

# **Primary Importance: New Physicians and the Future of Family Medicine**

PROFESSIONAL ASSOCIATION OF  
INTERNES AND RESIDENTS OF ONTARIO

*Position Paper on the  
Sustainability of Family Medicine*

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# Primary Importance: New Physicians and the Future of Family Medicine

## Introduction

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Ontario's internes and residents support and respect the discipline of family medicine. As front-line physicians, we understand the ways in which quality healthcare depends upon strong family doctors as well as specialists. The family medicine approach to primary care is cost-effective and beneficial to patients;<sup>1</sup> it is the hallmark of the Canadian healthcare system and stands in contrast to countries in which underdeveloped family medicine systems exist.

However, Canada's primary healthcare system is at a turning point, and the sustainability of family medicine as the core of that system is increasingly being called into question. Millions of Canadians are without a family physician,<sup>2</sup> and as patients turn to crowded emergency rooms and walk-in clinics to fill the void, they question the fundamentals of a system that does not seem to meet their needs.

At a time when primary care is centre stage in the minds of health policymakers, fewer and fewer medical students are selecting family medicine as their career of first choice.<sup>3</sup> Family physicians are reporting burnout in increasing numbers.<sup>4</sup> While other care providers play a vital role in the primary care system—one that is becoming increasingly more important as primary care reform occurs across the country—the issues plaguing family medicine remain to be addressed.

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<sup>1</sup> Mackino, J, Starfield B, Shi L. "The contribution of primary care systems to health outcomes within Organization for Economic Cooperation and Development (OECD) countries." Health Services Research. 2003, June; 1970-1998.

<sup>2</sup> The College of Family Physicians of Canada *Initial Data Release of the 2001 National Family Physician Workforce Survey*, October 2001 found at [www.cfpc.ca/communications/newsreleases](http://www.cfpc.ca/communications/newsreleases). Documented the serious shortfall of family doctors.

<sup>3</sup> In 1993, 41% of medical students listed family medicine as their first choice of career in the Canadian Resident Matching System (CaRMS). In 2003, that number had dropped to 24%.

<sup>4</sup> Macleans, "Your doctor prescribes a cure for health care." 2003, December 8; 116(49).

## **The Perspective of the Next Generation**

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As fresh graduates of the undergraduate medical education system, PAIRO members understand the factors at play in medical student career choice. As practising members of the medical profession, we also see the ways in which the healthcare delivery system has contributed to the breakdown in family medicine. Residents experience the frustration of falling short of patients' expectations because the system cannot respond to them; we also suffer the educational impact of the disconnect between family medicine and other disciplines. Our own growth as professionals is hindered by our inability to work as effectively with our colleagues as we would like to do.

Residents have a vested interest in being part of the solution in primary care, and want to play an active role in decision-making and policy implementation as the system moves to improve access and quality for Canadians.

### **The Breakdown Begins in Training**

Many residents observe that the breakdown in the primary care system begins at the medical school level, with an education in methods of practice that becomes difficult to unlearn. The difficulties in communication between practising family physicians and specialists are transmitted into medical school and residency culture and set patterns for the healthcare system of the future. These difficulties are influenced by lack of time, lack of electronic or other reliable means of communication, and an attitude among both family physicians and specialists that their work is done when they have finished caring for the patient rather than when they have communicated back to the other members of the patient's care team.

The feeling of so many family physicians that their colleagues view them as "second tier" also plays out at the residency level, and from there it trickles into our medical schools to influence students as they embark on their professional lives. The widely held belief that family medicine programs are less rigorous or challenging than other programs leads to a divide and at times even disrespect between residents in different disciplines. Family medicine residents participate in stereotyping as well, often viewing patient-centered care as their sole domain and failing to give credit to their specialty colleagues for their awareness of and respect for the psychosocial dimension of healthcare.

Residency training presents an enormous opportunity for change within the healthcare system. The interest of the "new generation" in more interdisciplinary models of care opens up possibilities for better cooperation between family physicians and specialists as well as other care providers, and could serve as a seed for transformation in the existing system. Within the medical profession, residents act as mentors to their student colleagues and an inspiring reminder of personal potential for established physicians—education and efforts at the resident level will pay off in the healthcare system of the future as well as the present. PAIRO members are committed to participating in the rejuvenation of family medicine.

### **Generational Conflicts as a Factor**

As important as resident perception of the existing education and healthcare systems are the perceptions policymakers and practising physicians have of residents. A growing body of

evidence shows that the comprehensiveness of family medicine practice is on the decline.<sup>5</sup> This trend is often attributed to a perceived lack of willingness on the part of new physicians to expand beyond office-based care due to lifestyle factors. Such a simplified analysis contributes to a generational divide, and leads established physicians to feel that they are part of a “dying breed” while new physicians feel disconnected from their own profession and feel defensive of their choices. If policymakers are to address the need of Canadians for comprehensive care, the forces driving decisions about practice style need to be understood. New models of care provision that meet patients’ needs while acknowledging differing practice style must be considered, and the discipline of family medicine needs to be supportive of that variety. Supports can be put in place to help new physicians practice comprehensive care. At the same time, models of primary care in which patients receive comprehensive care from a team of health professionals rather than a single overworked family physician should not be seen as the death of family medicine, but rather a re-imagining of the profession that achieves our shared goal: quality patient care from fulfilled professionals.

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<sup>5</sup> Chan, Ben. “The declining comprehensiveness of primary care.” Canadian Medical Association Journal. 2002, February 19; 166(4).

## **Factors at Play: Issues Shaping the Current State of Family Medicine in Canada**

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The factors affecting the discipline of family medicine are many, and have been studied extensively by many stakeholders.<sup>6,7,8</sup> While some are negative pressures that have contributed to a perceived crisis in the discipline, others are positive factors that open up opportunities for change. Broadly speaking, they can be summarized as follows:

### **Societal Factors**

The issue of career prestige is raised consistently as a factor discouraging medical students from entering family practice, and as a contributing factor in the burnout experienced by practising physicians. This lack of prestige manifests itself in many ways leading to lowered social status (“So, you’re just a GP”), less job satisfaction, and diminished remuneration vis-à-vis other medical disciplines.

Furthermore, an increasingly consumerist culture in healthcare has led to a phenomenon where family medicine is seen as a service industry whereas specialty care is seen as a privilege. Particularly in urban centres where most residents train, patients often demand referral to a specialist, even for conditions which could easily and appropriately be managed by a family physician. Not only is this demeaning but it turns family physicians into gatekeepers rather than allowing them to utilize their full scope of practice.

The roots of these factors are complex and their resolution will not come about as the result of any single initiative. It is counterbalanced by respect for family physicians in many smaller communities and a growing recognition amongst policymakers and governments that more work needs to be done to support the role of family doctors in the context of larger primary care initiatives.

### **Pre-Medicine Factors**

The recruitment of potential physicians from backgrounds in the hard sciences, the specialization and intense focus being emphasized at universities at the undergraduate level, and the selection bias towards research-focused applicants all contribute to a medical culture that celebrates narrow fields of expertise and looks down upon generalism. A recent study in British Columbia indicated that only 18% of first-year medical students are interested in family medicine on entry to medical school<sup>9</sup>—in this context it is not surprising that so few students choose family medicine upon graduation. Medical schools are increasingly recognizing the value of recruiting well-rounded individuals who may be more temperamentally suited for a career in family medicine than hyper-specialized applicants.

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<sup>6</sup> College of Family Physicians of Canada. “Primary Care and Family Medicine in Canada: A Prescription for Renewal.” October 2000.

<sup>7</sup> Ontario College of Family Physicians, “Summary of Proceedings from the Family Physician Check Up: A Forum Examining Why the Shortage and How to Solve It.” September 12, 2003.

<sup>8</sup> Rosser, W. “The decline of family medicine as a career choice.” CMAJ. 2002, May 28; 166(11).

<sup>9</sup> Dhalla, Kwong, Streiner, Baddour, Waddell, Johnston. “Characteristics of first year students in Canadian medical schools.” CMAJ. 2002, April; 166(8).

## **Medical School**

The perception that family physicians are “not as good as specialists” starts in the medical school classroom, where specialists do most of the teaching and family doctors often teach only the “soft” parts of medicine such as communication skills. There is a lack of family physician mentors in medical school and a lack of exposure to family physicians in leadership roles throughout undergraduate medical education. The imbalance is further propagated in clinical training through comments made in rounds, teaching cases, and the lack of communication back to family physicians when patients leave hospital. Exposure to the teaching practice environment is also a factor, since the academic family medicine environment is less true to life than the exposure students get to other specialties in medical school. Finally, in some cases students are led to believe that being a generalist means being an expert in absolutely everything, and are intimidated by the enormity of such an expectation.

Much of the undergraduate medical education in family medicine takes place in Family Medicine Clinical Teaching Units. The population of patients in a clinical teaching unit is often not reflective of the patients typically seen in most family medicine practices. Clinical teaching unit patients tend to have more co-morbid conditions, including mental health concerns, and can be very challenging to care for. While this presents an enhanced educational opportunity, it can be discouraging, and misrepresents family medicine when it provides medical students’ only exposure to family medicine.

Even within family medicine there are pressures which may have a negative effect on recruitment. Anecdotes of community family medicine preceptors criticizing academic family physicians, and of rural practitioners minimizing the scope of practice of urban family physicians, do not help any branch of family medicine.

There is also an understandable desire of many medical students to enter into a residency which will allow them to practice in an urban, tertiary setting—similar to the medical school environment they are most familiar with, and where they and their family may be settled. While there are abundant specialist positions within tertiary academic centres there is the (mis)perception that it is difficult to engage in comprehensive family medicine within the confines of a major city.

Taskforces at medical schools across the country are engaged in curriculum reform in an attempt to address some of these issues. Effective models exist across the country and programs are learning from one another. Family doctors are being encouraged to teach what they do, and medical schools are educating teachers about the effect of denigrating comments toward family physicians and other specialists.

## **Residency Factors**

At the level of residency training, the divide between family physicians and their specialty colleagues begins to widen. Lack of contact between family practice and specialty residents in their training programs can lay the groundwork for poor communication in their future professional lives. While family practice residents spend time training in a number of different disciplines and therefore develop an understanding of the environments in which their specialty

colleagues work, the dearth of exposure to family medicine for some Royal College residents leads to difficulty understanding the role family physicians play in the system.

Currently there are limited opportunities to transfer amongst programs once a medical student has entered residency training. In most provinces, it is relatively easy to transfer between Royal College programs as Royal College training is transferable and there is no requirement to find additional funding to pay the resident as the length of training in most Royal College programs is fixed at five years. Transferring from family medicine to a Royal College program, however, is difficult as the Royal College will accept at most six months of family medicine training and the program is obliged to find funding for the additional years of residency training. This drives medical students who are unsure about their career path into Royal College programs so as to preserve their ability to transfer programs. Ironically, though family medicine with its diverse exposure to all fields of medicine and the ability to custom-tailor family medicine practice patterns should be the most attractive field for those unsure about their future career, system factors deter the undecided medical student from considering family medicine.

Unfortunately many of the stresses on family medicine have led to a general decline in the morale of family practitioners. In addition, as the popularity of family medicine declines among medical students, more of the residents entering family medicine do not choose family medicine as their first career choice and this impacts upon family medicine resident morale, which has a spill-over effect on medical students exposed to this environment.

### **Practice Factors**

In addition to the distribution challenges in the area of health human resources, there is a sheer number shortage of family physicians in Canada. Those who work in underserved communities are burning out in the face of huge numbers of patients, increasing paperwork requirements and lesser compensation than their specialty colleagues. Family physicians are aware of an unfocussed pressure to reform, of but in many cases are ill-equipped to cope. Many are responding to this pressure by subspecializing in areas such as emergency care and walk-in clinics. While these physicians are filling a clear service void, their choices do contribute to the feeling of mass exodus from the traditional discipline.

At the same time, new models of family practice are emerging that present enormous opportunity for all physicians. Collaborative care between family physicians and specialists as an alternative to referral-focused care will undoubtedly lead to better patient outcomes, and the improved incorporation of allied health professionals into teams with physicians allows family doctors to better utilize their own skills and exercise their full scope of practice. Finally, there is a growing recognition that family medicine remuneration must be increased to reflect the value of the work that family doctors do.

Family physicians identify increasing and often unremunerated paperwork demands as being the least satisfying aspect of their job.<sup>10</sup> Family physicians are increasingly besieged with complex requests for information which increases the shift from clinician to documentarian. Inadequate and fragmented incorporation of information technology into primary care contributes to this burden.

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<sup>10</sup> Unpublished OMA data.

## **A Framework for Next Steps**

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Initiatives are underway at the level of governments, professional associations, medical schools and local communities to address the factors outlined in this paper. Residents—in their multiple roles as educators, trainees, practising physicians, policymakers and professionals—are working with other stakeholders towards a new vision for family medicine in Canada. Our vision of a successful rejuvenation of the system does not stop at a group of happy family physicians; it extends to specialties across the board and to other health professionals such that patients feel supported and cared for across the continuum of healthcare. Our success should be measured by the following outcomes:

- ❖ Increased patient access to family physicians and primary care professionals
- ❖ Increased numbers of medical students choosing family medicine
- ❖ Greater numbers of residents deciding to enter into comprehensive family medicine
- ❖ Increased numbers of practising family physicians who feel valued and fulfilled in their work
- ❖ Reduced tension between family physicians and specialty colleagues
- ❖ Increased public awareness of the role of the family physician in the healthcare system
- ❖ Improved models of primary care that allow family physicians to provide the care patients need while achieving professional fulfillment

PAIRO believes these goals can be achieved through initiatives that are by and large already underway. The key is to focus our efforts and to showcase the enthusiasm so many family physicians and their patients feel about the role of family medicine in their lives. Residents have a key role to play in this process.

### **Make Primary Care Appealing to Brilliant Young Minds**

The approach to medical student recruitment must be more sophisticated than simply taking students who say they want to be family physicians. Instead we must develop tools for identifying students who have shown a propensity for generalism in their pre-medical interests and reward students who have been community-based in their activities. Those students from generalist backgrounds who choose to pursue specialty careers are also likely to be predisposed to work harmoniously with their generalist colleagues.

PAIRO cautions against simply signing students into dedicated family medicine spots or the development of extensive Return of Service programs that would require students to select their career path before finishing medical school. Such programs inevitably lead to practising professionals who are unhappy in their work, and communities have expressed a clear desire to turn away from coercive measures.<sup>11</sup>

In addition to outreach to diverse young people and an overhaul of medical education, community-based initiatives need to be undertaken to raise the profile of family medicine and elevate it in the mind of the public.

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<sup>11</sup> NOW Alliance, “2004 Rural Health Action Plan”, [www.nowalliance.ca](http://www.nowalliance.ca)

The culture (in the undergraduate medical classroom and on the wards) that denigrates family medicine as a discipline needs to be transformed. Across Canada medical schools are working to increase sensitivity to family physicians amongst teachers in the medical school. This should include scrutiny of cases presented, formal urging of lecturers to be respectful of family medicine in their comments, and repercussions for those teachers who make derogatory comments towards family physicians. Increased exposure to family physicians in the pre-clinical years and in the classroom must also be a priority. This means looking at ways of making teaching attractive to family doctors (through financial and other incentives such as formal recognition) as well as allowing family physicians to teach medicine, beyond the soft subjects such as communications skills and community medicine.

The medical school curriculum should be re-focused such that its primary goal is to produce not proto-specialists, but well rounded physicians with a core bundle of skills. Effective models of producing interest in family medicine exist at medical schools which traditionally produce a large number of family medicine graduates. These best practices should be identified and adopted at medical schools which fail to produce sufficient numbers of graduates interested in family medicine.

Medical students interested in pursuing electives in family medicine, particularly in community-based practices, should not have to do so at their own expense. This principle also applies to those residents who choose to pursue training in communities farther away from academic teaching centres. The cost of travel, accommodation, and meals should be covered uniformly so as to support trainees interested in learning community-based family medicine.

Finally, the work being done by students in Family Medicine Interest Groups to increase awareness of the changes occurring in primary care and the different practice models available to family physicians must be supported. Students themselves can be very effective proponents of family medicine, and should be supported in their attempts to explore, understand and contribute to the discipline.

### **Value Family Medicine Training**

Initiatives that provide financial support to residents who choose family medicine as a career can function as an incentive, and PAIRO supports this notion.<sup>12</sup> In isolation, however, they will be ineffective because those residents who enter family practice will not be entering a vibrant and fulfilling discipline unless other factors are addressed. Furthermore, initiatives such as tuition relief must be in place in a context of reasonable medical school tuition for all so as not to create a two-class system of medical education in which lower-income students are forced to enter family medicine as a condition of tuition relief while high-income students can choose to enter other specialties.

The culture of the tertiary care teaching centre has the potential to put family medicine residents lower in the hierarchy than their specialty colleagues in terms of the attention that is paid to their learning (though of course this is not universally the case). Conscious effort is required on the part of educators and learners to maintain a high quality educational experience and high

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<sup>12</sup> NOW Alliance, “2004 Rural Health Action Plan”, [www.nowalliance.ca](http://www.nowalliance.ca)

expectations of our family practice residents. In terms of structural changes to residency programs, increased flexibility in terms of switching between College of Family Physicians of Canada and Royal College of Physicians and Surgeons of Canada programs would likely lead to increased numbers of residents entering family medicine over the course of their training.

Residents in every specialty should be strongly encouraged to complete a rotation in family medicine. Residency training should include more formal skill-building in communication between family physicians and their specialty colleagues. Some of the “soft” skills which have been emphasized in family medicine should be emphasized in Royal College programs such as the development of communication skills, attention to the financial cost of treatments and always being mindful of patient adherence factors.

Residents in family medicine are a potential source of enormous inspiration and mentorship to their medical student colleagues. Students should be exposed to family medicine residents as clinical teachers early on in medical school and often throughout their clerkship. Programs that encourage and support this type of interaction will also help to build the morale of family practice residents by acknowledging the expertise they have to offer.

Finally, the movement nationally for the establishment of a common first year of training (Common PGY1) would have an important impact on family medicine training. PAIRO supports solutions that increase career flexibility and delay early career decision-making for medical students.

### **Support and Celebrate the Work Family Physicians Do**

In focusing our energies on medical students and their career choices, we must not forget to work with the family physicians currently in the system. It is vital to help them connect with each other to form a community and to recognize the important work they do. Financial remuneration is part of this; but we must also apply the principles used for recruitment of new physicians to the retention of experienced physicians. Lifestyle factors, professional community, non-monetary recognition and personal support must be put in place for family physicians working in Ontario.

A great deal of work is being done in the areas of primary care reform, alternate funding mechanisms, information technology and systems integration to improve the professional quality of life of family physicians. In particular the need for significant investment in information technology to support efficiency in family practice is clear.

The emergence of different models of primary care reform across the country offers a host of opportunities to family physicians. In models that offer well-designed interprofessional team care, patients can receive the comprehensive care they need and family physicians and other professionals can maximize their professional satisfaction. It is vital, however, that the emergence of interprofessional models not shift the family physician into the role of “consultant” – this is precisely the role most family physicians consciously chose to avoid by entering their discipline. Practising the full scope of family medicine means developing relationships with patients over time, and not simply being brought in to care for patients when pharmaceutical solutions are required.

While well-designed primary-care reform can rejuvenate family medicine and address many problems, it is important that primary care reform not be seen as a panacea. Many challenges facing family medicine, such as medical school factors and social factors, will not be directly impacted by primary care reform. Furthermore, the pace of primary care reform has, to date, been ponderous and it would be irresponsible to continue waiting for primary care reform while the challenges facing family medicine continue to mount.

### **Provide Leadership Within Family Medicine and in Partnership With Others**

At various levels numerous groups represent family physicians and family medicine trainees, yet a clear direction on how to respond to the various challenges facing family medicine has not yet emerged. While different situations require unique solutions, it is important that we move beyond criticism of the status quo to construct the future. The multi-stakeholder group working at a national level should look at the external environment and internal factors within family medicine which have led to the current situation. System failures ought to be identified and a directed action plan ought to be drafted so as to realistically address the challenges facing the exciting field of family medicine. Decisive action is not just necessary to respond to this challenge, but to inspire confidence in the present and future providers of comprehensive family medicine in Canada.

In general, family physicians are respected in the community but they are not high profile as a group. It may be time for physicians to partner more closely with communities in order to work towards a greater understanding of where professional desires and community needs intersect. Initiatives such as the NOW Alliance (Negotiating Ontario's Wellbeing) have shown that partnerships between physicians and communities can lead to the development of innovative solutions to challenges such as the physician shortage in rural underserved communities. While organized medicine and elected politicians often lead the way in such partnerships, smaller groups of physicians and local groups should engage in ongoing dialogue rather than waiting for healthcare crises to arise in their communities before partnering.

Finally, it is important that an intergenerational dialogue between the emerging generation of family physicians and their more experienced colleagues occur. It is clear that models of practice developed in previous generations no longer work for patients or providers; however we must also be mindful that we preserve the essence of family medicine in all future models of care. An ongoing relationship and a dialogue based on mutual respect must drive the development of models that can meet the needs of established and new physicians.

## **Summary of Recommendations**

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This paper is not intended to provide an exhaustive list of solutions to the challenges faced by the discipline of family medicine. Rather, it aims to add the resident perspective to a growing movement to address those challenges at different levels across the country. As outlined in this document, PAIRO supports the following emerging and potential solutions:

### **Pre-medical and Undergraduate Medical Education Reforms**

1. A concerted effort must be made on the part of the medical profession, communities and governments to reach out to high school students in rural communities and underrepresented groups and encourage them to consider a career in medicine.
2. Medical student recruitment and admissions policies should aim to bring in students with generalist backgrounds who may be more suited to a career in family medicine. Coercive measures and return of service programs that force students to choose family medicine prior to completion of medical school are not appropriate solutions.
3. Family physicians should be central teachers in the undergraduate medical curriculum and should be remunerated for their work as educators. Their involvement should not be limited to teaching communications skills.
4. The undergraduate medical curriculum should be re-focused to emphasize a general set of skills rather than consisting of a series of mini-specialty courses.
5. Practising family physicians and specialists should be made aware of the importance of speaking respectfully about the work their colleagues do, both to medical students and to the public.
6. Undergraduate medical exposure to family medicine should move beyond clinical teaching units, in order to expose students to other styles of practice as well as a diversity of patient populations.
7. Medical students and residents who pursue training in family medicine outside major centres should be reimbursed for all expenses incurred.
8. Family Medicine Interest Groups should be supported by faculties and professional associations.

### **Postgraduate Medical Education Reforms**

1. Concrete initiatives need to be put in place to ensure contact between family practice and Royal College residents (i.e. joint clinics, seminars, joint rounds etc.). Training in effective communication between care providers inside hospitals and in the community must be put in place.
2. All Royal College programs should include some element of training in family medicine.
3. Increased program flexibility and ease of transfer between family medicine and Royal College programs should be put in place. The Common PGY-1 year may also contribute in this area.
4. Financial incentives for residents who choose family medicine and family physicians who choose comprehensive care should be considered, but should be implemented in a non-coercive context.
5. Family medicine residents should be trained and encouraged to participate in teaching clinical skills to medical students.
6. Dialogue between established physicians and new physicians needs to occur on the issue of comprehensive care and other models of healthcare delivery in order to increase

understanding of the factors driving decision-making and the variety of potentially successful models.

### **Reforms Affecting Physicians in Practice**

1. Financial support should be provided to new physicians entering practices in the form of practice set-up funds, infrastructure support, and an increased number of “turn-key” practices.
2. Support for physicians in practice in the form of programs to minimize overhead costs should be put in place.
3. Remuneration for family physicians must be increased, and models of payment should include a variety of Alternate Payment Plans in addition to fee-for-service models.
4. Models of primary care reform should continue to evolve, and information technology and infrastructure investment must be key components of primary care reform.
5. Interdisciplinary, team-based care should continue to evolve in the primary care setting; it should not reduce the scope of practice of family physicians but rather allow them to increase their professional satisfaction.
6. Increased numbers of “turn-key” practices and financial help in setup and overhead costs should be made available to new and established family physicians.
7. Retention initiatives must be put in place to support established family physicians, including strong locum programs, vacation/sabbatical and professional development opportunities, and flexibility of practice models to accommodate changing priorities.
8. Collaborative care between family physicians and specialty colleagues should be encouraged through concrete programs and mechanisms.

### **Community-Based Reforms**

1. Community-based and mass media initiatives should be undertaken to increase the profile of family medicine and elevate it in the mind of the public.
2. National leadership is required by multi-stakeholder groups to address the challenges facing family medicine. A coordinated approach and wide publicity of success stories is required.
3. New health professionals in medicine, nursing, and other health professions must improve communication at the organizational level.
4. Family physicians and communities should engage in meaningful partnerships to address community needs and physician needs in terms of recruitment, retention and healthcare planning.