES OF THE FAMILY PHYSICIAN'S EXPERTISE AND COMPETENCIES

The family physician's solid and diversified training and his day-to-day practice contribute to his unique expertise and experience in comprehensive health assessment and the development of plans to treat or relieve patients' problems:

Basic training and continuing professional development

- › Family physicians in Quebec all undergo specific training to acquire the knowledge and skills they need to fulfil their various responsibilities (e.g., comprehensive health needs assessment, episodic care, long-term follow-up of patients with chronic health problems, delivery of care in an office, emergency room, hospital, delivery room, home, CHSLD). Continuing professional development activities allow the family physician to expand and complete his knowledge and maintain his competencies throughout his career.

A versatile day-to-day practice

- › Most family physicians work in a number of different health care settings (e.g., office, CLSC, hospital, emergency room, CHSLD, home care) and are consulted by patients of all ages about all kinds of health problems. The family physician works in complementarity with primary care professionals to contribute to the assessment and management of most health problems they are consulted about. The family physician's versatility increases opportunities for meeting with patients and with the members of his team and also contributes to better mutual knowledge and a stronger patient-physician therapeutic relationship.

ISSUE - THE EROSION OF THE FOLLOW-UP OF PATIENTS IN PRIMARY CARE

Over the years, family physicians have, to some extent, moved away from the follow-up of patients in primary care. According to the literature consulted and the groups the working group met with, there are multiple reasons for this situation:

- › An increasing number of patients with more complex care needs combined with the multiplicity and severity of chronic health problems associated with an ageing population.
- › The high expectations of patients and their families.
- › Difficulties with access to and wait times for specialist physicians, specialist consultants and technical platforms (secondary and tertiary care) for investigations or treatments, whereas these difficulties and wait times are reduced if their patients are hospitalized or seen in an emergency room.
- › Inconsistent and sometimes clearly deficient administrative and clerical support, in particular in CLSCs and family medicine units (FMUs).
- › A remuneration model that favours some of the family physician's hospital-based tasks (e.g., emergency room work) over a community-based primary care practice.

Other factors that are reducing the appeal of family medicine appear to be related to medical training and the perceptions of young physicians during their training and when they first enter practice, namely:

- › University and scientific life in hospital seems more interesting and exciting to them than providing follow-up to patients in primary care.

- › There is immediate positive stimulation when they work with patients who are admitted with an acute disease or whom they see for a consultation on a stretcher in the emergency room (probably partly due to the more rapid validation of the accuracy of diagnoses and the effect of treatments). They are afraid they will not get the same feeling providing follow-up to patients who, in their opinion, have already been diagnosed and whose therapies are stable (e.g., diabetes, hypertension). One of the keys to successful interaction in the long-term follow-up of a patient is based on the development of a special patient-physician relationship and it often takes several years for this relationship to become a reality.
- › During their training in the university network of family medicine units (FMUs), they see the extent and complexity of the situations of the patients they have to follow negatively and are deterred by the many tasks, such as filling out medical forms, they consider administrative, but which are nonetheless part of medical practice, since the diagnostic issues have to be documented.
- › The perception that there is a limited number of primary care practice settings in Quebec that offer an attractive and stimulating environment for new recruits (versatile group practice, dynamic team working in a rich, collaborative interprofessional relationship in a pleasant atmosphere, sufficient human resources and appropriate premises, a high degree of computerization, a mix of acute care and follow-up, possibility of pursuing specific professional interests).

ISSUE - THE FAMILY PHYSICIAN, PATIENTS' EMOTIONAL DISCOMFORT AND MENTAL HEALTH

The high prevalence of mental health problems in primary care and the frequency with which emotional factors are closely connected to or influence physical ailments represent an enormous challenge for the family physician with respect to the diagnosis, treatment and support of the patients concerned. The scientific literature and the people the working group met with mentioned the following points:

- › Although the family physician plays an important role with respect to mental health problems, he seems relatively isolated to deal with them. The role of other team members should be expanded and facilitated, including that of the liaison nurse, the psychologist, the social worker and the first-line psychiatrist. Health professionals, and physicians in particular, should also improve their knowledge and use of community resources.

- › The majority of family physicians say they feel comfortable with the assessment and follow-up of common mental health problems. However, only a minority feel competent addressing serious psychiatric problems. Their competence in the field of mental health is thought to be influenced by their medical training, their practice setting, their remuneration models, whether they practice solo or as part of a team and the profile of the patients themselves. Fewer than one quarter of family physicians provide long-term follow-up for patients with serious mental health problems.⁶
- › Given the importance and the prevalence of mental health problems and to better meet patients' needs, reduce medication use and ease the burden for family physicians, patient access to mental health and human relations professionals and, if necessary, to people who are qualified to provide psychotherapy, should be facilitated. This could be achieved by integrating psychologists or social workers into family medicine groups (FMGs) or by facilitating access to them in the public health system.

ISSUE - HOME CARE

The reality of the family physician who makes frequent home visits has clearly declined in recent decades. Despite this perception, many family physicians continue to make home visits on a regular basis, particularly for palliative care, as part of CLSC home care programs and even as part of their office activities.

In the coming years, the ageing of the population will increase the demand for home care. Family physicians and primary care teams have a social responsibility to prepare for this and to meet the challenge of ensuring continuity of care for their patients, of providing follow-up in an office, at a CLSC or in the patient's home.

POSITIVE FACTORS FOR THE FUTURE OF PATIENT FOLLOW-UP BY NEW FAMILY PHYSICIANS

In addition to government initiatives and agreements with the Fédération des médecins omnipraticiens du Québec (FMOQ), the following points are worth noting:

- › The young generation of physicians, like a growing number of their older colleagues, believes in teamwork and is open to collaborative practices with other care providers.

⁶ Fleury, M.-J., et al. (2012). "La prise en charge des troubles de santé mentale par les omnipraticiens du Québec", *Canadian Family Physician*, Vol. 58, No. 12, pp. e725-e731 (available in French only).

- › Young physicians strive for excellence and want to be able to demonstrate their professional expertise with patients.
- › The next generation of family physicians is part of the digital generation. They want to make use of technology and be able to communicate easily with other professionals and with patients. In clinical settings, they expect to have access to a high-performance electronic medical record (EMR) and modern information technology.
- › For several years now, the number of family medicine graduates has been increasing. This situation is contributing to a certain glut in hospitals (fewer positions available) that should facilitate orientation (or reorientation) of a higher proportion of family physicians to patient follow-up.

Chapter 6/ Interprofessional teamwork: a valuable resource and a must

Innovations to the *Professional Code* since the early 2000s have changed the work environment of Quebec's health network and are contributing to improved interprofessional collaboration.⁷ All the stakeholders the working group met with consider teamwork, interdisciplinarity and interprofessional collaboration imperative.

TEAMWORK IN PARTNERSHIP WITH THE PATIENT AND HIS FAMILY

Collaboration is not a goal in itself; it is a way of ensuring that Quebecers receive quality, safe, effective and efficient health care and services at a frequency that meets their needs. The interprofessional team's shared objective is to meet patients' needs and help them self-manage their health as best they can given the circumstances, which means working in partnership with these patients and their families. The situation may call for a single care provider, for example, the family physician himself or the team nurse. In other situations, multiple care providers will have to collaborate in providing care consecutively or simultaneously.

COMMUNICATION: THE KEY TO INTERPROFESSIONAL COLLABORATION

"What do the other health professional and I need to share to have a common understanding and intervene effectively to resolve or relieve Mrs. Tremblay's (fictitious name) health problems?"

⁷ The well-known expression "interprofessional collaboration" will be used in this position statement, although it does not represent all the types of interactions that occur in primary care. For the purposes of this document and to simplify the text, it will also refer to interactions between members of the same profession but from different disciplines as well as between care providers who are not members of a professional order.

Whether care providers are in the same place or in different locations, communication is the key to successful collaboration. Productive communication underpins a reciprocal understanding of each person's roles and the development of a relationship of trust that will allow the mutual clarification of objectives and expectations, the sharing of relevant information and the consultation needed to take action.

The quality of communication is not, however, always ideal and information sharing does not always go as smoothly as it should. For example:

- › The information provided on the consultation requests the family physician sends to a secondary or tertiary care medical consultant is sometimes inaccurate and incomplete.
- › The family physician receives no information (or only receives it at a very late stage) about his patient's hospital stay or visits to the emergency room.
- › Secondary or tertiary care specialist physicians' reports are not forwarded correctly to the family physician and are sometimes written in a way that is of little help in his task of providing long-term follow-up for the patient.

Of course, a face-to-face discussion, speaking on the telephone, exchanging text messages or emails (while respecting the confidentiality of these communications) are all helpful, although they vary in terms of efficiency. One of the essential tools for communicating in and with primary care is the electronic medical record (EMR). The EMR is an indispensable tool that must be interoperable with the Québec Health Record (QHR) so that health professionals can access the health network's databases and so that the different care providers can enter their observations, recommendations and comments as well as exchange and communicate with one another and possibly with the patient and his family. Deficiencies in this regard will be discussed again in the section on practice models.

FACTORS FOR SUCCESSFUL INTERPROFESSIONAL COLLABORATION

Research and the organizations the working group met with identified a number of factors that facilitate collaboration between the family physician and the different health care providers:

- › Clear knowledge of the roles, functions and competencies of each member of the health care team and the community resources available reduces the risk of confusion, misunderstandings and tension.

- › Training in interprofessional collaboration during initial training and through continuing professional development activities.
- › Shared, collegial, non-authoritarian leadership creates a climate conducive to collaboration between physicians, health care team members, patients and their families.
- › An explicit, shared team vision.
- › Time set aside for discussion as well as places where care providers can come together (sharing a common area often helps but is, however, often impossible in primary care given the existing infrastructure). Ideally, family physicians and health care team members would work in proximity to one another or, failing this, be able to use a high-performance interoperable computerized clinical record.
- › Proactive interprofessional conflict management.
- › Laws, regulations and payment models that are coherent and facilitate interprofessional collaboration.
- › The use of collective prescriptions and joint follow-up protocols.

ACCESSIBILITY: AN ISSUE THAT IS NOT LIMITED TO FAMILY PHYSICIANS

When it comes to access to care, physicians, in particular family physicians, are often targeted. Yet, many health problems require the simultaneous contribution of other health professionals to complete the assessment of the problems or to provide treatment.

Difficulties with access to secondary and tertiary care specialist physicians have already been mentioned. In addition, in terms of communication, the exchange of good practices does not always go smoothly and easily. Even when bridges are built to facilitate communication between professionals (e.g., first-line psychiatrist), their respective involvement varies and is sometimes distinctly disappointing (e.g., family physicians are unaware of or do not use the services of the first-line psychiatrist, psychiatrists decide not to participate in this activity). One source of these difficulties appears to be the relative isolation of specialist physicians, on the one hand, and family physicians on the other.

Access is also a major problem when the patient is referred to another health professional, in particular in psychology, physiotherapy and nutrition. All the parties concerned, and society too, must recognize that the restriction of certain ambulatory services causes real difficulties, perpetuates or extends

suffering and results in significant social costs (e.g., increased absenteeism, persistent morbidity, impact on families). While access to these types of care seems costly at first glance, it would generate savings that are often overlooked, such as reduced work absenteeism and reduced medication use.

Thus, in mental health, it has been shown that, for some problems, psychotherapy will have a more significant and more lasting long-term impact than medication in developing a patient's ability to manage his difficulties. A similar example is that of physical health, in particular access to physiotherapy for patients whose cases are not the responsibility of the Commission des normes, de l'équité, de la santé et de la sécurité du travail (CNESST) [Labour standards, equity, health and safety commission] or the Société de l'assurance automobile du Québec (SAAQ) [Quebec automobile insurance board]. Other similar examples exist involving other health professionals.

THE RELEVANCE OF THE FAMILY PHYSICIAN'S OPINION FOR REFERRAL TO OTHER CARE PROVIDERS

In many situations, and in order to optimize care, a preliminary diagnosis and a discussion between the family physician and the patient about the medical treatment plan are recommended if the patient is receiving care from another health professional (including another physician). The issue of the two-way flow of information between the family physician and other health professionals (including other physicians) is crucial to the quality, even the safety of care, even if the patient decides to meet directly with another health professional. Some of the reasons that support this are as follows:

- ▶ Differential biopsychosocial diagnosis is the strength of the family physician. The level of training of the different health care providers has improved enormously in recent decades and many professionals now obtain graduate and postgraduate degrees in their discipline. This, added to the media coverage of some controversies that are seen by many as power struggles, may trivialize the act of clinical diagnosis in the eyes of the public. Yet, for example, exacerbation of shortness of breath in a patient who is known to have respiratory failure may, of course, be associated with a "simple" decompensation of his pulmonary disease, but may also be the result of a new problem that must be suspected and identified (e.g., anemia, heart failure, pulmonary embolism). A 60-year-old woman who has been feeling a little tired lately may be suffering from depression, a hormonal problem, anemia, occult cancer, boredom ...

- › The family physician's competencies, in partnership with the patient and his family, mean that he is in the best position to integrate information about the patient's health. This is all the more true when the family physician has known the patient for some time, giving him a more comprehensive view of his health situation.
- › The family physician's training and clinical experience mean that he is appropriately equipped to complete a systemic assessment of his patients' difficulties, establish investigation and action priorities with them and choose the professionals who are best able to help them.

For all these reasons, it is more effective and efficient for the family physician to meet with the patient in order to make a diagnosis about the situation and then discuss whether or not a consultation with a specialist physician or another health professional is warranted, in accordance with the treatment plan. However, the family physician or a member of his team (who can contact him easily if necessary) must be directly available by telephone, fax or Internet to the patient or the specialist physician or health professional consulted, as the case may be. The family physician cannot fulfil his role as *conductor* of the primary care team and integrator of health information unless he is truly available in a timely manner.

IDENTIFICATION OF THE ATTENDING FAMILY PHYSICIAN

In the course of our work, we found that the attending family physician is not always identified by the various stakeholders in the system. Despite the systematization and often the computerization of administrative procedures, the family physician is frequently not identified or is incorrectly identified by administrative staff, even in cases where patients have a family physician (which is true for over 90% of Quebecers aged 55 years and older according to the Commonwealth Fund 2014 Survey, p. 33⁸). This oversight greatly hinders the family physician in his role as integrator of information and coordinator of investigation and treatment plans.

⁸ See http://www.csbe.gouv.qc.ca/fileadmin/www/2014/CWF/CSBE_Rapport_CWF_2014.pdf (available in French only).

With respect to the issues mentioned and to ensure robust primary care built on the expertise of the family physician, the Collège makes the following recommendation:

RECOMMENDATION NO. 1

Improve and increase interprofessional collaboration for the benefit of the population being served. To do this, the following conditions must, at a minimum, be met:

- › Promote reciprocal knowledge of the roles and area of expertise of the family physician, the various care providers working in primary care and the community resources available in the environment.
- › Create conditions conducive to smooth communication and timely access between family physicians and physicians from other specialties as well as between family physicians and other health professionals.
- › Ensure public access for patients, as needed, to health professionals who work in collaboration with family physicians.

Chapter 7/ High-performance primary care practice models: success factors

For years, people have suggested developing a new, more effective practice model for family medicine in primary care. Research and expert opinion suggest that the main difficulty is not the lack of promising models but rather resistance or barriers to their full implementation. Experiences in the United Kingdom (Primary Care Groups), Ontario (Family Health Teams), Quebec (Family Medicine Groups) and the United States (Kaiser Permanente Medical Groups) provide insight into the components that form the basis of an effective primary care practice model. A fine summary and description of these characteristics, which were first proposed many years ago by a number of leaders and experts, are provided in the “Patient’s Medical Home” model published more recently by the College of Family Physicians of Canada (CFPC).⁹

For its part, the Government of Québec, following the Clair Commission and its recommendations, made a strong commitment in this direction with the creation, in 2002, of family medicine groups (FMGs). Since the first FMGs were created, discussions and negotiations between the Ministère de la Santé et des Services sociaux (MSSS) and the Fédération des médecins omnipraticiens du Québec (FMOQ) resulted in the initial concept being adapted to different situations and it is in this context that Network FMGs (FMG-Ns) and University FMGs (FMG-U) were developed.¹⁰ Additional efforts are, however, needed to ensure all FMGs, FMG-Ns and FMG-U are organized in accordance with the desired characteristics for quality, effective and efficient primary care practices.

KEY COMPONENTS OF AN EFFECTIVE AND EFFICIENT PRIMARY CARE PRACTICE MODEL

Based on research and experience, the following have been identified as the main characteristics of a high-performance primary health care model:

⁹ The College of Family Physicians of Canada (2009). *A Vision for Canada: Family Practice - The Patient’s Medical Home*: www.cfpc.ca/A_Vision_for_Canada/.

¹⁰ These terms have been translated for ease of understanding. The French term is the correct designation, i.e., “Groupes de médecine de famille (GMF)”; “GMF-réseau (GMF-R)”; “GMF universitaires (GMF-U)”.

- › Patient-centred organization of care (clear organizational vision and values focused on patients' needs and expectations).
- › Organizational accessibility (access to a wide range of health care owing to the availability and expertise of the group as a whole, and not to that of each individual team member).
- › An interprofessional team where each member's roles are clarified, defined and distributed among family physicians, nurses and other health professionals and that maintains a positive climate of collaboration.
- › A high-performance electronic medical record (EMR) adapted to the physician's practice (and not the other way round) and that he is fully trained in using so that he can maximize its potential (quality indicators for patient monitoring and interoperability with decision support tools).
- › An advanced access appointment scheduling system.¹¹
- › Adequate and timely access to technical platforms and specialist physicians.
- › Sufficient (well-trained) support staff, functional, appropriate-size premises and the necessary patient care, investigation and treatment equipment. Also, the need for incentives for excellence in patient care.
- › Team funding and payment models for professionals that are in keeping with the organization's mandate and care providers' functions.
- › Assessment of the effectiveness of services as part of a continuous quality improvement program.

A PATIENT- AND CITIZEN-CENTRED APPROACH

In the past, the solo family physician's response to patients' complaints was ad hoc (reactive individual approach). Currently, best primary care practices are those of interprofessional teams who are informed about their community's health needs and who plan how they will meet these needs in advance (proactive population-based group approach). Hence the relevance for care providers in primary care settings, in collaboration with regional public health branches, of finding out and being informed about local population health data and interacting with public health branches to tailor their actions to local needs.

¹¹ "Advanced access" refers to an appointment scheduling system that was first developed in the United States in 1990 and is supported by the FMOQ and the CFPC:
www.lemedecinquebec.org/Media/115897/001-090Syndi0212_v2.pdf (in French only).

Furthermore, to help citizens to manage their health better and to navigate the health care network more easily, the government should promote the provision of public Internet access where people could find regularly updated information and online help about health, the management of common diseases, services available locally and how to navigate the network. Incentives should also motivate the various FMGs to put information about their mission, their team, the services they offer, their opening hours, etc. online. User-friendly access to this type of information and decision aids, in addition to helping citizens directly, should help lighten the workload of primary care providers.

AN INDISPENSABLE TOOL: A HIGH-PERFORMANCE AND FUNCTIONAL EMR

Quebec lags behind other developed countries when it comes to physician use of electronic medical records (EMRs). A few clarifications are needed before we go any further, for there is confusion in the media and among the public about the different information technology tools: EMR, QHR, CCR.

The Québec Health Record (QHR) is not the same as the electronic medical record (EMR) that health professionals should be able to use. The QHR is mainly a link to allow authorized health care providers to access and search databases (e.g., lab results, imaging tests) from any location in Quebec.

Moreover, the computerized clinical record (CCR) created by scanning the pages of a medical record in order to do away with paper and reduce the space needed for archives in public network institutions is not the same as introducing a real electronic medical record. In fact, scanning is simply the same as photocopying and, since the data is scanned as a whole (and not word by word), it is not user friendly or quick for health professionals to search and does not allow comparisons to be made between data.

A number of difficulties and irritants explain the lag in the use of information technology by health professionals in Quebec's public health network:

- › The challenge (time, effort, cost ...) of entering data collected in paper records (e.g., list of problems, medications, history) into a new EMR.
- › The poor user-friendliness of information technology in the public health network (e.g., different software has to be used for lab tests, imaging, medications; numerous futile clicks, separate passwords, sudden loss of connection to the server) means that the QHR itself is not directly connected to EMRs as a source of information.

- › Efforts to protect the confidentiality of information and respect each patient's autonomy are sometimes in conflict with accessibility and the smooth flow of communications between health care providers.
- › The multiplicity of government-authorized EMR developers increases the complexity of data transfer and physician mobility between clinics.
- › Lastly, for family physicians, particularly those who work in institutions, the conflict between the relevance of using an EMR, the institution's willingness to make the CCR a priority and difficulties with interoperability, both local and remote, between these two types of records.

The EMR is an indispensable tool in primary care: it must be supported rapidly and its use by family physicians and interprofessional primary care teams facilitated in interconnection with patients, the community as well as with secondary and tertiary care providers.

TEAM-BASED STRATEGIES DEVELOPED FOR PRIMARY CARE THAT ARE PATIENT CENTRED

In light of the funding and efficiency issues facing health systems, management experts have suggested various approaches modelled after big business and often influenced by the challenges of hospital practice. Thus, a number of care protocols have been adopted (e.g., management of respiratory failure in hospital, of diabetes in ambulatory care) that have contributed significantly to both excellence of care and the improved efficiency of processes. Disease management and the associated practice guidelines have become essential elements of a proactive approach to chronic disease follow-up. It is, however, important to appropriately tailor these approaches to the needs of patients followed in primary care by family physicians and their team.

Thus, interprofessional practice tools and processes often focus on a specific disease (e.g., diabetes) or problem (e.g., cardiovascular risk) instead of focusing on the patient and his multiple problems and, rarely or never, on a patient who does not have an immediate health problem. Yet, the reality of primary care practice is that many patients suffer from various health problems at the same time (e.g., diabetes, hypertension, osteoarthritis, depression), some are healthy without an identified chronic disease, while others have undifferentiated ailments that cannot be accurately diagnosed.

This is why interprofessional practice tools and processes along with methods of collaboration in primary care should be developed or rethought so that they are centred on the patient, his health and his various health problems and not on each of his diseases in isolation.

A similar issue exists with respect to the expertise of the members of primary care teams. Of course, the responsibility for the overall picture of patients' health falls to family physicians. But must primary care collaborators be generalists or must they be specialists in a particular field? The question remains unanswered if we are to go by the opinions heard on the subject. Some people believe that those who collaborate with family physicians should also be generalist professionals or, at the very least, have some versatility in order to avoid an isolated approach that would mean that patients would, for instance, have to see several different specialized nurses. Other people mention the relevance of a psychiatric nurse's or a diabetes expert's activities. Everyone was in agreement in one respect: collaborators' expertise and the processes used must be adapted to the specific needs of primary care and not be a carbon copy of what is done in secondary and tertiary care settings.

DIFFICULTIES IMPLEMENTING CHANGE OR INNOVATION: THE RELEVANCE OF SUPPORT

The working group noted the vital role played by dynamic, motivated and inspiring leaders (*champions*) when introducing innovations, such as integrating a new care provider into a team (e.g., nurse practitioner, pharmacist), changing procedures in an office, a CLSC (e.g., adoption of advanced access, introduction of an EMR) or creating an FMG. At the moment, most of the time, each team, each person has to find their way and their motivation on their own (or virtually).

Given the size of Quebec's territory, the number of changes required and the diverse personalities involved, it is essential to explore ways of helping those individuals or teams who need it and to promote this service. Some professional associations (e.g., FMOQ, CFPC) already offer advice and some degree of support, but it would be appropriate, when introducing major changes, to provide for, formalize, fund and publicize support processes for individuals and teams who would like to make use of them and to ensure their follow-up.

ALIGNING FUNDING AND PAYMENT MODELS WITH DESIRED OUTCOMES

The Collège des médecins du Québec is not responsible for negotiating working conditions and remuneration for physicians. It is, however, important to stress that research and numerous experts indicate that funding mechanisms for primary care organizations and the type of remuneration model used for professionals have an enormous impact on the orientation of care and services and on interprofessional practices. Blended funding and remuneration models aligned with desired care and service outcomes, combining hourly rates, fee-for-service and activity-based payment, appear to promote greater individual and team efficiency.

In light of society's needs, family physicians have a collective social responsibility to agree with the government on individual payment models and team funding models that are most likely to promote quality, safe, effective and efficient primary health care and services that, among other things, should include a reduction of the percentage of remuneration that comes from fee-for-service payment.

FROM THE ASSESSMENT OF INDIVIDUALS TO THE ASSESSMENT OF PRIMARY CARE TEAMS AND ORGANIZATIONS

As part of its mandate and responsibilities as a professional order, the Collège des médecins du Québec has established procedures for assessing physicians' professional practice that focus on the quality of the medical act based on the group they belong to or their type of practice.

Thus, timely access for patients to their family physician or a member of his team and continuity of care (long-term follow-up of health, ailments and diseases) are essential components of quality of care and should be among the criteria used to assess practices. Moreover, the "Patient's Medical Home" model provides a fine summary of the characteristics of a functional quality primary care organization and could serve as a basis for establishing indicators for practice improvement.

In practical terms, a new era in professional practice improvement should be initiated by promoting and developing continuous quality assessment processes for practice, teamwork and collaborative practices centred on the patient and his family. In this way, teams and professionals could be equipped to self-assess their practices and professional orders equipped to make external visits to assess health care and services improvement, activities that partner organizations could also collaborate in.

With respect to the issues mentioned and to ensure robust primary care built on the expertise of the family physician, the Collège makes the following recommendations:

RECOMMENDATION NO. 2

Complete the implementation of FMGs, FMG-Ns and FMG-Us in primary care by supporting the introduction of exemplary, high-performance, dynamic organizational models and by establishing quality indicators to ensure practices are adapted swiftly.

RECOMMENDATION NO. 3

Provide for, formalize and fund support processes in family medicine when introducing major changes in a primary care clinical setting.

RECOMMENDATION NO. 4

Ensure the population of Quebec has access, in each region, to reliable general and specific information resources in primary health care and to up-to-date, integrated tools to navigate the health and social services network (e.g., decision aid for symptoms, guidance for some common diseases, information about changes in the organization of primary care and services in the region, online appointment scheduling).

RECOMMENDATION NO. 5

Implement a strategy to develop a culture within primary care organizations (FMGs, FMG-Ns, FMG-Us, clinical networks, CLSCs) where primary care teams are informed about the population health data for their environment (picture of their community) so that they can respond appropriately to the needs of local citizens, in particular the most vulnerable (e.g., the disabled, patients with impaired mobility, the homeless, marginalized individuals). This proactive strategy should be implemented in collaboration with public health branches.

RECOMMENDATION NO. 6

Include, in professional orders' practice improvement strategies, specific approaches for primary care that go beyond individual practice assessment and that seek to introduce a continuous improvement culture and promote safe care by focusing on the assessment of interprofessional practices. During primary care professional practice assessment visits, the different professional orders, whose members are part of primary care teams, should be invited to participate.

RECOMMENDATION NO. 7

Offer primary care facilities (FMGs, FMG-Ns, FMG-U, clinical networks, offices) that would voluntarily like to improve their performance the possibility of having the quality of their practices, their teams and their functioning assessed by a recognized independent body and, in this way, obtain accreditation, similar to what is done in health care institutions. To do this, provide primary care facilities that volunteer with the necessary support and funding.

Chapter 8/ Family medicine and family physicians: recruitment, training, research and practice support

Faculties of medicine, applicant selection processes, training content and methods are often targeted when new physicians adopt questionable behaviours, attitudes and practices.

Yet these elements have all evolved significantly in recent decades. Selection processes now take several dimensions into account including, for instance, applicants' interpersonal attitudes and competencies (e.g., communication, humanism). These requirements mean that future physicians must not only be experts but must demonstrate their professionalism as well as their collaboration and communication skills.

Furthermore, *generalism* is the strategic direction the Association of Faculties of Medicine of Canada has adopted for undergraduate medical education in Canada.¹² This means focusing training on common problems, reducing the use of tertiary centres in order to make greater use of community sites, increasing the participation of family physicians and curbing the disparaging attitude towards generalist physicians and the practice of family medicine.

Discussions among the members of the working group and various stakeholders concerning the current training of family physicians identified a number of issues facing universities.

¹² "The Future of Medical Education in Canada" projects. The Association of Faculties of Medicine of Canada: <https://www.afmc.ca/medical-education/future-medical-education-canada-fmec>.

SOLID TRAINING THAT IS TRULY FOCUSED ON DEVELOPING COMPETENCIES

The curricula that are used throughout the continuum of medical education in Canada (undergraduate level, postgraduate training, continuing professional development activities) are designed to train physicians who satisfy the requirements of the CanMEDS framework.¹³ This means that every physician must develop and demonstrate the competencies identified as essential to the practice of medicine (in addition to medical expertise itself, these include, for example, collaboration and communication skills).

Those responsible for training family physicians have also made tremendous efforts to adapt programs to the needs of the Canadian population and to meet expectations concerning family physicians' actions and attitudes (adoption of CanMEDS-Family Medicine,¹⁴ introduction of the Triple C Curriculum¹⁵).

Clinical training facilities in family medicine (FMUs) aim to be models of a quality, effective and efficient family medicine practice. Interprofessional collaboration has been practiced in FMUs for many years. In Quebec, many have become FMGs and some have adopted an advanced access system. These orientations apply to all FMUs in family medicine training networks.

EMERGING ISSUES AND OTHER ONGOING ISSUES

Despite the efforts of universities, many issues persist in connection with training, educators, students' and residents' experience as well as training sites:

- › Residents see the clientele in FMUs as more complex and are discouraged by the lack of support available for the administrative tasks inherent to practice. For many, long-term follow-up is one of the least popular residency activities.
- › Despite the efforts of family medicine teachers, the influence of a highly specialized hospital environment persists throughout residency training. Furthermore, in the university hospital network, to varying degrees depending on the site, a *hidden curriculum* still exists that disparages family physicians' work and the practice of family medicine compared with other specialty practices.

¹³ Frank J. *The CanMEDS 2005 Physician Competency Framework. Better standards. Better physicians. Better care*, Ottawa: The Royal College of Physicians and Surgeons of Canada. - The 7 roles identified in the 2015 version of CanMEDS are: medical expert (in family medicine in the context of this working group), communicator, collaborator, leader, scholar, professional and health advocate: www.royalcollege.ca/portal/page/portal/rc/canmeds.

¹⁴ CanMEDS-Family Medicine, College of Family Physicians of Canada: <http://www.cfpc.ca/projectassets/templates/resource.aspx?id=3031&langType=4105>.

¹⁵ Triple C Curriculum, College of Family Physicians of Canada: <http://www.cfpc.ca/projectassets/templates/landing.aspx?id=53&langType=4105>.

- › The family physician's specific role as integrator of patient health information and *conductor* of the primary care team appears to be poorly assimilated by students and residents in contrast to their perception that the family physician needs to know it all and do it all, which they do not believe they can do and do not want to be able to do.
- › Several institutional FMUs have a bureaucracy and local rules that hamper their organization and functioning or that create undue barriers.

All decisions concerning FMUs' core mission (FMG-U management framework) must be made following proper consultation of the different partners involved in order to maintain FMUs' teaching mission and promote the university network's adaptation to the clinical and educational needs of practice settings in order to create a climate conducive to change.

FROM TRAINING TO PRACTICE: STRESSORS AND POTENTIAL SOLUTIONS, INCLUDING MENTORING

Family medicine residents, like those in other medical disciplines, have to cope with the high stress level associated with the study of family medicine due, among other things, to the complex clinical situations they encounter and the many formal and informal assessments they undergo. Universities and clinical facilities are aware of the potential risks for their students' and residents' mental health and well-being. Efforts are made to inform them of the support resources available. Training sites provide students and residents with tools to develop the resilience needed to cope with the stressors of medical practice (e.g., meditation, mindfulness, relaxation) in order to help them manage difficult situations better emotionally during their training and future practice.

Mentoring is seen by many stakeholders as a promising avenue and a culture that must be developed to facilitate residents' transition from training to practice. Every young physician should have the option of being supported by a mentor at his practice setting in his first months of practice. This support consists of welcoming new physicians to practice, meetings and advice. The FMOQ has started to develop this type of program and is currently working on disseminating it. Other organizations, such as the Collège québécois des médecins de famille (CQMF), are also working on this type of program.

IS THE FAMILY PHYSICIAN ADEQUATELY TRAINED TO DEAL WITH THE MULTIPLE TASKS ASSIGNED TO HIM?

Canada is, among developed countries that recognize the specialty of family medicine, the only one that requires only two years of training after basic medical training. The issue of the length of residency training has long been controversial. A proposal put forward a number of years ago for three years of training was rejected.

The working group cannot speak for or against maintaining or extending training in family medicine. However, it received input that suggests that student support must be rethought to ensure a greater transfer of knowledge, for instance, in mental health, management and entrepreneurship. If universities were to decide to review the training provided in these fields and in general, they should carefully examine the ratio of theory to clinical exposure so that the latter can be given much greater emphasis in order to allow a more lasting transfer of knowledge. This would also imply that theoretical knowledge would be acquired more through self-study.

It should be noted that the optional mentoring mentioned previously is primarily intended to ease some residents' transition to practice, not to provide additional training to all residents.

THE RELEVANCE OF AND ABSOLUTE NEED FOR RESEARCH ON THE ISSUES SURROUNDING PRIMARY CARE

Evidence from research must guide decisions about primary care, both with respect to clinical approaches and organizational models and the development of training programs. It is vital to maintain and increase efforts in this area. However, clinical knowledge must be accessible using clinical decision support tools (ideally integrated into the EMR) that are based on practice guidelines or recommendations produced by learned societies.

With respect to the issues mentioned and to ensure robust primary care built on the expertise of the family physician, the Collège makes the following recommendation:

RECOMMENDATION NO. 8

Ensure family physicians receive solid training that prepares them to meet societal needs and to adapt their practices to these needs. To do this, the following conditions must, at a minimum, be met:

- › Ensure the participation of a high number of family physician teachers who are positive role models at all stages of medical training.
- › Train residents in stimulating and exemplary settings that resemble their future practice settings and where they are exposed to the realities of different health problems (with a particular focus on mental health and the management of multimorbidity) and to collaborative practices, including those with the patient and his family.
- › Encourage dialogue between future family physicians and future specialist physicians so that they will have a better understanding of their respective roles and develop a more effective working relationship.
- › Introduce extended training in leadership and management (including notions of entrepreneurship) to better prepare future physicians to play a leadership role at different levels of governance in the health and social services system.

Chapter 9/ Building robust primary health care and services: a need for multitargeted action

To strengthen the family physician's role in the long-term follow-up of patients and to build more robust primary care, a number of actions must be undertaken simultaneously. While targeting *macro* and *meso* structures in the health system, decision makers must also be careful not to overlook more *micro* activities, processes and methods specific to primary care. These may differ from one place to another to ensure they are adapted to local needs.

Quebec society would like the government to clearly identify the actions that it is willing to support and implement to give primary health care and services the means to achieve its ambitions. These include, in particular, the development of a global vision of primary care mandates and activities, the consequent realignment of processes and funding, support for clinical and training facilities in primary care and a strategy to enhance the visibility and recognition of the value of interventions and actors who work in primary care.

Although it is important to provide secondary care and tertiary care with the resources they need, primarily in institutions, to fulfil their mandates, it is also important that this does not happen at the expense of the development of sustainable primary care. It must be acknowledged that the media exposure of institutions specialized in secondary and tertiary care and the associated lobbying may be done at the expense of building more robust, effective and efficient primary care.

It is essential to reaffirm that making adequate investments in primary care infrastructure and operation (FMGs, FMG-Ns, FMG-Us, clinical networks, family medicine offices) is worthwhile in the long term for the public health care network that physicians participate fully in so as to counter and check the private sector's unwanted participation in some sectors.

Therefore, this position statement reaffirms that primary health care and services will be all the more effective if they can rely on the expertise of a sufficient number of motivated family physicians supported, in particular, by a dynamic interprofessional team, a high-performance and functional EMR, timely access to technical platforms and specialist physicians, clinical approaches based on the best available data and adapted to the primary care setting, appropriate premises, truly incentivizing remuneration linked to responsibility and the performance of tasks as well as the capacity, where needed, to recruit new young physicians who are adequately trained and supported by a mentoring program.

With respect to the issues mentioned and to ensure robust primary care built on the expertise of the family physician, the Collège makes the following recommendation:

RECOMMENDATION NO. 9

Mandate regional general medicine departments (départements régionaux de médecine générale - DRMGs) to prioritize the development and organization of public network primary care services in medical clinics (including FMGs, FMG-Ns and FMG-Us) and CLSCs.

- › Ensure this organization includes the additional human and financial resources needed for its operation.
- › Provide for a provincial round table with the expertise to guide and support regional structures.

In collaboration with all major stakeholders (especially the Ministère de la Santé et des Services sociaux, the Fédération des médecins omnipraticiens du Québec, the Fédération des médecins spécialistes du Québec, the Collège des médecins du Québec, the other orders of health professionals, universities, the Collège québécois des médecins de famille, the Québec Medical Association, the councils of physicians, dentists and pharmacists, the directors of professional services and public health directors), this organization, now more robust, would be given the following mandates:

- › Support the continuous improvement of primary care and services.
- › Improve access to specialist physicians and technical platforms in secondary and tertiary care.

- › Promote and facilitate interprofessional collaboration.
- › Ensure the response to the population's needs is aligned with population health data, in conjunction with public health authorities.
- › Provide a mentoring program with a minimum duration of one year for physicians entering practice.
- › Structure a program to welcome and support new family physicians when they first arrive in their practice setting.
- › Make recommendations on the basket of services (addition, removal, maintenance).
- › Promote and facilitate training in management and entrepreneurship for family physicians.
- › Support the work of physician executives.
- › Provide support to primary care organizations when major changes are introduced (electronic medical record, arrival of new types of professionals).
- › Establish relations (communication/input) with the Minister of Health and Social Services and the Minister of Education and Higher Education as well as with educational settings in order to ensure the training provided to future family physicians is aligned with realities in the field (e.g., input on programs, human resources, funding).
- › Recommend any relevant changes to decision makers and, at least once a year, publish a formal status report and recommendations.

Chapter 10/ List of statements and recommendations

STATEMENT NO. 1

As numerous studies and much research and evidence show, a strong, high-performance, accessible and viable public health and social services system must be founded on robust primary care and services where the family physician plays a vital role. To ensure quality, effectiveness, efficiency and robustness, resources and funding must be allocated accordingly.

STATEMENT NO. 2

Physicians (*all specialties combined*) share a collective social responsibility to meet the health care needs of the community they practice in and must adapt their practice to local needs (e.g., timely access to acute care and patient follow-up), subject to the resources available. Consequently, close, effective “family physician – specialist physician” collaboration that ensures easy, direct access is imperative.

STATEMENT NO. 3

Quebec’s citizens must, if they so wish, be able to register with a family physician and be seen in a timely manner by him or by a professional on his team.

STATEMENT NO. 4

The family physician’s primary mission is to accept responsibility for the long-term follow-up of patients in primary care (e.g., health promotion, treatment of acute ailments, follow-up of chronic diseases).

STATEMENT NO. 5

The great versatility of many family physicians in Quebec, who provide both patient follow-up and secondary care, is an added value.

STATEMENT NO. 6

The family physician's training, both in biological sciences and human sciences, as well as his versatile primary care practice make him a key care provider, the integrative leader and *conductor* of the primary care team. He is the health professional who, by sharing and integrating information from other health care team members, is best qualified to create a complete picture of the patient's health with each patient, coordinate their care plans and, if necessary, help them navigate the health and social services system.

STATEMENT NO. 7

Concrete action must be taken to increase recognition of the value of family medicine in society given its importance for robust primary care. Any remarks that run contrary to this recognition of the value of family medicine, irrespective of the context (teaching, training, practice), must be swiftly denounced and steps taken immediately to put an end to them.

RECOMMENDATION NO. 1

Improve and increase interprofessional collaboration for the benefit of the population being served. To do this, the following conditions must, at a minimum, be met:

- › Promote reciprocal knowledge of the roles and area of expertise of the family physician, the various care providers working in primary care and the community resources available in the environment.
- › Create conditions conducive to smooth communication and timely access between family physicians and physicians from other specialties as well as between family physicians and other health professionals.
- › Ensure public access for patients, as needed, to health professionals who work in collaboration with family physicians.

RECOMMENDATION NO. 2

Complete the implementation of FMGs, FMG-Ns and FMG-U's in primary care by supporting the introduction of exemplary, high-performance, dynamic organizational models and by establishing quality indicators to ensure practices are adapted swiftly.

RECOMMENDATION NO. 3

Provide for, formalize and fund support processes in family medicine when introducing major changes in a primary care clinical setting.

RECOMMENDATION NO. 4

Ensure the population of Quebec has access, in each region, to reliable general and specific information resources in primary health care and to up-to-date, integrated tools to navigate the health and social services network (e.g., decision aid for symptoms, guidance for some common diseases, information about changes in the organization of primary care and services in the region, online appointment scheduling).

RECOMMENDATION NO. 5

Implement a strategy to develop a culture within primary care organizations (FMGs, FMG-Ns, FMG-U's, clinical networks, CLSCs) where primary care teams are informed about the population health data for their environment (picture of their community) so that they can respond appropriately to the needs of local citizens, in particular the most vulnerable (e.g., the disabled, patients with impaired mobility, the homeless, marginalized individuals). This proactive strategy should be implemented in collaboration with public health branches.

RECOMMENDATION NO. 6

Include, in professional orders' practice improvement strategies, specific approaches for primary care that go beyond individual practice assessment and that seek to introduce a continuous improvement culture and promote safe care by focusing on the assessment of interprofessional practices. During primary care professional practice assessment visits, the different professional orders, whose members are part of primary care teams, should be invited to participate.

RECOMMENDATION NO. 7

Offer primary care facilities (FMGs, FMG-Ns, FMG-Us, clinical networks, offices) that would voluntarily like to improve their performance the possibility of having the quality of their practices, their teams and their functioning assessed by a recognized independent body and, in this way, obtain accreditation, similar to what is done in health care institutions. To do this, provide primary care facilities that volunteer with the necessary support and funding.

RECOMMENDATION NO. 8

Ensure family physicians receive solid training that prepares them to meet societal needs and to adapt their practices to these needs. To do this, the following conditions must, at a minimum, be met:

- › Ensure the participation of a high number of family physician teachers who are positive role models at all stages of medical training.
- › Train residents in stimulating and exemplary settings that resemble their future practice settings and where they are exposed to the realities of different health problems (with a particular focus on mental health and the management of multimorbidity) and to collaborative practices, including those with the patient and his family.
- › Encourage dialogue between future family physicians and future specialist physicians so that they will have a better understanding of their respective roles and develop a more effective working relationship.
- › Introduce extended training in leadership and management (including notions of entrepreneurship) to better prepare future physicians to play a leadership role at different levels of governance in the health and social services system.

RECOMMENDATION NO. 9

Mandate regional general medicine departments (départements régionaux de médecine générale - DRMGs) to prioritize the development and organization of public network primary care services in medical clinics (including FMGs, FMG-Ns and FMG-Us) and CLSCs:

- › Ensure this organization includes the additional human and financial resources needed for its operation.
- › Provide for a provincial round table with the expertise to guide and support regional structures.

In collaboration with all major stakeholders (especially the Ministère de la Santé et des Services sociaux, the Fédération des médecins omnipraticiens du Québec, the Fédération des médecins spécialistes du Québec, the Collège des médecins du Québec, the other orders of health professionals, universities, the Collège québécois des médecins de famille, the Québec Medical Association, the councils of physicians, dentists and pharmacists, the directors of professional services and public health directors), this organization, now more robust, would be given the following mandates:

- › Support the continuous improvement of primary care and services.
- › Improve access to specialist physicians and technical platforms in secondary and tertiary care.
- › Promote and facilitate interprofessional collaboration.
- › Ensure the response to the population's needs is aligned with population health data, in conjunction with public health authorities.
- › Provide a mentoring program with a minimum duration of one year for physicians entering practice.
- › Structure a program to welcome and support new family physicians when they first arrive in their practice setting.
- › Make recommendations on the basket of services (addition, removal, maintenance).
- › Promote and facilitate training in management and entrepreneurship for family physicians.
- › Support the work of physician executives.
- › Provide support to primary care organizations when major changes are introduced (electronic medical record, arrival of new types of professionals).
- › Establish relations (communication/input) with the Minister of Health and Social Services and the Minister of Education and Higher Education as well as with educational settings in order to ensure the training provided to future family physicians is aligned with realities in the field (e.g., input on programs, human resources, funding).
- › Recommend any relevant changes to decision makers and, at least once a year, publish a formal status report and recommendations.

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