



The College of  
Family Physicians  
of Canada

Le Collège des  
médecins de famille  
du Canada



The Royal College of  
Physicians and Surgeons of Canada  
Le Collège royal des médecins  
et chirurgiens du Canada

## **Conjoint Discussion Paper**

**FAMILY PHYSICIANS AND OTHER SPECIALISTS:  
WORKING AND LEARNING TOGETHER**

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## **Mission**

### **The College of Family Physicians of Canada**

The College of Family Physicians of Canada is a national voluntary organization of family physicians that makes continuing medical education of its members mandatory.

The College strives to improve the health of Canadians by promoting high standards of medical education and care in family practice, by contributing to public understanding of healthful living, by supporting ready access to family physician services, and by encouraging research and disseminating knowledge about family medicine.

### **The Royal College of Physicians and Surgeons of Canada**

An organization of medical specialists dedicated to ensuring the highest standards and quality of health care.

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## **Executive Summary and Recommendations**

The College of Family Physicians of Canada (CFPC) and The Royal College of Physicians and Surgeons of Canada (RCPSC) addressed the issues surrounding the relationships between family physicians and other specialists in a two day Colloquium, with the goal of improving working and learning relationships to enhance patient care, and patient and physician satisfaction. Colloquium participants also discussed and refined the recommendations and guidelines of an earlier report published by the two organizations, *The Relationship between Family Physicians and Specialist/Consultants in the Provision of Patient Care*.

Five main themes emerged from the Colloquium: Collegial Relationships, Practice Environments, Changing Models of Care and Collaboration, Education, and Physician Resourcing. In addition, the enabling roles of Information Technology / Management and Communications Skills in improving intra-professional relationships were considered.

Collegiality is at the core of good relationships between family physicians and other specialists. Elements of mutual trust, respect, and knowledge of the other's expertise, skills and responsibilities are important in establishing collegial relationships; but there is a lack of evidence about what makes these relationships work. The image of the "doctor's lounge" was used to illustrate a place where collegial relationships flourish. Where is the new hub of activity where such relationships will have a chance to develop and thrive?

Collegial relationships affect referral and consultation processes, as well as the comprehensiveness and continuity of care. Colloquium participants reviewed research on referral and consultation processes; this review generated practical suggestions for change and improvement.

Referral and consultation issues in the academic practice environment highlight the importance of communication between family physicians and other specialists. The dwindling number of family physicians involved in hospitals presents an added challenge. Traditionally, most physicians practice in either community or academic environments. Now, as academic health centres become academic networks, community practice settings are becoming more active in teaching, learning, and research. Research and experimentation about more collaborative models of care between family physicians and other specialists should be undertaken in both environments.

Collaborative models are being developed in efforts to improve patient care and effective management, not just between physicians and other health care professions, but also between family physicians and other specialists. The work of examining patient outcomes and provider and patient satisfaction relative to these new models of practice is just beginning.

Relationships between family physicians and other specialists can be improved along the continuum of education from undergraduate to postgraduate, and CME/CPD, including faculty development. There has been a call for more generalist-based undergraduate education to help combat stereotyping of the roles of family physicians and other specialists, and to promote the value of generalism. At the postgraduate level, specialty and family medicine residents could learn from working together in referring to and consulting with one another, as well as learning from behavior modeled by their teachers. There are also collaborative CME/CPD opportunities to help develop intra-professional relationships.

Canadians should have appropriate access to family physicians and other specialists as required for their health care. Shortages of family physicians and shortages of many categories of other specialists are challenges to appropriate access that must be addressed.

In their discussions, Colloquium participants recognized that system-wide change can be difficult to implement, and the importance of starting transformation with small manageable pieces. They also recognized that the implementation of recommendations and action plans would occur at different levels: organizational, professional, and individual. Finally, they expressed a desire to focus their recommendations on those activities that relate to the mandates of the two Colleges.

The CFPC, the RCPSC, their leaders and members are resolved to address the issues outlined in this discussion paper, the ultimate goal being to improve patient care and professional satisfaction by creating health care environments and practice patterns where good relationships between family physicians and other specialists are highly valued and promoted. To this end, the following recommendations are proposed:

## **Recommendations**

### **I. Education and Training**

It is recommended that:

- i) The CFPC and the RCPSC work conjointly to develop common accreditation standards for postgraduate education governing the professional relationships between family physicians and other specialists. Among other aspects this should include the referral/consultation process.
- ii) The CFPC and the RCPSC, in association with the AFMC, examine undergraduate education and its influence on the relationships between family physicians and other specialists, and act collaboratively in the pursuit of excellent relationships.

- iii) To guide educators and practitioners, the CFPC and the RCPSC continue to work conjointly to define core competencies implicit in the CanMEDS roles and Four Principles of Family Medicine related to relationships between family physicians and other specialists.
- iv) The continuing medical education / professional development (CME/CPD) maintenance programs of each College encourage collaboration to deliver CME/CPD programs that promote good intra-professional relationships.

## **II. Practice**

It is recommended that:

- i) The CFPC and the RCPSC, in collaboration with other key stakeholders, explore all opportunities to promote and facilitate collegial interactions between family physicians and other specialists in community and hospital practice environments.
- ii) To integrate practices more effectively, the two Colleges create and disseminate tools:
  - a. That address appropriateness of referrals and consultations
  - b. That facilitate efficient and effective referral / consultation processes
  - c. That contribute to collaborative CME/CPD sessions on the referral / consultation process
- iii) The continuing medical education / professional development maintenance programs of each College encourage the use and evaluation of practice tools that enhance the referral / consultation process.
- iv) The two Colleges, in association with health authorities and other key stakeholders, improve the integration of ongoing primary care with appropriate access to specialty care by:
  - a. Expanding existing models of shared and collaborative care between family physicians and other specialists in community and hospital environments, including academic health centres
  - b. Encouraging the use of patient care plans that clearly outline the roles and responsibilities of family physicians and other specialists, from the time of hospital discharge and ongoing

- c. Identifying barriers to the use of indirect and less formal supports such as telephone and email interactions between family physicians and other specialists
- d. Examining the effects of changing models of shared and collaborative care on such issues as remuneration and liability

### **III. Other**

It is recommended that:

- i) The CFPC and the RCPSC, in association with governments, medical schools and other key stakeholders, continue to advocate for sufficient physician human resources so that every Canadian has the opportunity to have a family physician and timely access to appropriate specialty care.
- ii) The CFPC, the RCPSC, and other key stakeholders, in association with regulatory authorities, advocate for the evaluation of intra-professional relationships, including the referral / consultation process, as an important part of peer review programs.
- iii) The CFPC and the RCPSC support and encourage further research in the area of intra-professional relationships between family physicians and other specialists
- iv) The CFPC and the RCPSC promote the acceleration of the adoption of electronic information, e.g. EMRs, to facilitate communication between family physicians and consultants, with the appropriate protections for privacy.
- v) The CFPC and the RCPSC support activities to address the recommendations contained in this discussion paper including the development, implementation, monitoring and evaluation of a sound action plan.



## **A. Introduction**

In 1991, a joint Task Force of The College of Family Physicians of Canada (CFPC) and The Royal College of Physicians and Surgeons of Canada (RCPSC) was established to advise on strengthening the relationship between family physicians and specialists / consultants in the provision of patient care. The Task Force found that the most significant relationship issue between family physicians and specialists / consultants developed around patient care, particularly during the process of consultation and referral. The Task Force focused on the consultation and referral process, and in 1993 produced guidelines and a set of specific recommendations in two categories: patient-centred and profession-centred.

The guidelines of the 1993 report are still valid today but only a few of the nineteen recommendations led to further action. This lack of follow-up could be partially attributed to the lack of specificity of many of the recommendations. The dissemination of the Report could also have been improved. Concern that the Report did not stimulate more change gave impetus to the preparation for and development of the current discussion paper.

The landscape has changed significantly in health care since 1993 and it is quite apparent that physicians are facing new challenges that were not as obvious at that time. Some of these challenges include this country's extreme shortage of family physicians, and the existing and looming shortages of many other specialists. Public opinion about health care and Canada's health system, though improved in some areas of the system, remains gloomy in others. Of Canadian adults surveyed for the 2005 Canadian Medical Association (CMA) report card, 50% said they expect the health services available in their communities to become somewhat or much worse over the next three years, compared with 37% in 2003. The proportion of respondents giving the system a lower grade (B grade) reached its highest level (45%) in the five years the CMA has been producing the report card. The impact of lack of access to primary care remains clear - respondents with no family physician were much more likely to give the system a failing grade (14%).

Since 1993 there have also been dramatic developments in information technology / management. The explosive growth of the Internet and electronic communications across all sectors, and the increasing development and use of electronic medical records (EMRs), telemedicine, and computerized clinical decision support systems in the health sector, have expanded the health service expectations of Canadians and the potential for change in health care delivery.

Since the 1993 Report, there have been several collaborative initiatives between members of the two Colleges:

- CFPC /Canadian Psychiatric Association Collaborative Working Group on Shared Mental Health Care
- Joint Action Committee On Child & Adolescent Health (JACCAH)
- Collaborative Advisory Group for General and Family Practice Anesthesia in Rural Canada (CAGA)
- Publication of the Joint Position Paper on Rural Maternity Care, in association with the Society of Rural Physicians of Canada and the Society of Obstetricians and Gynaecologists of Canada
- Development of the National Physician Survey (NPS), in partnership with the Canadian Medical Association (CMA)
- Task Force Two, co-chaired by the CFPC, the RCPSC and the CMA

The preceding examples represent supporting activities developed by medical organizations, mainly intra-professional <sup>1</sup> associations. The more determinant relationships operate at the personal level, between physicians and patients, between physicians, and between physicians and other healthcare providers. Positive collaboration must be sought and fostered at the organizational (including intra-professional) and individual levels to attenuate the kinds of tensions that still exist in the relationships between family physicians and other specialists.

In collaborating to explore opportunities for improvements in these areas, the CFPC, the RCPSC, their leaders and members have built on the strong relations that the two Colleges have nurtured for over fifty years. It is expected that the activities leading up to and following this discussion paper will enhance these relations even further and be an important contributor to the goals of this joint endeavour – to strengthen the relationships between family physicians and other specialists in the provision of high quality patient care.

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<sup>1</sup> “Intra-professional” is used in this discussion paper to mean “within the professions of medicine and surgery”.

## **B. 2006 CFPC-RCPSC Colloquium**

In 2005 the two Colleges decided to revisit the issues surrounding the relationships between family physicians and other specialists, and to further discuss and refine the recommendations and guidelines of the 1993 report. A planning committee was created to review the peer-reviewed literature on relationships between family physicians and other specialists, as covered in literature published since the 1993 Report. With the benefit of this information, the committee designed a two-day Colloquium with the goal of improving working and learning relationships to enhance patient care, and patient and physician satisfaction.

At the Colloquium in late January 2006, participants heard presentations from family physicians and other specialists -- researchers, physicians from the academic environment, and physicians from community practice. Delegates convened in small groups to resolve issues presented in three case-based scenarios. Facilitated reporting and discussion sessions of the entire group followed the small group discussions.

Colloquium participants were particularly interested in developing recommendations that would lead to action. They also recognized that the implementation of recommendations and action plans would occur at different levels: organizational, professional, and individual. In addition, it was recognized that there are external factors that the two Colleges do not control, but that impact the opportunities for success related to recommendations and action plans. For example, fee structure is not under the direct control of either College but clearly has a very important effect on patterns of practice and collegial relationships.

In their discussions and recommendations to strengthen the relationships between family physicians and other specialists, Colloquium participants emphasized:

- The recognition that system-wide change can be difficult to implement, and the importance of starting with small manageable pieces, even if the ultimate goal is profound transformation
- A desire to focus their recommendations on those activities that relate to the mandates of the two Colleges
- The importance of seeking commitment and engagement from all stakeholders
- The importance of change management

## **C. The Goal: High Quality Patient Care**

Five main themes emerged from the Colloquium: Collegial Relationships, Practice Environments, Changing Models of Care and Collaboration, Education, and Physician Resourcing. In addition, the enabling roles of Information Technology / Management and Communications Skills in improving family physician/specialist relationships across all themes were considered. These five themes can also be identified in the literature.

There is a complex web of connections among these themes. For example, Collegial Relationships are influenced by Education, and vice versa; Education impacts Physician Resourcing; and Practice Environments are affected by Education.

### **1) Collegial Relationships**

The Canadian Oxford Dictionary, 2004, defines collegial as *characterized by collaboration among colleagues; pertaining to or involving a body of colleagues; of or pertaining to a college*. This definition captures the importance of “belonging” and emphasizes the elements that many physicians at the Colloquium expressed as so important in establishing collegial relationships - mutual trust, respect, and knowledge of each other’s expertise, skills and responsibilities.

Collegiality is at the core of good relationships between family physicians and other specialists. How do we build collegiality into new healthcare environments? Collegiality means more than just electronic communications and networks. It means finding a focus for family physicians in the community and other specialists in the hospital to get together.

The image of the “doctor’s lounge” has been used to illustrate a place where collegial relationships flourish. A key question that arose at the Colloquium was: With the doctor’s lounge now almost non-existent, where is the new hub of activity where such relationships will have a chance to develop and thrive?

Collegial relationships are central in our efforts to deal with change, but they are a challenge to define. What makes them work and what hinders them? How do we promote them? Why is it that collegial relationships seem to work in particular areas in specialty care? How can that help with development of better care overall? How do the two Colleges promote collegial relationships?

## **i) Research**

Mangiardi and Pellegrino discuss the privileges and obligations of the academic and medical collegium in one of the few articles on collegiality in the biomedical literature. A qualitative study in the U.K. found that general practitioners and hospital consultants demonstrated good levels of agreement, mutual understanding and respect between themselves, although there were significant differences in terms of attitudes towards financial parity (Marshall). While research on collegial relationships is scarce, a considerable body of literature exists about the interface between family physicians and psychiatrists, including Craven and Bland's bibliography on shared mental health care. There is much less literature on the interface between other specialists and family physicians.

There may be some fundamental differences in the ways family physicians and other specialists view patient care. For example, Rosser hypothesizes that there are differences in approach to diagnosis and clinical problem solving: consultants commonly focus on organ systems, disease, or investigation; whereas family physicians often focus on the patient as an individual in the context of family and community. Physicians need to learn about these differences in order to develop respect for and trust in each other. It is also instructive to see how such differences between family physicians and other specialists may emerge in their relationships with one another. For example, Shaw's study of psychiatric referral letters illustrates that general practitioners may refer to consultants for reasons that differ from the consultants' view of the patients' problems.

## **ii) CanMEDS Roles and The Four Principles**

Understanding and respecting each other's roles is important for good collegial relationships. The CanMEDS Roles implemented by the RCPSC and the Four Principles of Family Medicine used by the CFPC are key instruments that help physicians in each sphere to define and understand their own roles.<sup>2</sup> The ongoing attempt by the two Colleges to find common language and ground between the roles and principles, and the development of "core competencies", should be helpful in promoting mutual understanding and respect. Nevertheless, while the CanMEDS Roles and Four Principles are considered important at intra-organizational and intra-professional levels, they have not been translated into relationship building at the level of individual physicians. It is recognized that practical approaches will be required to build relationships at this level.

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<sup>2</sup> The CanMEDS Roles and Four Principles are appended to this discussion paper.

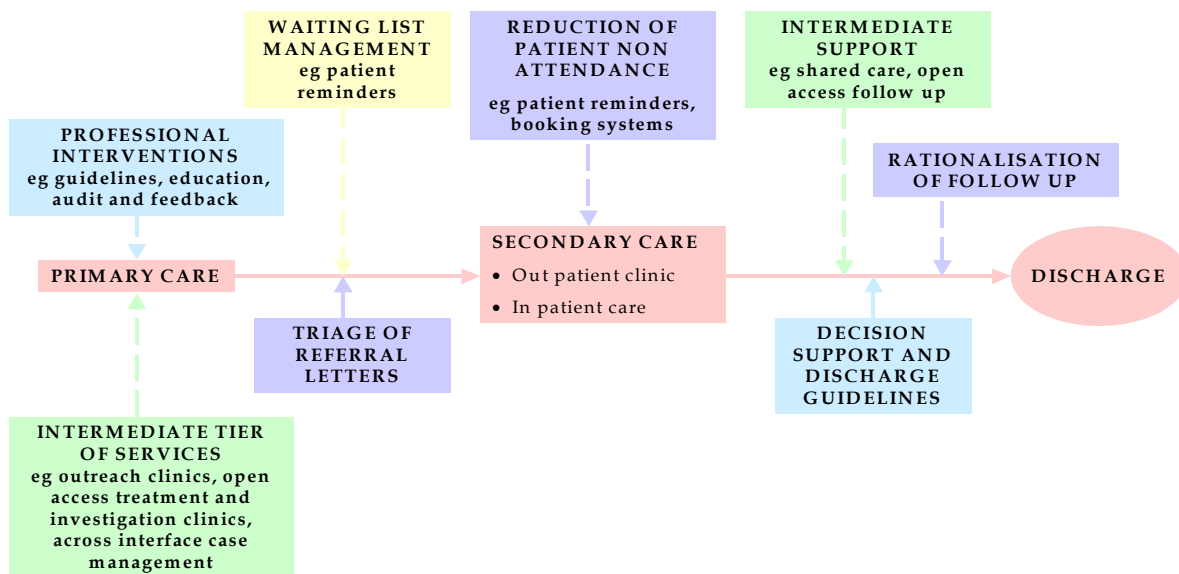
### iii) Referral and Consultation

Good collegial relationships are essential for effective and efficient referral and consultation processes. As identified in the Colloquium, improvements to this process could include:

- Defining a single reliable access point, e. g. web-based or 800 number, within local referral / consultation systems
- Using a template approach for referral and consultation advice
- Reaching agreement with key players for referral / consultation criteria

A recent systematic review by Grimshaw highlighted research into outpatient referrals and suggested solutions to unresolved referral / consultation issues. Despite their importance, there is limited evidence of rigorous interventions to improve referral / consultation systems. Colloquium participants also noted a lack of research on Canadian systems. Grimshaw concluded that passive dissemination of guidelines was ineffective, but guidelines plus other interventions, such as structured referral letters, showed some positive effects. 'In-house' consultations and other alternatives to referral were also seen to be promising, e.g. primary care intra-professional consultations. Financial incentives had mixed effects on the referral / consultation process. Grimshaw suggests taking a systemic approach to referrals / consultations, and that this may be more beneficial than focusing on general practitioners' referral processes. Grimshaw's diagram below illustrates his holistic view of the referral and consultation process, and highlights potential influences

#### Model of Referral System (Grimshaw 2006)



#### **iv) Ensuring Comprehensiveness and Continuity**

Collegial relationships affect the comprehensiveness and continuity of care. For example, a study by Kinchen found consultants' efforts to return patients to primary care physicians very important in the primary care physician's subsequent choice of specialist. In another example, the experience of physicians in the CFPC-Canadian Psychiatric Association's Shared Mental Health Care project is that, not only are generalist consultants much more likely to diagnose problems earlier in the continuum of care, but they are more apt to ensure continuity by more timely referral of the patient back to the primary care physician. In a third example, a pilot primary care oncology project in Manitoba focused on timely and appropriate referrals of patients back to the community, ensuring continuity of care between referring family physicians and consulting oncology specialists (Norman).

#### **v) Understanding the Boundaries**

The development of new physician specialties may create challenges to collegial relationships. Specialties are not static and sometimes arise in spontaneous and unplanned ways, resulting in the fragmentation of existing specialties and confusing overlaps of scopes of practice. The boundaries between family physicians and other specialists are no longer as clear as they used to be. In the USA, there has been considerable overlap and ambiguity in the roles and responsibilities of primary care providers and specialists (Lanier). In Canada, inadequate physician supply has meant that specialists are required to manage "orphan" or "unaffiliated" patients, or that family physicians must change their scopes of practice to fill roles vacated by other specialists. Forrest suggests that the boundaries of the primary-specialty care interface are fluid, i.e. they shift in response to physicians' demands for advice or specialized skills and patients' expectations for specialty care. Such shifts suggest the need to focus, not on defining specialty borders but on recognizing and negotiating their overlaps. In the changing environment of medical practice, it should be emphasized that overlaps need to be addressed at many levels:

- Organizational
- Professional
- Individual
- Patient care team

## **2) Practice Environments**

Traditionally most physicians practice in either of two environments, community or academic. While there are differences in both environments, there are also common elements. In fact, as academic health centres become academic networks, traditional community practice settings are becoming more active in teaching, learning, and research. An examination of different practice environments helps to illuminate elements that either facilitate or impede relationships between family physicians and other specialists.

### **i) Community Practice Environment**

At the 2006 Colloquium, a longstanding community practice and education model in Sault Ste. Marie with a rostered population of 61,000 (Group Health Centre) was described as an example of a successful community practice environment for those physicians involved. Funding is capitation-based with some fee-for-service. Most physicians are in one group, and there is a strong organizational culture. The main challenge is seen to be maintaining enthusiasm in the face of inadequate human resources.

In this setting, the EMR system, the largest primary care EMR system in Canada, is a major enabler of effective communication and referral among providers. The system is accessible from hospital and home; all physicians have access to a common chart. The system supports patient registries for chronic diseases, allowing research and systematic management.

A successful Health Promotion Initiative, developed through linkages and networks with academic institutions, health agencies, and consumer groups, has been in operation at the Group Health Centre since the early 1990's. The following elements are embodied in its mission and serve to facilitate good relationships between family physicians and other specialists:

- Addressing the community's priority health issues
- Fostering patient / provider partnerships focused on primary care
- Using multi-disciplinary teamwork
- Educating patients as well as providers
- Using appropriate quality management principles

### **ii) Academic Practice Environment**

Referral and consultation issues in the academic practice environment highlight the importance of communication between family physicians and other specialists. Hospital referrals / consultations include the following communication challenges:



- The potential for mixed messages with multiple physicians involved in caring for any given patient at the hospital site
- Lack of an effective electronic medical record for sharing patient information among specialties
- Late or inadequate documentation resulting in a lack of awareness for the family physician about what has been accomplished for the patient
- Uncertainty for consulting specialists as to whether a family physician is available to resume care following hospital discharge
- Lack of patient knowledge of consultation process and physician roles

The dwindling number of family physicians involved in hospitals, and the improbability of attracting them back, presents a key communication challenge. This challenge is impacted by major structural differences across the country in integrating hospital and community care, such as is seen in Regional Health Authorities across Canada, Local Health Integrated Networks in Ontario, and the role of some faculties of medicine for care in rural or remote locations. On the positive side, the integration of hospital and community is improving as hospitals become better connected with their communities under the leadership of regional health authorities.

The relocation of consulting specialists has also increased the gap in communication and collegial relations between family physicians and hospital-based consultants. For example, consulting specialists have been brought back into the hospital with the development of the geographic full-time system or with the availability of additional space in small hospitals seeking consultant physicians in certain specialties. Family physicians and other specialists need to work more collaboratively and in different ways to promote the educational and practice benefits of the hospital environment for all physicians, recognizing that hospitals are centres for education and training, while the community is where the majority of patient care is provided by family physicians.

Traditional academic health centres have contributed to the cultural separation of family and specialty medicine, but have an important role to play in seeking solutions to this problem in the future. Research and experimentation about more collaborative models of care between family physicians and other specialists should be undertaken in both academic health centres and in the community.

### **3) Changing Models of Care and Collaboration**

Collaborative models are being developed in efforts to improve patient care and effective management, not just between physicians and other health care professions, but also between family physicians and other specialists. Some examples are given below. While successful collaboration in health care teams can be attributed to numerous elements, including interpersonal relationships between physicians and the organizational factors that support good relations, how and why collaboration works in these specific areas needs to be studied and monitored more closely. Colloquium participants identified the effects of changing models of shared and collaborative care on remuneration and liability as a particularly important area for research.

A major challenge in promoting good relationships between family physicians and other specialists is dealing with change that is creating new models of care with potential barriers to collaborative practice. For example, the increasing focus on primary care models by federal and provincial / territorial governments without identifying its integration with secondary and tertiary levels of care could be detrimental to collaborative patient care. Intra-professional relationships need to be considered within a system of health and health care, focused on the patient, and integrated for referral and consultation purposes.

The Shared Mental Health Care mentorship program is an example of good intra-professional relationships. In this program, family physicians are grouped according to clinical interests with psychiatrists and psychotherapists as mentors whom they can contact for help. Evaluation of the pilot program, based on survey responses before and after the program as well as focus group feedback, showed that physicians appeared to have more confidence, learn more, and refer less after mentoring (Rockman). Collaborative care in mental health is more than just relationships; it is relationships to achieve specific outcomes. A lesson learned in this program is that collaboration develops slowly, and the best collaboration develops between providers who are involved clinically (Kates). In another example in the U.K., a recent systematic review of 7 randomized controlled trials showed that better collaboration between general practitioners and specialists appears to improve function and outcomes in chronically ill psychiatric patients (Mitchell).

The Improving Cardiovascular Outcomes in Nova Scotia (ICONS), a study of congestive heart failure, found that improvements in outcome were related to the multidisciplinary nature of the care provided (Howlett). A recent retrospective cohort study found patients with congestive heart failure followed by both cardiologists and family physicians had significantly better survival than those followed by family physicians alone, or those who received no specific cardiac follow-up. (Ezekowitz).

Task Force Two has examined physician satisfaction relative to new models of practice through discussion with stakeholders and an examination of specific models, i.e. clinical practice models and combined teaching / research / clinical models. A high degree of physician satisfaction has been found associated with collaborative care, especially in the clinical practice models (community environments), where the positive elements for physicians included collaboration, in addition to greater opportunity to spend more time with patients and to achieve better balance between personal and professional commitments. Physicians in these models showed higher degrees of satisfaction in working with colleagues than those working in the combined models. In the combined teaching / research / clinical models (academic environments) the most attractive elements were found to be support for an appropriate balance between clinical care, research and teaching (Task Force Two).

## **4) Education**

When looking at ways to improve the relationships between family physicians and other specialists, education should be examined as a continuum from undergraduate to postgraduate education, and CME/CPD, including faculty development at all levels of the education and training continuum. Changes at one point will cause change at other points, and at different times, along the continuum. While changes to undergraduate medical education will affect working and learning together in the future, CME/CPD has the potential to affect working and learning together now. Colloquium participants felt that family physicians and other specialists working together on faculty development committees would be a particularly effective force for change.

The two Colleges have significant leverage in driving educational change through the development of specific accreditation standards that require emphasis on educational content, environment and evaluation that is relevant to these issues. Educational opportunities to foster collaboration between family physicians and other specialists should be pursued in association with other stakeholders, e.g. the Association of Faculties of Medicine of Canada (AFMC), to achieve improved relationships.

### **i) Undergraduate Education**

From both the Colloquium and the literature, there has been a call for more generalist-based undergraduate education. This thrust starts with the consideration for the type of candidates who are selected through the admissions process.

There needs to be an appropriate balance of generalist and specialist teachers at the undergraduate level. Several Colloquium participants expressed the belief that a significant shift towards more generalist teachers will result in the generalist role being better understood and valued. Rosser argues that there is too much emphasis on sub-specialization in medical schools, but points out that new undergraduate curricula and problem-based learning are now seeking to address problems that were identified in traditional curricula.

Stereotyping of the roles of family physicians and other specialists remains a challenge in undergraduate education. While this can result in the de-valuing of certain roles, a recent article (Albanese) suggests a more positive approach is to use problem-based learning in education as a link to an improved understanding about intra-professional collegiality in practice.

### **ii) Postgraduate Education**

Specialty and family medicine residents could benefit from training experiences in which they work together in referring to and consulting with one another to allow each to learn what they can do, and how to develop good

intra-professional relationships. Such experiences would provide the opportunity to more clearly define boundary overlap issues, and to facilitate the implementation of the CanMEDs competencies and Four Principles in real life scenarios involving individual patients or specific patient populations.

A major training challenge is to prepare residents for the realities of the practice environment. During their training, residents benefit from seeing good intra-professional relationships modeled by their teachers in practice. For example, even writing a good referral or consultation letter will be of major importance when residents get into practice. Related to this, Keely describes the experience of teaching residents to write effective consultation letters.

In addition, there is a need to learn more about how models of intra-professional teaching in postgraduate education can prepare residents better for good intra-professional relationships in practice. An exploration of how psychiatrists have been integrated into family practice teaching units should be pursued for its potential application to other specialties.

Evaluation drives education, and efforts should be made to improve the assessment of intra-professional relationship skills through various means – In-Training Evaluation Reports (ITERs), Final In-Training Evaluation Reports (FITERs), examinations, and informal methods. Revised accreditation standards should require formal teaching, learning, and evaluation of intra-professional relationship skills.

### **iii) Continuing Medical Education / Professional Development (CME/CPD)**

Collaborative CME/CPD opportunities exist to help develop intra-professional relationships. CME/CPD can be used as a tool, with family physicians and other specialists working together to plan CME/CPD programs. For example, a CME program on shared diabetes care would model good relationships as well as being clinically relevant. Hospitals have an opportunity to attract physicians back from the community for CME/CPD activities. Perhaps hospitals could become a new hub of collegial educational activity. Opportunities also exist at the individual and self-directed level, e.g. learning from the content of referral/consultation letters (Gagliardi).

As promoters of life-long learning and managing CME/CPD program credentials for the maintenance of physician competence and certification throughout Canada, the two Colleges have considerable opportunity to leverage learning in CME/CPD by enhancing good relationships between family physicians and other specialists through the content of existing programs.

#### **iv) Education for Collaborative Practice**

Collaboration is becoming more important as health care providers increasingly work in teams and groups with each other to provide comprehensive patient care. Training in collaborative practice should occur throughout the educational continuum. A recent study by Beaulieu et al. provides a valuable perspective by consulting family medicine residents and specialist residents, as well as those charged with preparing them to step into their roles in practice, on their thoughts about collaboration. The European Working Party on Quality in Family Practice has identified “bringing general practitioners and specialists together and developing personal and group relations through education and processes of task sharing for change” as a target (Kvamme). Health Canada’s Interprofessional Education for Collaborative Patient-Centred Practice (IECPCP) initiative has also accomplished work in this area.

Colloquium participants made suggestions for incorporating collaborative practice into education:

- Reviewing current problem-based curricula to ensure that they model good collaborative practice
- Ensuring that student evaluation and program accreditation standards specifically examine collaborative competencies
- Developing national evidence-based guidelines for collaborative practice skills, e.g. in referral / consultation, shared care, and team function

## 5) Physician Resourcing

Canadians should have appropriate access to family physicians and other specialists as required for their health care. Physician human resource challenges currently endanger access to care for Canadians. These include:

- Shortages of family physicians
- Shortages of generalist specialists, (e.g. general surgeons and general internists)
- Trends towards sub-specialization and fragmentation of specialties
- The undervaluing of generalism in the medical profession

The dynamics of the changes in practice in Canada are complex. The shortages of family physicians are in part the result of changes in the practices of other specialists – where family physicians have moved in to fill vacated roles that specialists used to have. Practices have changed to fill needed services for the population, but now many family physicians have chosen to be more selective in what has traditionally been thought of as family practice (Chan). Supporting and recruiting family physicians who practice “comprehensive, continuing” family medicine has become a significant challenge.

Career prestige has been raised as a factor discouraging medical students from entering family practice and other generalist specialties. The lack of value for generalism manifests itself in inappropriate levels of remuneration, challenges to job satisfaction, and perceptions of worth during training and practice.

Remuneration is another factor that affects the choice of medical career. While the two Colleges are not responsible for negotiating fee schedules, payment plans, or salaries, a key objective over the last few years has been to increase the value of certain specialties to align with more appropriate remuneration. Unless family physicians and other specialists, particularly generalists, are compensated for their contribution to the health of Canadians there will be continuing challenges to recruit medical students and to retain practitioners.

The past few years have seen increasing concern about the move from generalist to highly specialized physicians. With the development of more teams to provide patient care, the health system will likely require more generalists with the ability to integrate and co-ordinate care. For example, the management of patients with chronic disease may benefit from all physicians – both family physicians and other specialists – understanding their contributions to the overall care of the patient.

## **6) Enablers**

### **i) Information Technology/Management**

Colloquium participants recognized the role of information technology/management as a tool to improve family physician and other specialist relationships. There are many examples of its use where patients and providers are very satisfied with the results, both mentioned by Colloquium participants, and in the literature (e.g. Pondichetty). These uses include:

- “Real time” consultation
- EMRs for patient care teams
- Electronic interchanges of data to dramatically reduce waiting times
- Electronic dissemination of practice advisories and guidelines

However, Coiera notes that the way clinicians communicate with each other has been largely ignored in informatics thinking. He suggests that direct support of communication in health care organizations will lead to improvements in organizational effectiveness and an opportunity to improve patient care.

The development of EMRs to enhance patient care will require collaboration with agencies outside the two Colleges, at the national, jurisdictional and individual practice levels.

### **ii) Communications Skills**

Research supports the relationship of good intra-professional communication to provider and patient satisfaction. For example, Bourguet’s study shows that the likelihood of valued feedback from the consulting specialist is strongly related to appropriate communication by the family physician to the consultant at the time of referral, leading to good patient care and family physicians more satisfied with the referral. A qualitative study of the relationships and roles of family physicians and oncologists highlights the importance of maintaining two-way communications and including all players in discussions and treatment plans (Wood).

Communication with the patient about the referral and consultation process, and about the relationships between family physicians and other specialists, has been under-emphasized. Patients may know very little about why or how they are referred, and what their own responsibilities are during the process. Many physicians are unaware that patients know so little, and physicians may not understand the implications of patients’ lack of knowledge. Suggestions have been made to copy referral letters to patients, or to develop care plans that patients take to every appointment. Much more research on this topic is needed. Informed patients could drive major changes in practice leading to improved patient and provider satisfaction.



## **D. Recommendations**

These recommendations are limited to intra-professional collaboration, with the intent to build upon the broader context of growing inter-disciplinary collaboration in health care. A major challenge for this initiative is to translate these recommendations into action plans. This will require appropriate dissemination of the discussion paper and the engagement of physicians at organizational and clinical care levels. For example, if guidelines, forms, or other tools result from these action plans, there should be a range of options that can be selected and adapted locally.

## **E. Education and Training**

It is recommended that:

- i) The CFPC and the RCPSC work conjointly to develop common accreditation standards for postgraduate education governing the professional relationships between family physicians and other specialists. Among other aspects this should include the referral/consultation process.
- ii) The CFPC and the RCPSC, in association with the AFMC, examine undergraduate education and its influence on the relationships between family physicians and other specialists, and act collaboratively in the pursuit of excellent relationships.
- iii) To guide educators and practitioners, the CFPC and the RCPSC continue to work conjointly to define core competencies implicit in the CanMEDS roles and Four Principles of Family Medicine related to relationships between family physicians and other specialists.
- iv) The continuing medical education / professional development (CME/CPD) maintenance programs of each College encourage collaboration to deliver CME/CPD programs that promote good intra-professional relationships.

## II. Practice

It is recommended that:

- i) The CFPC and the RCPSC, in collaboration with other key stakeholders, explore all opportunities to promote and facilitate collegial interactions between family physicians and other specialists in community and hospital practice environments.
- ii) To integrate practices more effectively, the two Colleges create and disseminate tools:
  - a. That address appropriateness of referrals and consultations
  - b. That facilitate efficient and effective referral / consultation processes
  - c. That contribute to collaborative CME/CPD sessions on the referral / consultation process
- iii) The continuing medical education / professional development maintenance programs of each College encourage the use and evaluation of practice tools that enhance the referral / consultation process.
- iv) The two Colleges, in association with health authorities and other key stakeholders, improve the integration of ongoing primary care with appropriate access to specialty care by:
  - a. Expanding existing models of shared and collaborative care between family physicians and other specialists in community and hospital environments, including academic health centres
  - b. Encouraging the use of patient care plans that clearly outline the roles and responsibilities of family physicians and other specialists, from the time of hospital discharge and ongoing
  - c. Identifying barriers to the use of indirect and less formal supports such as telephone and email interactions between family physicians and other specialists
  - d. Examining the effects of changing models of shared and collaborative care on such issues as remuneration and liability

### **III. Other**

It is recommended that:

- i) The CFPC and the RCPSC, in association with governments, medical schools and other key stakeholders, continue to advocate for sufficient physician human resources so that every Canadian has the opportunity to have a family physician and timely access to appropriate specialty care.
- ii) The CFPC, the RCPSC, and other key stakeholders, in association with regulatory authorities, advocate for the evaluation of intra-professional relationships, including the referral / consultation process, as an important part of peer review programs.
- iii) The CFPC and the RCPSC support and encourage further research in the area of intra-professional relationships between family physicians and other specialists
- iv) The CFPC and the RCPSC promote the acceleration of the adoption of electronic information, e.g. EMRs, to facilitate communication between family physicians and consultants, with the appropriate protections for privacy.
- v) The CFPC and the RCPSC support activities to address the recommendations contained in this discussion paper including the development, implementation, monitoring and evaluation of a sound action plan.

## **F. Conclusions**

The CFPC, the RCPSC, their leaders and members are resolved to address the issues outlined in this discussion paper, the ultimate goal being to improve patient care and professional satisfaction by creating health care environments and practice patterns where good relationships between family physicians and other specialists are highly valued and promoted. Both Colleges along with their leaders and members affirm the centrality of the patient in good intra-professional relationships.

In addition, both the CFPC and the RCPSC intend to:

- Ensure the transition of the medical profession's proven values and principles to future generations of physicians, by promoting intra-professional relationships relevant to:
  - Patient-centredness
  - Physician collaboration
  - Respect and courtesy
  - Professional satisfaction
  - Changing patterns of practice
- Define and launch specific actions that are required at the undergraduate, postgraduate, and continuing professional development levels, including revisions to accreditation standards that are designed to promote collegial relations between physicians in all specialties.
- Build on the recommendations of this discussion paper and the shared understanding that has resulted from its development between family physicians and other specialists to create action plans that address collegial relationships.
- Implement, monitor, and evaluate the impact of this discussion paper and its related activities in the short, medium and long term, taking or recommending corrective measures when required to ensure support for and action related to enhancing relations between family physicians and other specialists.

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## H. Appendices

### i) 1993 Recommendations

In: Task Force. College of Family Physicians of Canada and Royal College of Physicians and Surgeons of Canada. *The Relationship between Family Physicians and Specialist/Consultants in the Provision of Patient Care*. [Mississauga]; 1993.

1. Referring physicians should involve patients in the decision to refer, the choice of specialist/consultant, and the proposed management plan including follow up and continuity of care.
2. Referring physicians and specialist/consultants should be responsible for making available to patients appropriate consultations within a reasonable time.
3. Both Colleges' planning for their educational programs should be based on the understanding that everyone in Canada should have access to comprehensive and continuous primary medical care.
4. Both Colleges should affirm the central role of family physicians in the provision of comprehensive and continuous primary medical care to patients of all ages.
5. Both Colleges should emphasize that the consultation and referral process is central to the provision of optimal patient care.
6. Both Colleges should agree that the role of specialist/consultants is to address the problems that lead to referrals, assess patients, and promptly communicate findings and recommendations to patients and referring physicians. Under normal circumstances, specialist/consultants should return patients to referring physicians. However, it can be appropriate for specialist/consultants to provide concurrent, ongoing care for specific problems.
7. If, during a consultation, other problems are identified, specialist/consultants should discuss the management of these problems with referring physicians whenever feasible.
8. Specialist/consultants should encourage any patient who does not have a personal family physician to select one.
9. Both Colleges should adopt guidelines on the referral and consultation process.
10. Both RCPSC and CFPC should discuss specialty-specific guidelines on the referral and consultation process with national specialty societies, RCPSC specialty committees, and CFPC. Such guidelines should encompass requests from referring physicians to specialist/consultants for direct patient care and laboratory services in ambulatory care, hospitals, or other facilities.



11. The CFPC and RCPSC, together with other interested parties where appropriate, should encourage the development of methods for reviewing the consultation and referral process; in terms of quality assurance and accountability, these might include methods of peer review and system analysis, such as continuous quality improvement. These methods should be used to make qualitative and quantitative assessments of requests and responses, and to define and determine measures of success.
12. Universities and both national Colleges should include effective models of the referral and consultation process and of the family physician-consultation relationship in their undergraduate and postgraduate medical education.
13. Both national Colleges, universities, and hospitals should ensure the appointment of family physicians in hospitals and health care facilities that will enable them to participate in the care of their patients, in medical staff activities, and in continuing medical education activities. They would then be role models for residents in family medicine and specialty training programs.
14. The CFPC's accredited family medicine programs should ensure that residents learn their role as referring physicians. One strategy might be to invite specialists to work as consultants in the family medicine clinical teaching unit.
15. The RCPSC's accredited specialty programs should ensure that residents learn their role as consultants. Relevant clinical experience, where specialists interact with family physicians over patient care, should be part of the training program.
16. Both Colleges' training programs should emphasize that physicians should demonstrate courtesy, respect, and good communication in their interactions with patients, colleagues, health professionals, and all members of the health care team.
17. Both Colleges' training programs should emphasize that family physicians should provide their patients with a system of primary medical care that is accessible, comprehensive, and continuous.
18. Universities and both Colleges should ensure that graduates have demonstrated competence in the consultation and referral process, including its ethical aspects, patient-centred clinical decision making, effective communication, and awareness of the roles of the health professionals involved in the process.
19. Both Colleges should evaluate the consultation process through assessment of programs and trainees for which they are responsible.

## ii. 2006 Colloquium: Planning Committee and Delegates

Albritton, William  
Bailey, Tom  
Beaulieu, Marie-Dominique  
Belliveau, Paul  
Brazeau, Michel (Planning Committee)  
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Collins-Nakai, Ruth  
Collins Williams, Don  
Craven, Marilyn  
Crookston, David  
Fitzgerald, William  
Frank, Jason  
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Giguère, Paule (Planning Committee)  
Goldsand, George  
Goldszmidt, Mark  
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Gutkin, Cal (Planning Committee)  
Heard, Patricia  
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Howlett, Jonathan  
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Kates, Nick  
Katz, Alan  
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Kerr, Jonathan  
Kline, Stephen (Planning Committee)  
Leduc, Denis  
Lemire, Francine (Planning Committee)  
MacKean, Peter (Colloquium Co-chair, Planning Committee)  
MacLean, Cathy (Planning Committee)  
Maniate, Jerry (Planning Committee)  
Marturano, Patricia (Planning Committee)  
Maxted, John (Colloquium Facilitator, Planning Committee)  
McDonald, John (Colloquium Co-chair, Planning Committee)  
Nasmith, Louise (Planning Committee)  
Nasmith, James  
Pavilanis, Alain (Planning Committee)  
Rainsberry, Paul (Planning Committee)  
Raymond, Bernard  
Rourke, Jim  
Samson, Louise  
Scharfstein, Briane  
Seal, Rob  
Sirek, Ann  
Smith, Preston  
Thompson, Christine (Planning Committee)  
Turnbull, Jeff (Planning Committee)  
Ullyot, Suzanne (Planning Committee)  
Watkins, Todd (Planning Committee)  
Woodside, Blake (Planning Committee)  
Wright, Ryan (Planning Committee)

### iii. CanMEDS Roles Definitions<sup>3</sup>

As Medical Experts, physicians integrate all of the CanMEDS Roles, applying medical knowledge, clinical skills, and professional attitudes in their provision of patient-centered care. Medical Expert is the central physician Role in the CanMEDS framework.

As Communicators, physicians effectively facilitate the doctor-patient relationship and the dynamic exchanges that occur before, during, and after the medical encounter. As Collaborators, physicians effectively work within a healthcare team to achieve optimal patient care.

As Managers, physicians are integral participants in healthcare organizations, organizing sustainable practices, making decisions about allocating resources, and contributing to the effectiveness of the healthcare system.

As Health Advocates, physicians responsibly use their expertise and influence to advance the health and well-being of individual patients, communities, and populations

As Scholars, physicians demonstrate a lifelong commitment to reflective learning, as well as the creation, dissemination, application and translation of medical knowledge.

As Professionals, physicians are committed to the health and well-being of individuals and society through ethical practice, profession-led regulation, and high personal standards of behaviour.

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<sup>3</sup> In: *The CanMEDS 2005 Physician Competency Framework*. Ottawa: Royal College of Physicians and Surgeons of Canada; 2005.

#### **iv. Four Principles of Family Medicine<sup>4</sup>**

1) The family physician is a skilled clinician.

Family physicians demonstrate competence in the patient-centred clinical method; they integrate a sensitive, skillful, and appropriate search for disease. They demonstrate an understanding of patients' experience of illness (particularly their ideas, feelings, and expectations) and of the impact of illness on patients' lives.

Family physicians use their understanding of human development and family and other social systems to develop a comprehensive approach to the management of disease and illness in patients and their families.

Family physicians are also adept at working with patients to reach common ground on the definition of problems, goals of treatment, and roles of physician and patient in management. They are skilled at providing information to patients in a manner that respects their autonomy and empowers them to "take charge" of their own health care and make decisions in their best interests.

Family physicians have an expert knowledge of the wide range of common problems of patients in the community, and of less common, but life threatening and treatable emergencies in patients in all age groups. Their approach to health care is based on the best scientific evidence available.

2) Family medicine is a community-based discipline.

Family practice is based in the community and is significantly influenced by community factors. As a member of the community, the family physician is able to respond to people's changing needs, to adapt quickly to changing circumstances, and to mobilize appropriate resources to address patients' needs.

Clinical problems presenting to a community-based family physician are not pre-selected and are commonly encountered at an undifferentiated stage. Family physicians are skilled at dealing with ambiguity and uncertainty. They will see patients with chronic diseases, emotional problems, acute disorders (ranging from those that are minor and self-limiting to those that are life-threatening), and complex biopsychosocial problems. Finally, the family physician may provide palliative care to people with terminal diseases.

The family physician may care for patients in the office, the hospital (including the emergency department), other health care facilities, or the home. Family physicians see themselves as part of a community network of health care providers and are skilled at collaborating as team members or team leaders. They use referral to specialists and community resources judiciously.

3) The family physician is a resource to a defined practice population.

The family physician views his or her practice as a "population at risk", and organizes the practice to ensure that patients' health is maintained whether or not they are visiting the office. Such organization requires the ability to evaluate new information and its relevance to the practice, knowledge and skills to assess the effectiveness of care provided by the practice, the appropriate use of medical records and/or other

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<sup>4</sup> In: *The Postgraduate Family Medicine Curriculum: An Integrated Approach*. Mississauga ON: College of Family Physicians of Canada; 1995.

information systems, and the ability to plan and implement policies that will enhance patients' health.

Family physicians have effective strategies for self-directed, lifelong learning.

Family physicians have the responsibility to advocate public policy that promotes their patients' health.

Family physicians accept their responsibility in the health care system for wise stewardship of scarce resources.

They consider the needs of both the individual and the community.

4) The patient-physician relationship is central to the role of the family physician. Family physicians have an understanding and appreciation of the human condition, especially the nature of suffering and patients' response to sickness. They are aware of their strengths and limitations and recognize when their own personal issues interfere with effective care.

Family physicians respect the privacy of the person. The patient-physician relationship has the qualities of a covenant – a promise, by physicians, to be faithful to their commitment to patients' well-being, whether or not patients are able to follow through on their commitments. Family physicians are cognizant of the power imbalance between doctors and patients and the potential for abuse of this power.

Family physicians provide continuing care to their patients. They use repeated contacts with patients to build on the patient-physician relationship and to promote the healing power of interactions. Over time, the relationship takes on special importance to patients, their families, and the physician. As a result, the family physician becomes an advocate for the patient.

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