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THE COLLEGE OF FAMILY PHYSICIANS OF CANADA  
LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

## The 2<sup>nd</sup> Annual Sadok Besroun Global Health Conference

### **Strengthening the Foundations: Summary Report**

November 5–8, 2013  
Renaissance Hotel  
Vancouver, Canada

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## **Executive Summary**

The 2<sup>nd</sup> Sadok Besrouer Conference (November 5 to 8, 2013) built on the groundwork established one year earlier during the 1<sup>st</sup> Besrouer Conference. This family medicine–focused global health network set the stage in November 2013 for three days of collaboration. The result was the creation of tangible tools and strategies aimed at not only at translating the Sadok Besrouer Foundation’s broad vision into reality, but also developing the materials required to “make the case” for family medicine with policy makers and deans in the represented countries.

The conference brought together faculty from departments of academic family medicine in Canada and delegates from 15 low- and middle-income countries. Presenters brought their unique perspectives on a wide variety of topics including the unique contributions of the generalist physician, the experience of primary care in Brazil, information about the systemic changes in primary care in Ontario over the last decade, academic foundations at the Northern Ontario School of Medicine, and experiences and lessons learned in both Uganda and Tunisia. Lively discussion followed these sessions during which delegates explored critical concepts and key themes with their peers.

The goal of the sessions was to take the information presented by the speakers, as well as knowledge from the discussions, and develop several foci of work which could be translated into deliverables for development and release throughout the year.

As the themes took shape, five working groups formed:

1. **Besrouer papers:** A series of documents that could help provide the evidence for the value of family medicine.
2. **Tool kit for community engagement:** Tools such as an activity map/inventory, community assessments, train-the-teacher workshops, and community engagement activities designed to facilitate partnership with the community.
3. **Narrative development:** Gathering a collection of case studies that focus on inherent relationships critical to family medicine.
4. **Advocacy framework:** Tools that help to advocate for family medicine with policy makers.
5. **Continuing medical education (CME) and faculty development for specialists teaching family medicine:** The need to educate specialists tasked with training early cohorts of family physicians.

The CFPC will play a significant role in supporting these working groups as they develop their tools and strategies, which will be presented at the 3<sup>rd</sup> Besrouer Conference in the fall of 2014.

## Introduction

In 2008 the World Health Organization (WHO) issued its ground-breaking report entitled *Primary Health Care: Now more than ever*.<sup>1</sup> The report clearly highlighted the pivotal role of primary care in achieving the chief goal of “Health for All in the 21<sup>st</sup> Century,” set at 1978’s Declaration of Alma Ata.<sup>2</sup>

“If you had the resources, what would the College do to help develop family medicine worldwide?”

In 2008, Tunisian-born, Montreal-based family physician Dr Sadok Besrouer had an idea to explore how the CFPC could help to strengthen family medicine globally. Many Canadian academic departments of family medicine were involved in educational partnerships with institutions from low- and middle-income countries but, as Dr Besrouer observed, there was little communication or sharing between them. He began to think not only about how these linkages might be fostered, but how to reach out to international partners who might want to contribute to a family medicine–focused global health network. Dr Besrouer also posed a critical question to the College of Family Physicians of Canada (CFPC); if it had the resources, what would the College do to help develop family medicine worldwide?

It was with this question that the Sadok Besrouer Global Health Conferences began.

In November 2012, the first Besrouer Conference was held in Toronto, Ontario, Canada. While the enthusiasm of Besrouer 2012 provided welcomed validation, the next issue was to address how 2013 conference participants could address the pivotal strategic goal identified in 2012. How would participants come together to collaborate and what would be the focus of their collaboration?

This 2<sup>nd</sup> Besrouer Conference provided an opportunity for Canadian departments of family medicine and their low- and middle-income country (LMIC) partners to meet, exchange ideas, and collaborate. Nearly 60 delegates representing 15 countries gathered to translate the Besrouer Conference vision into tangible tools and strategies to enable the development and strengthening of family medicine globally, with particular attention to targeting leaders in government and academia. What was clear in watching delegates interact both informally and in the more formalized conference setting was that the spirit of collaboration and engagement was strong among all participants.

What follows is a summary of the work that occurred over three days in November 2013.

## Acknowledgements

Thank you to each of the delegates who took time out of the work they do on a daily basis to attend. Your enthusiasm and commitment directly contributes to this conference’s success. Thank you to Dr Besrouer for your vision and financial and moral support in moving this critical work forward.

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<sup>1</sup>World Health Organization. World Health Report 2008. *Primary Health Care: Now more than ever*. Geneva, Switzerland: World Health Organization; 2008. Available from: [www.who.int/whr/2008/whr08\\_en.pdf](http://www.who.int/whr/2008/whr08_en.pdf). Accessed 2014 May 12.

<sup>2</sup>World Health Organization [website]. Global Health Declarations. Available from: [www.who.int/trade/glossary/story039/en/](http://www.who.int/trade/glossary/story039/en/). Accessed 2014 May 12.

## **Day 1: Setting the Stage – Chair of the CFPC Global Health Committee, Dr Katherine Rouleau**

### **Welcome and introductions – CFPC President Dr Marie-Dominique Beaulieu and CEO Dr Francine Lemire**

The 2<sup>nd</sup> Annual Sadok Besrouer Conference was opened by Dr Beaulieu and Dr Lemire, who welcomed the international and Canadian delegates. Dr Beaulieu offered gratitude to the CFPC Executive, the CFPC Board, and the Global Health Committee.

In order to set the tone for the event, Dr Lemire spoke to one of the CFPC's chief goals: social accountability. She noted that the work done at the Besrouer conferences and the continuing development of resources fit well with this goal.

Dr Lemire also spoke about relationships, a theme that underscores family medicine, global health, and the connections that develop through, and out of, this conference. She reminded delegates that as part of the relationship-building process, collaboration should not end at the end of the conference. Delegates were encouraged to continue to work together to build on the work that this conference will begin throughout the upcoming year.



### **Setting the context**

Dr Katherine Rouleau provided the context for the three-day conference by highlighting its overarching goal: to develop several foci of work that can be advanced throughout the year and then added to a virtual space to act as a roadmap to global family medicine.

Dr Rouleau went on to anchor this second conference in both the past and the future. The first conference was focused on consultation. Its key strategic direction was to establish family medicine as a viable and pivotal element of health care worldwide. Next year's conference, the third and final in this initial cycle of collaboration, will be focused on communication and the dissemination of tools and strategies. These tools will include a virtual space that will allow participants to connect with each other and with their communities to support the development of family medicine as an effective and viable discipline in various health systems.

This second conference serves as the launch of the collaboration; the work carried out over the three days will come to fruition in a year. The presentations, proposed tools, and established working groups will inform and orient the creation of tangible materials that can be utilized not only by the delegates, but by anyone interested in global health strategies.

**Keynote: “Family medicine: New perspectives” – Dr Nulvio Lermen (Brazil)**

In his keynote presentation, Dr Nulvio Lermen provided insights into the state of family medicine in his native Brazil. Brazil is a large, culturally diverse country with a population base that is not only physically spread out in vast and sometimes remote areas, but is also a country in which there are the extremes of great wealth and poverty. Money spent on football (soccer) stadiums and upcoming Olympics infrastructure has surpassed health care spending in Brazil.

Despite these geographical and fiscal challenges, family health teams were established in order to provide critical services to the population. The teams are typically comprised of one physician, one nurse, one nurse assistant, and anywhere between four to ten community health workers who must live in the community they help to serve. It is the community health workers who serve as the link between the health care team and the population. Each family health team serves a territory and is responsible not only for the health of the population, but for monitoring conditions, such as sanitation, that could impact the health of community members.

With a broad understanding of the conditions and the structure of family medicine in Brazil, Dr Lermen spoke about changes in global health and the implications of those changes for family medicine. Dr Lermen pointed to changes in health and social services that impact the way in which the family physician interacts with his or her patients. These changes encompass two key areas. First, a more “connected patient” who has access to the Internet and its associated communication platforms, such as Facebook, is more demanding of a variety of health services and preventative measures. Second, physicians have access to new technologies that they can learn for the betterment of patients.

In addition to the changes in health and social services, there are also a series of demographic changes to which physicians must adapt, including migration, globalization, an aging population, greater social inequalities, shifting family structures, the increasing ubiquity of online networking platforms, and increased cultural distinctions and language barriers. Changes in health include increased comorbidity, increased disability, and increased social exclusion.

In the context of Brazil, Dr Lermen articulated some of the key goals that family physicians must work toward in order to better serve the health needs of the population. The entire structure of family medicine needs to be strengthened by policy makers and academics in Brazil, health services must be better promoted worldwide, evidence of the need for family medicine must be produced, and decision-making needs to be facilitated.

By highlighting the work done in Brazil through these family health teams in the broader context of a culture of change in family medicine, Dr Lermen helped to set the tone for the next few days of work by positioning the family physician at the centre of the primary care team.

## Day 2: Establishing Family Medicine As a Key Element of National Health Systems – Chair, Dr Ruth Wilson

### “The unique contribution of generalism to an effective and equitable health care” – Moderator, Dr Curtis Handford

Dr Curtis Handford is a family physician affiliated with the University of Toronto and St. Michael's Hospital, an inner-city teaching hospital that serves disadvantaged urban populations in Toronto, Ontario. Dr Handford's particular clinical interest is in addictions medicine.

Dr Handford opened the second day of the Besrouer Conference by providing his thoughts on the unique role of the generalist in primary care. He explored the concept of generalism and of the generalist (family) physician, and he discussed how the family physician serves as an anchor for the Canadian health system.

*“The crux of the generalist skill set is dealing with “unselected patients with unselected conditions.”*

Generalists deal with whole populations from the very young to the elderly. They practise in single or multiple settings, which can include ambulatory, home, hospital, and/or nursing home settings, as the community requires. They respond to common acute problems, handle the chronic care of their patients, and often manage psychosocial problems.

Dr Handford presented the often quoted Green et al. survey<sup>3</sup> and it was noted that three-quarters of the population will experience some type of medical symptom at some point during any given month. Of those, roughly 200 will visit a physician. Of those 200, an even smaller number will visit an out-patient hospital and an even smaller number will go to the emergency room. Of those who go to the emergency room, roughly 1 out of 1,000 will be admitted to a hospital.

If we take from this information that part of the role of the family physician is to keep people healthy and in their community, then teaching family medicine in hospitals is not reflective of what will be seen in a typical family practice. Because the crux of the generalist skill set is comprehensiveness that comes from dealing with “unselected patients with unselected conditions,” recognition of diseases in their earliest stages is not something easily learned in a hospital environment, where patients are generally further along in the course of their illness.

Family physicians face the unique challenge of having to translate and integrate many sources of evidence to address the needs of their patients with multiple conditions. The majority of guidelines are written for a single disease and not for diseases that might occur in combination. The generalist therefore uses cumulative knowledge of his or her patient in order to apply recommendations for treating multiple conditions. This cumulative knowledge comes not only from a degree of technical expertise, but through the relationship that the generalist must have with the patient. Trainees in family medicine must be taught these principles of generalism. If they were to learn only in academic teaching hospitals, they would miss critical elements that are integral to the creation of a comprehensive family physician.

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<sup>3</sup>Green LA, Fryer GE Jr, Yawn BP, Lanier D, Dovey SM. The ecology of medical care revisited. *N Engl J Med* 2001;344:2021-2025.



While the literature defining the value of the generalist is growing, and while in countries like Canada family physician is well-established as a critical piece in the primary care structure, challenges and additional opportunities still exist. Moving forward, it is imperative that family physicians continue to articulate to policy makers the nature of their skills in order to fully understand the role of the generalist as the anchor in a primary care structure.

### *Discussion*

The discussion that ensued from Dr Hanford's talk was lively and there was much conversation around two key areas: 1) measurement tools for understanding the work that the family physician does and 2) the way in which family medicine is taught.

The discussion around measurement tools focused on the unmeasurable aspects of family medicine. In the case of family medicine, how does one begin to measure the quality of care or time involved in helping to establish the patients' agenda? Similarly, how does one establish a measurement for the physicians' ability to discern if a symptom needs to be investigated more fully? Finally, how can family physicians quantify the time that it takes to build rapport and trust with a patient?

As the conversation progressed it became clear that there is a great degree of unquantifiable work in which the family physician engages, and that there are no easy answers for how to measure this work within standard tools. It is important to note that while patient satisfaction surveys are often utilized as a key indicator of physician success, these, too, can prove unreliable.

Inherently, standard physician measurement techniques, such as those focused on outcomes, impact, and quality, cannot be easily applied to the family physician. This, in turn, can impact payment. There are no easy answers to these questions; rather, better measurement tools for family medicine are required in order to fully appreciate the role that the family physician plays. The group acknowledged that there is an "art" to the process of measuring the unquantifiable work of the family physician.

The second area of discussion focused on learning about family medicine. As Dr Hanford pointed out in his talk, standard training for physicians occurs in a hospital setting. As one respondent noted, learning family medicine in a hospital is akin to studying forestry in a lumberyard. In other words, without the process of being able to teach family medicine in a community-based setting, family medicine will not be adequately taught. The agreed that ensuring that family medicine is taught outside of the hospital settings is, indeed, critical.

## Morning panel

Moderator, Dr Curtis Handford

Panelists: Dr Nulvio Lerman (Brazil) and Dr Joshua Tepper (Canada)

### ***“From policy to implementation: The lessons and challenges of family medicine in Brazil” – Dr Nulvio Lerman***

In the 1980s the Brazilian health system was based on a hospital structure. In the 1990s, this system began to change by moving from a hospital-based system to a family health team system comprised of one doctor, one nurse, one nurse assistant, and four to ten community health workers (five to six being the norm). These teams work in primary health care units and have access to a broader support system of psychologists, social workers, physiotherapists, nutritionists, etc.

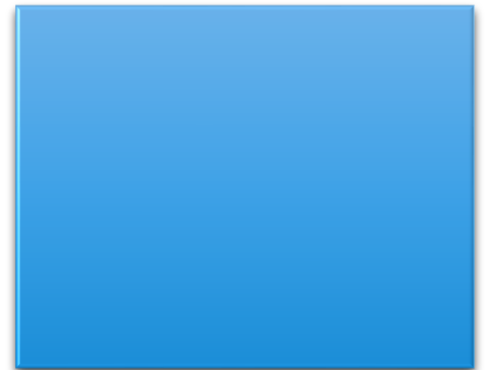
Each team works within a geographical region and is responsible for the patients within that territory. Each territory is typically comprised of roughly 3,000 to 4,000 people. The team’s primary job is to monitor and review the health status of the patients in the area. Understanding social and community structures is critical in order to provide proper care. The overarching goals of each family health team are public health, health promotion, and prevention.

The community health agents on each team must live in the area they serve and thus are aware of community problems and challenges. These team members provide necessary facilitation and communication skills between the health care providers and community members, and serve as the core of Brazil’s primary health care strategy.

Prior to these teams developing in the 1990s (after a three-year implementation period), Brazil moved to a universal health coverage system in 1988. Between 1998 and 2008 coverage improved vastly as family health teams took root and began to serve the needs of the population.

Today, there are more than 30,000 family health teams who work with more than 230,000 community health workers. Primary health care in Brazil has not only been a huge advancement for the health of the population, but also for greater social inclusion.

In the last decade, resources for primary care have grown and there has been measurable evidence that these family health teams have made a difference. Research shows that for every 10 per cent increase in the coverage of primary health care, there is a 0.6 per cent reduction in infant mortality. This demonstrates that family health teams are having a positive impact. Additionally, the United Nations Children’s Fund (UNICEF) credits the decision to move from a hospital-based model to a community-based model for the drop in infant mortality in Brazil. These numbers are not solely attributable to the rise of the family health care team. Literacy, access to clean water, higher family incomes, and an increase in the numbers of health care providers have all also contributed to the lower infant mortality rate. Research from the northwest portion of Brazil, the poorest region in the country, shows that with the rise of family health care teams, this area has now reduced its hospitalization-due-to-malnutrition rate to a level that is commensurate with the rest of the country.



These positive changes in Brazil since 1988 are attributable to the rise of the family health team, the teams' increased responsibilities, support from patients, and greater political importance placed on primary health care.

Despite positive change, challenges still exist. For example, poor overall management of the family health system, high rates of turnover, a lack of qualified family health professionals, and the academic arena—which has been slow to make the changes necessary to support family physicians—still need to be addressed. To mitigate these challenges, Dr Lerman focused on articulating the need to build capacity in both management and infrastructure supports for primary care, direct funds to universities that support primary care, and improve the integration between the family health team and the rest of the system.

### *Discussion*

Dr Lerman's talk also sparked lively dialogue; many delegates were quite interested in the work being done in family medicine in Brazil. Delegates shared their perspectives both from within the Canadian and international contexts.

One Canadian delegate pointed out that there is an inherent lack of regard for the role of the general practitioner in Canada, just as Dr Lerman had stated there is in Brazil. In Canada, the roots of this lack of understanding of the pivotal role played by family physicians is fostered in universities, where, until relatively recently, family medicine was not considered a viable option. This educational bias has, in turn, fed a long-standing cultural perception that the family physician is simply a failed specialist. While the group acknowledged this is changing in Canada, Dr Lerman was asked how Brazil has worked to mitigate this issue.

Dr Lerman responded by pointing out that with changes in education come changes in culture. Educational systems are notoriously slow to change. Therefore, making changes in this sphere initially will help to usher in broader cultural change, which tends to occur more rapidly. Currently in Brazil, trainees spend only three to four months in family medicine rotations. However, new rules have been established to increase family medicine rotations to 1.5 years. The hope is that this approach, while not perfect, will help to shift cultural perception.

A Ugandan delegate noted that in Uganda, there are practitioners who practise without any residency training and asked what incentives were used by Brazil to increase the family residency training programs. Dr Lerman explained that in Brazil, financial incentives will be offered to universities that change their curriculum to include family residency training.

The conversation then moved away from some of the more practical elements of family medicine training into the area of the delivery of primary care. A discussion began about the percentage of time a family physician in Brazil spends seeing patients and Dr Lerman noted that approximately 80 per cent of the family physicians' time is spent in direct patient care.

The conversation moved on the extent to which primary health care reform in Brazil is dependent on having the family physician as part of the health care team. Does having the family physician on the

family health team make a difference to the health of the population? Are there any of those key measurements that were discussed earlier in the morning to support the necessity of the family physician as a member of the primary health team?

What makes the case in Brazil so fascinating and rich is that there are statistics that do support the necessity for a family physician on the family health team. As Dr Lerman pointed out, nurse-led teams do function well but there is evidence that shows that the family health team is stronger with, and that patients benefit from, having a family physician on the team (a family physician who spends approximately 80% of his or her time seeing patients). The group agreed that, without a doubt, this research from Brazil would be beneficial to be shared not only with the group, but with policy makers at all levels across the globe.

### *“Family medicine in Ontario: A decade of change” – Dr Josh Tepper*

Dr Tepper began his talk with a key question: how important is the family physician? If the short answer is that the role of the family physician is pivotal, why is it that 20 years ago medical students were not choosing family medicine as a specialty?

Many years ago *MacLean’s Magazine* did a story on the family physician and reported that many felt their status had been diminished, that they were disconnected from patients, and that they worked very hard for little gain. Morale issues abounded and from a health system perspective, this was a crisis in access to care.

It was with this history that between 1995 and 2005 Ontario began to make a conscious policy shift toward changing the framework from family medicine to primary care. In Ontario, the definition of primary health care was established by government to mean the first point of contact between the patient and the health care system. The primary care provider is the navigator of the health care system and deals in illness prevention and health promotion. The idea of 24/7 care, connecting patients to physicians, helping physicians establish a practice population, funding based on patient care, and preventative and comprehensive care all developed as part of this shift.

A steady evolution between fee-for-service models and a comprehensive care model began to take root. Patients became better engaged and these new models of care became the norm. Those working on this policy shift also understood that there could be no single model that worked for the entire population. There was no magic bullet; models had to be different but they all had to be underscored by the core principles of primary care.

While this history presents a linear and clear shift in the way in which Ontario approached primary care, Dr Tepper was clear that this change was far from easy or linear. A great deal of trial and error occurred to get to this stage.

Dr Tepper also articulated a few specific challenges in this new system. Care needed to be delivered to diverse populations over a geographically large area and no cookie-cutter solution could be applied. Another issue that warranted some debate was in the area of after-hours care. While 24/7 care was to

*“Family medicine residents are now accepted by clinical practice groups, greater capacity has been created, and curricula have been innovated. As a result, there has been an increase of 70 per cent in the number of family physicians since 1995.”*

be the standard, this did not mean the physician should be tied to his or her pager consistently; rather, it was about creating the systems and structures needed to help set up a 24/7 system.

Compensation moved away from a fee-for-service model, increasing the average income for a family doctor closer to the range of what other physicians earn. Interdisciplinary and interprofessional models of care were also explored in order to build capacity in the system for this new primary care-based structure.

Family medicine programs also needed to be adapted. Family medicine residents are now accepted by clinical practice groups, greater capacity has been created, and curricula have been innovated. As a result, there has been an increase of 70 per cent in the number of family physicians since 1995. According to Dr Tepper, academic institutions rose to the challenge of restructuring the system and have become a critical part of the Ontario story.

Dr Tepper also reminded the delegates that while all of this change was necessary in order to shift the focus to primary care, it came at a time when resources to support this broad systemic shift were abundant.

### *Discussion*

The conversation that evolved out of Dr Tepper's talk began with a statement of context by one delegate, who indicated that, in his opinion, while a great deal of work in the area of family medicine integration into primary care structures has occurred within the last 20 years, a great deal of work by family physicians had also been done prior to this period by family physicians during the 1960s and 1970s. Dr Tepper clarified that while there were pockets of innovation in family medicine outside of the period he spoke of, it has only been within the last 20 years that there has been greater scaling and spreading of innovative models of practice.

It was within this framework and statement of context that the rest of the discourse ensued. Just as occurred after Dr Hanford's presentation on the role of the generalist, the idea of needing better patient outcome measurement tools was raised. Dr Tepper reiterated the points made earlier and indicated that the evidence of the impact of family medicine is not yet clear in Canada. Family physician morale has increased but the evidence of the impact is not yet available.

The group agreed that a growth plan for family medicine needed to be addressed. Quality of care issues need to be addressed and more data is needed in order to "make the case" for family medicine. In discussing measurement tools, the group began to explore the nature of the health system as a complex biological system and the need for a unit of analysis that could take into account the relationship between this complex system and patients.

This lack of clarity around the unit of analysis often means that the role of relationships in family medicine is often not adequately explored. As with the conversation that occurred earlier, the group identified a critical need to better adapt standard measurement techniques that take into account the unique role of the family physician.

### ***Morning Panel Discussion***

The first point of conversation was focused on two areas: first, there was a question about whether or not the number of family health teams in Ontario had been frozen, and second was a question focused on quality outcomes and the measurement tools discussed earlier. As the delegates pointed out, there had been a focus on understanding the number of hours primary care teams were available to patients and the number of patients seen, but there was little data that measured the *quality* of that interaction.

The group stated that it is important to consider that a cap on the number of family health teams in Ontario should not be considered a negative. The process of simply rolling out teams is not a proper answer to this complex question. The idea is to consider what is required in an area and roll out the effective solution, which, in some cases, may not be a primary health care team, but perhaps the use of other allied health professionals. It is also necessary to note that Ontario is in a recession so budgets do not flow as freely as perhaps they once did. These factors must also be considered when thinking about the rollout of primary health care teams.

Data on the quality of the physician-patient interaction is not abundant and the measurement tools used in this area are inherently flawed. More work is required to ensure that what we mean by quality can be more appropriately measured in the context of the family physician. There was additional conversation about the unit of analysis in a complex health care system. Better understanding of the unit of analysis will yield better results.

Additional questions came up about the educational systems in both Canada and Brazil and how these systems might be applied to other countries that have a shortage of family physicians. As noted earlier, Brazil is using a method of financial rewards to incentivize universities to improve their family medicine training. While Canada does not provide such financial incentives, Canadian infrastructure is both well-developed and well-established, allowing the educational systems to be adapted in different ways.

Finally, the group reiterated that the evidence Dr Lerman presented on the benefit of having a family physician on the family health team would go a long way when advocating to policy makers and others about the role of the family physician.

### ***Key themes***

From the discussions that occurred after each presentation and in the broader context of the morning panel, several clear themes emerged, which were explored through the lens of each speaker over the course of the presentations:

- Measurement tools that adequately capture the nuances and the relationship-building aspects of family medicine need to be developed
- Strong family medicine educational foundations are imperative to not only positively impact the training of family physicians, but to help affect cultural change around the perception of family physicians
- Evidence that supports the necessity of having a family physician on a primary health care team will go a long way in making the case for family medicine at the policy level

## Group Work, Part 1

Delegates were asked to break into small groups to use the key lessons from the morning presentations and the delegates' respective experiences to identify one to three potential foci for the Besrouer working groups. Five small groups engaged in discussion.

As the groups reported back to the delegation, a series of common themes emerged. These themes were focused around developing materials and evidence in the following areas:

1. **Definitions:** The need to define what a generalist is. What makes an effective and comprehensive family physician? In what ways has this been operationalized in different settings? What does *comprehensiveness* mean?
2. **Evidence:** Provide evidence-based justification for the comprehensive expert generalist as an integral part of a health care system. The proof must include a systematic review in this area. What research methods have been used to determine the evidence?
  - a) Case studies and the development of a true narrative
  - b) Measuring the impact of competent, comprehensive family medicine (use the partnerships established to do so)
  - c) Research and evaluation protocols
  - d) Successes and—equally important—failures to establish lessons learned
  - e) Demographic tools
  - f) Tools that measure access to care
3. **Advocacy:** Tools to help those who advocate at the policy level:
  - a) The elevator pitch, or the 30-second pitch that will help people understand the importance of the family physician
  - b) A checklist or tool kit of materials that could be used as a series of advocacy templates
  - c) Use the evidence to advocate
4. **Education and curriculum:**
  - a) Early integration of family medicine into the curriculum using accreditation standards
  - b) Tools to help support adapted curricula
  - c) Tools and strategies to increase the teaching of family medicine at the undergraduate level could be lessons learned, checklists, etc.
  - d) Methods of increasing recruitment at the post-graduate level

Goals: Groups use their own experience and the information presented by speakers to generate ideas about the following:

- What content should be included in a roadmap in response to questions addressed by the morning panel?
- What needs to be clarified for a working group to address these questions?
- Where are the best opportunities for international collaboration to contribute to answering those two questions?

- e) Tools that facilitate distance learning and education

## 5. Funding opportunities:

- a) Streamlined inventory of funding opportunities

### Afternoon Panel Discussion

*Moderator, Dr Howard Bergman*

*Panelists: Dr Innocent Besigye (Uganda), Dr Roger Strasser (Canada), and Dr Ahmed Maherzi (Tunisia)*

Dr Howard Bergman is the Chair and Professor of Family Medicine at McGill University in Montreal, Quebec. He has an interest in care of the elderly in both clinical practice and research. He has been involved in a variety of global health initiatives for a number of years.

Dr Bergman began the afternoon session by discussing family medicine in the context of global health. He noted that despite challenges, things have improved, particularly over the last 10 years. Family medicine has gained respect from governments and the public. There has been a greater realization that chronic disease is driving the health care system, and only by basing a system on family medicine and primary health care can the system be sustainable.

This change has also been realized in many places at an academic level, where family medicine has developed as a viable academic discipline and has become an important contributor to medical education.

#### *“Family medicine in Uganda” – Dr Innocent Besigye*

Dr Besigye began his talk by reminding the delegates that Uganda is quite different from the other countries that had been discussed up to this point in the conference.

In 1989 family medicine training began when Professor Ross, from Memorial University of Newfoundland, came to Makerere University in Uganda. While the program developed in an era of funding, as money evaporated so did support for the program.

The department of family medicine has remained in existence since its establishment, though there was very little activity until 2008, when Dr Besigye and a colleague began working to re-establish the department. Presently, there are 10 people in the department. Family medicine is also taking root at a new medical school based in Kampala, where family medicine is the focus.

Dr Besigye reminded delegates of the cultural structures in which family medicine is evolving in Uganda. The traditional healer remains the first point of care for the majority of Ugandans, not the family physician. It is within this construct of traditional medicine that family medicine is developing.

*“The traditional healer remains the first point of care for the majority of Ugandans, not the family physician. It is within this construct of traditional medicine that family medicine is developing.”*



He also pointed to a series of efforts working in conjunction to develop family medicine in Uganda, including work and funding through the following agencies:

- Canadian International Development Agency (CIDA)
- Volunteer services and opportunities overseas that are being established
- Global Health through Education, Training and Service (GHETS)
- The PRIMAFAMED Network
- Friends of Family Medicine in Uganda
- Hillman Medical Education Fund
- East Africa Family Medicine Initiative

Achievements in Uganda to date include government recognition of family medicine as a specialty in 1989, an increase in both the activity of family medicine departments and the number of family medicine trainees, and the development of undergraduate family medicine training. Key issues and challenges remain and include the need to define family medicine in an African context, the requirement for greater community integration and orientation, the necessity to shift away from hospital-based programs, a lack of evidence for family medicine, and increased policy change that will support family physicians.

Dr Besigye concluded his talk on a hopeful note. While there is work to do, the 2008 WHO report focusing on the role of primary health care in providing “health for all,”<sup>4</sup> government support for family medicine, and what he termed a “regional-wave” of family medicine support spreading through East Africa, coupled with an increase in the number of conferences, has made for positive change in family medicine in Uganda.

#### *Discussion*

Delegates were very interested in the information provided by Dr Besigye. The challenges faced in East Africa and the stage at which the development of family medicine in the area is occurring proved fascinating to the group. Delegates acknowledged the hard work done by Dr Besigye and his family medicine colleagues in Uganda.

A question was asked regarding the traditional healers in Ugandan culture. Dr Besigye noted that Ugandans are deeply rooted in their traditional forms of healing and the traditional healer serves at the centre. This traditional healer is part of the community and in effect, speaks to people in a language of culture and tradition that they understand and respond to. Because the healers are integrated into communities, this person provides a great source of community information for the family physician. Therefore, family physicians in Uganda must work with these traditional healers in order to adequately treat the population.

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<sup>4</sup>World Health Organization. World Health Report 2008. *Primary Health Care: Now more than ever*. Geneva, Switzerland: World Health Organization; 2008. Available from: [www.who.int/whr/2008/whr08\\_en.pdf](http://www.who.int/whr/2008/whr08_en.pdf). Accessed 2014 May 12.

**“From community engagement to academic foundations: Drawing on the experience of the Northern Ontario School of Medicine” – Dr Roger Strasser**

Dr Strasser began by setting the stage for health services in the 20<sup>th</sup> century, discussing a century of specialization with an emphasis on hospitals and technology. He also pointed to the rise of the teaching hospital as the norm.

Dr Strasser then moved on to an orientation of family medicine by describing the key focus in family practice as the people, their community, and the ability to evaluate undifferentiated health conditions. With family practice comes a strong degree of commitment and responsibility to the patient, and he pointed to Starfield’s definition of primary care in support.<sup>5</sup>

Additionally, countries that have good comprehensive primary health care have better health outcomes at a lower cost. Those with a higher concentration of specialists produce lower health outcomes.

He highlighted the 2008 WHO report<sup>6</sup> and used it to emphasize that the time is right to focus on primary care. The WHO also points to a degree of social accountability for medical schools to direct education to the needs of the region and the country that the educational institution is mandated to serve.

Dr Strasser also referenced the Association of Faculties of Medicine of Canada (AFMC) report, *The Future of Medical Education in Canada (FMEC): A collective vision for MD Education*,<sup>7</sup> in which the value of generalism is highlighted. In addition, the report highlights the need to integrate family medicine at all stages of undergraduate education.

This foundation set the stage for understanding the methodology and practices at the Northern Ontario School of Medicine (NOSM). Northern Ontario is a geographically large area with only 800,000 people. From a health perspective, the health status of those living in Northern Ontario varies greatly and is markedly worse than those living in Southern Ontario.

In 2001, NOSM was established in response to the health status of those in Northern Ontario and to help alleviate the physician shortage. It was established with a mandate of social responsibility, and to ensure that the people in the area get the most out of their providers.

“NOSM has had impressive results with its graduates. Unlike any other medical school in Canada, residencies were matched at 100 per cent. Further, students from NOSM do better than students in other medical schools on their standardized exams. Sixty-two per cent of graduates chose rural family medicine as their pathway. This represents double the national average for Canada. Finally, approximately 70 per cent of graduates remain in Northern Ontario.”

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<sup>5</sup>Starfield B. Cited in: University of Ottawa [website]. Primary Care: Definitions and Historical Developments. August 2013. Available from: [www.med.uottawa.ca/sim/data/Primary\\_Care.htm](http://www.med.uottawa.ca/sim/data/Primary_Care.htm). Accessed 2014 May 14.

<sup>6</sup>World Health Organization. World Health Report 2008. *Primary Health Care: Now more than ever*. Geneva, Switzerland: World Health Organization; 2008. Available from: [www.who.int/whr/2008/whr08\\_en.pdf](http://www.who.int/whr/2008/whr08_en.pdf). Accessed 2014 May 12.

<sup>7</sup>Association of Faculties of Medicine of Canada. *The Future of Medical Education in Canada (FMEC): A collective vision for MD Education*. Ottawa, ON: Association of Faculties of Medicine of Canada. Available from: [www.afmc.ca/fmec/pdf/collective\\_vision.pdf](http://www.afmc.ca/fmec/pdf/collective_vision.pdf). Accessed 2014 May 14.

NOSM has had impressive results with its graduates. Unlike any other medical school in Canada, residencies were matched at 100 per cent. Further, students from NOSM do better than students in other medical schools on their standardized exams. Sixty-two per cent of the graduates chose rural family medicine as their pathway. This represents double the national average for Canada. Finally, approximately 70 per cent of graduates remain in Northern Ontario.

The key question is how did this happen? To answer this, Dr Strasser articulated several factors that have led to NOSM successes. These include distributed and engaged learning, teaching and learning activities that occur at multiple locations, partnerships with communities in which clinical learning occurs, and the use of electronic communication methods.

It is NOSM's principle of distributed community-engaged learning across 70 sites throughout Northern Ontario that allows for continuity of relationships and a strong degree of community engagement, which enhances the student learning experience. The benefit of the community-based clinical studies is that, according to Dr Strasser, "The curriculum walks through the door."

As a result, NOSM produces more generalist physicians, has enhanced health care access across Northern Ontario, and has contributed to the responsiveness to Aboriginal, Francophone, and rural and remote health needs. From Dr Strasser's perspective, a successful family medicine program is achieved most notably through a process of authenticity and by learning from and listening to the community in which care is provided.

### *Discussion*

Dr Strasser painted a clear picture of success for the work accomplished by NOSM in a relatively short period of time. As he noted, one of the key ingredients for this success was community involvement and participation. Following Dr Strasser's talk, and understanding the necessity of community engagement, questions were raised about *how* community participation was secured. What methods did NOSM use in order to gain the support of communities who would house students during their clinical studies?

The answer to this proved to be straightforward: go to the community and talk to its leaders. Dr Strasser noted that it is imperative that community leaders be engaged in the process and understand the value and benefit to the community of hosting students engaged in clinical studies in both the short and long terms. Dr Strasser stressed that taking the time to talk to community leaders and to include them on committees takes a great deal of effort and developing and maintaining these relationships requires consistent fostering in order to sustain the level of engagement required. However, the benefits are well worth the reward; strong community engagement has been critical to NOSM's success.

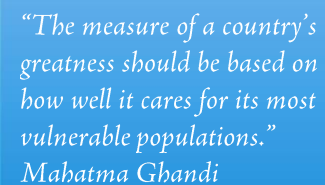
Further questions for Dr Strasser centred on students and how NOSM ensured that they were meeting the necessary points of their curriculum in the communities. Students at NOSM log each and every case they see. This log is then supplied to educators who review it and ensure that critical curriculum points are being hit. If for any reason it's clear that key areas are being missed, educators will change the structure of the clinical study to ensure that all of the necessary curriculum is covered.

What was clear in listening to Dr Strasser speak is that community engagement and student engagement both involve high levels of deliberate and carefully planned communication and collaboration. The institution cannot exist in a vacuum and neither can the communities or the students they host. Communication and collaboration are crucial in order to ensure that NOSM students, the curriculum, and the communities are all contributing to the education of family physicians.

The conversation then evolved into a definition of *primary health care* vs *primary care*. Without a doubt, these definitions have been, and will likely be, debated for many years to come. However, it was noted that for the purposes of the delegates and the group that primary health care is more broadly focused on the system level and describes an approach to health policy and services delivered both to individuals and at the population level, whereas primary care is a narrower concept that concentrates on the idea of care at the principal point of consultation—for example, the care provided by a family physician. The delegates acknowledged that having a clear understanding of the important distinctions between primary health care and primary care would be very important.

**“Lessons from Tunisia: Strategies to strengthen family medicine” –  
Dr Ahmed Maherzi**

Dr Maherzi stated that it is important to acknowledge at the outset the difficult political and socio-economic conditions in Tunisia. It is through the lens of this political transformation that Dr Maherzi provided a quote from Ghandi: “The measure of a country’s greatness should be based on how well it cares for its most vulnerable populations.”



“The measure of a country’s greatness should be based on how well it cares for its most vulnerable populations.”  
Mahatma Ghandi

In Tunisia, regional inequalities exist in terms of access to care. The four medical schools are all located on the coast, exacerbating regional challenges. Moreover, the regions that need the most physicians have the fewest number of physicians available to the population. How can this inequality be reduced and how can Tunisia’s medical schools help with this challenge?

Until recently, medical education faculties have only existed to train physicians and not to verify the impact of this training. This goes against the principles set forth by the WHO, whereby there is a responsibility to serve the population in which the educational institution is housed.

Dr Maherzi and his colleagues have been grappling with key questions such as the following: should medical education be reformed? Is the answer simply putting more medical schools in poorer areas? How can the goals of social accountability for medical schools be achieved given the challenges? How can quality and equitability of care be ensured for all Tunisians?

Critical to answering these questions is addressing policy makers. It has been difficult to convince policy makers that the job of the educator is not just to train physicians, but also to promote public health. Several meetings with the Minister of Health have begun in an effort to open this dialogue.

In spite of a difficult political climate, much has been achieved by Dr Maherzi and his Tunisian colleagues. Family medicine is increasingly being promoted as a specialty. Previously, in order to be a generalist, one had to become a specialist, and at no point in the duration of residency was there any focus on general practice. What happened as a result was that students who failed their specialty exams became generalists. This has now changed, thanks to new educational reforms, which mandate two years of family medicine practice.

Additionally, since 2006 there have been gains in the academic world by the creation of family medicine associations and inter-faculty groups. Further, 100 front-line physicians have been trained to oversee the work of students. Approval has been given to create a partnership project to work in poor areas so that underserved populations can also get the care they need. The schools of medicine will oversee this training in poor areas. There is also dialogue about policies and strategies in national health care plans. The goal is to reform health care so that access is universal.

Tunisia is also a member of a Francophone research action project that strives to improve medical schools' impact on health care. This project will be implemented in three phases: applicability, experimentation, and evaluation. Faculty will work on primary health care, curriculum, and evaluation while each country chooses a theme. All of the objectives of his project centre on social accountability. Two concepts that must be understood are that any training program must be adapted according to priorities set by primary health care, and that family medicine is an effective and pivotal element of national health systems.

### *Discussion*

It was evident that the delegates had a great deal of admiration for Dr Maherzi and his colleagues for their focus on family medicine during a time of great political upheaval. Rather than questions, delegates focused on accolades and recognized that the work coming out of Tunisia was highly valuable in the scheme of global family medicine.

### *Key themes*

Despite the diversity of presentations during the afternoon session, key themes emerged:

- Family medicine exists at a variety of levels depending on where one is in the world. That noted, in spite of challenges, whether they be political, cultural, social, or economic, family medicine programs are thriving
- Successful family medicine programs have achieved community integration and are highly collaborative
- Work has started but still needs to be done to strengthen the educational foundations of family medicine globally

### **Group Work: Part 2**

Delegates were asked once again to break into their groups to refine and focus the issues identified in the morning through the lens of academic

- *What content should be included in a roadmap in response to questions addressed by the afternoon panel? Does what was said this afternoon change what we discussed this morning?*
- *What needs to be clarified for a working group to address these questions?*
- *Where are the best opportunities for international collaboration to*

information provided by the afternoon panel.

While broad themes remained largely the same, some additional detail was provided as the delegates worked toward the development of working groups.

Key themes from the afternoon session were as follows:

1. Tool kit development to be used primarily for authentic community engagement
2. The development of resources such as:
  - a) Activity map/inventory
  - b) Train-the-teacher workshops
  - c) Community engagement
  - d) Facilitate partnerships
3. The need to support teaching and early exposure to family medicine
4. The development of relationship narratives that describe the inherent relationships that are part of family medicine
5. The development of “Besrouir papers,” which could be developed to address the following:
  - a) Literature reviews, including grey literature, to scan the files for the evidence of the impact of family medicine
  - b) A document or study that highlights the different conditions for family medicine in rural and urban settings
  - c) A thorough analysis of the evidence to adapt curriculum to support family medicine training
  - d) The partnerships that are inherent and significant in the area of family medicine (patient/provider as well as community/provider)

### **Establishing working groups**

Key themes were mirrored both in the morning and afternoon sessions. It was the common themes that led to the development of a series of loose working groups as the delegates headed into their third day (working groups were finalized on Day 4).

Anyone interested in participating in a group was invited to attend break-out meetings in order to help define a draft work plan, including the goals and proposed activities of each working group for the following year. While the initial expectation of the organizing committee had been to identify two or three working groups, strong consensus about priorities and the dedication with which participants opted to engage with a working group, resulted in the adoption of five groups:

1. Besrouir papers, led by Dr David Ponka
2. Tool kits for community engagement, led by Dr Michael Dillon

3. Narrative development, led by Dr Christine Gibson
4. Advocacy framework, led by Dr Dr François Couturier
5. Continuing medical education and faculty development for specialists teaching family medicine, led by Dr Lynda Redwood-Campbell

The draft work plans proposed by these groups are provided in the following section.

## Days 3 and 4: Defining the Roadmap – Chair, Dr Katherine Rouleau

The final day of the 2<sup>nd</sup> Sadok Besrouir Conference began with a check-in from the CFPC's CEO, Dr Francine Lemire. She provided a short presentation that helped to anchor the previous days' work in the broader goals of both the CFPC and the Besrouir Centre.

*If establishing family medicine as a viable and effective element of health systems is the ultimate goal, what work could be undertaken in the coming year in each of these core areas?*

Dr Lemire began by talking about the Besrouir Centre starting to operationalize the work that needs to be done.

Dr Besrouir has played a significant role in getting the Centre to its current stage. It is his vision that is now being carried out in the work that will take delegates forward into 2014.

In talking about lessons learned, Dr Lemire articulated that she had come to a realization that face-to-face relationships matter, and that it is the closeness of these relationships that defines the path forward. She also noted that she has come to learn that there are key areas that can be worked on first that will help to affect the greatest change: continuing professional development and faculty development.

In the coming year, staffing and planning for the November 2014 Besrouir conference will be moving forward at full steam. As of January 2014, a full-time Besrouir Centre coordinator will be employed. This coordinator will help put the work from this conference into action and will help the CFPC coordinate with additional funding sources in order to continue the work started by Dr Besrouir's donation. The journey may have "rapids and rocks" (to borrow from Dr Lemire's canoe analogy), but the group will navigate them together.

### The way forward: Reports from the working groups

#### Group 1: Besrouir papers, led by Dr David Ponka

1. *Gap, barrier, challenge, or open question:*

*The lack of evidence of the impact of family medicine training on population health.*

2. *What could be included in a virtual roadmap to address or assist with addressing the issue?*

*Publish a series of articles ("Besrouir papers") that address the where, what, why, who, and how of global family medicine training.*



3. Method/Plan:

*Publish an initial scoping review article that addresses the question, “Does formal family medicine training in low- and middle-income countries have an impact on population health.”*

**Data gathering**

- From various countries:
  - Brazil (clinic with GP vs without GP) (published), Uruguay
  - Uganda (British research group data on health indicators of family medicine in Gulu), Tunisia, China
  - From organizations, WONCA

**Literature review**

- Research question: Does formal family medicine training in low- and middle-income countries have an impact on population health?
- Define indicators of population health

**Article selection**

*Write the scoping review*

4. Working group participants:

*Dr David Ponka (writing)*

*Dr Neil Arya (writing)*

*Dr Anahi Barrios (reviewer)*

*Dr Nulvio Lermen (reviewer)*

*Dr Basia Siedlecki (methodology, writing)*

*Dr Jessica Lee (lit review, writing)*

*Dr Mandi Irwin (lit review, writing)*

*Dr Heather Baxter (reviewer)*

*Dr Lynda Redwood Campbell*

*Dr Videsh Kapoor*

*Dr Stephen Pomedli*

*Dr Katherine Rouleau (writing)*

5. *Timeline:*

Nov 2013:	Refine methodology
Monthly:	Skype meetings
Dec 2013 to Feb 2014:	Data gathering, literature review
Spring 2014:	Face-to-face meeting
2014:	Article publication

6. *Resources needed:*

*Funding for face-to-face meeting of working group members (Spring 2014?)  
Research assistant/Graduate student/Dr Paula Godoy-Paizl (University of Toronto,  
Department of Family and Community Medicine)  
Could the CFPC help facilitate the publication of the articles in 2014?*

**Group 2: Tool kits for community engagement, led by Dr Michael Dillon**

1. *Gap, barrier, challenge, or open question:*

*Need to develop tool kits for community needs assessment: practical, concrete tools to facilitate hands-on engagement with tailored evidence and business model support.*

2. *What could be included in a virtual roadmap to address or assist with addressing the issue?*

- *Must provide definitions of central concepts (eg, family medicine, aka “primary care” as defined by Barbara Starfield)*
- *Definitions must be:*
  - *In clear, common language (not jargon)*
  - *Definitions not specific to one region or system*
  - *Definitions tailored to the “level” of focus. Levels of focus include:*
    - *Community/client/families/faith community/cultural groups*
    - *Doctors/other existing first-contact care providers*
    - *Health service administrators/managers*
    - *Government/funders/bureaucrats*

### 3. Methods/Plan:

- Development of tool kit resources and evidence:
  - To support and reinforce the benefits of family medicine, tailored to each level of community engaged
- Development of actual tool kit:
  - Tools to obtain narrative and stimulate imagination
- Describe “what could be”: models from international partners with ideas in practice
- Obtain short, focused, uploaded YouTube videos describing key elements of practice from WONCA partners
- What demonstrates:
  - Community engagement/responsiveness?
  - The core essence of comprehensive primary care (eg, family medicine?)
- Obtain narrative from community:
  - "In your experiences with health care, tell us what has worked well"
  - “Why did you think it worked well?”
- Diorama construction:
  - "Build us your dream clinic/health centre" (supply modeling clay, other sculptural items)
  - Put some people in it (dolls, models):
    - “What do the providers do?”
    - “What do the patients/clients experience?”
- Identify barriers and challenges: where is the current system not meeting needs? How should these gaps be addressed?
- Make the pitch: collate the narratives, develop a model, and present to the four levels of community

### 4. Working group participants:

Roger Strasser, Northern Ontario School of Medicine  
Sarah Strasser, Northern Ontario School of Medicine  
Robert Miller, Memorial University of Newfoundland  
Michael Dillon, University of Manitoba/Global Health Committee  
Videsh Vapour, University of British Columbia/Global Health Committee

### 5. Timeline:

TBD

6. Resources needed:

*Ongoing navigation support from before start to after end of each needs assessment process:*

- Support for tool kit use
- Pitfall avoidance
- Cultural competence/safety
- How do you know you are talking to the right people?
- How to capture the “quiet voices”:
  - Old-school: “talking stick”
  - Hi-tech: text message polling, Twitter, real-time interaction

**Group 3: Narrative development, led by Dr Christine Gibson**

1. Gap, barrier, challenge or open question:

*There are many examples of success stories across our partnerships, but no way to actively find out more about them.*

2. What could be included in a virtual roadmap to address, or assist with addressing, the issue?

*Collecting appreciative inquiry narratives was initiated last year; we need to build on this learning.*

3. Methods/Plan:

*We will improve on the process for gathering stories and determine a method to manage and share them interactively, and in a way that benefits both Canadian and international partners.*

4. Working group participants:

*Dr Bob Woollard, Dr Videsh Kapoor, Dr Christine Gibson (Canada)*

*Dr Katrina Butterworth (Patan Academy of Health Sciences, Nepal)*

*Dr Innocent Besigye (Makerere University, Kampala, Uganda)*

*Dr Wilmoth (Andy) Shillingford (Caribbean College of Family Physicians)*

5. Timeline:

*We hope to have further progress on the collection by next year, ideally sufficient to produce a pamphlet or similar product. This information should be available online and should be searchable by keyword (including school and country).*

6. Resources needed:

- *Central administration to maintain the living document*
- *Full participation of the partners in populating their stories*
- *Online platform in which to share the information globally*
- *College resource around partnership maps*

**Group 4: Advocacy framework, led by Dr Francois Couturier**

1. Gap, barrier, challenge, open question:

*Strength: Recognition of social accountability, role of family medicine in Canadian medical schools, strength of the CFPC, Canadian family medicine as a mature specialty*

*Barrier: Lack of knowledge on where influential stake holders stand on family medicine (especially the political and financial stake holders)*

*Challenges: Need for strong evidence about the short- and long-term impact of family medicine in low- and middle-income countries (LMICs); need for well-presented case studies and narratives that target audiences for advocacy activities; need for robust, yet adaptive and flexible strategic plans*

2. What could be included in a virtual roadmap to address or assist with addressing the issue?

- Systematic review of existing literature:
- Gathering good knowledge of family medicine and primary health care–related issues around the world
- Collections of advocacy strategies and activities used (and results) by Besrouer partners
- Stratégie pour l'élaboration et le déploiement d'activités de **plaidoyer** en soutien au développement, à la valorisation et à la pérennité de la médecine de famille
- Des activités de plaidoyer sont nécessaires pour obtenir les appuis, le financement, les ressources matérielle, humaines et financières nécessaires à l'implantation, au développement et au maintien et à la croissance de toute activités de partenariat en médecine de famille
- Ces activités de **plaidoyer** sont essentielles et doivent être mené à toutes les étapes du développement de tel projet. Elles doivent être prévues dans leur grande ligne et budgétées au moment même de la conception des projets
  - Identifier à qui s'adresse ces activités (public cible)
  - Préciser la démarche initiée pour aborder ces différents groupes

*En se basant sur des exemples concrets et des arguments porteurs*

3. *Methods/Plan:*

- *Collecting and analyzing data (qualitative and quantitative), creation of an observatory on family medicine worldwide*
- *Providing assistance transforming generic advocacy strategic plan into strategic plan tailored to individual and specific situations*
- *Organiser des focus group avec tous les intervenants (exemple : méthode de Delbeque) : il est important que le public cible s'approprié le projet*
- *Adapter les argumentaires et les exemples en fonction du public cible*
- *Echanges réguliers entre les membres du groupe (téléconférence par Skype...)*
- *Coordonner les actions avec les autres groupes de travail*

*Etablir un agenda finalisant la feuille de route*

4. *Working group participants:*

*Cecil Canteenwalla (University of Toronto)*

*Sadok Besrouer (Besrouer Center)*

*Ahmed Meharzi (Université de Tunis)*

*François Couturier (Université de Sherbrooke)*

*Janie Giard (Université Laval)*

*Martine Morin (Université de Sherbrooke)*

*Katherine Rouleau (University of Toronto)*

5. *Timeline:*

TBD

6. Resources needed:

- Librarian for continuously up-to-date literature review
- Strategic planning consultant, advocacy coordinator
- Help from other working groups for narratives, data, arguments, etc.
- Besrouer Center achieving the status of the Davos and Porto Allegre of primary care and family medicine

**Group 5: Continuing medical education and faculty development for specialists teaching family medicine, led by Dr Lynda Redwood-Campbell**

1. Gap, barrier, challenge, or open question:

*LMICs need resources to help educate specialists about family medicine and help prepare specialists to train new family physicians.*

2. What could be included in a virtual roadmap to address or assist with addressing the issue?

- Review the literature to find previous experiences in training specialists to train family physicians, and share this information online
- Develop a two-day workshop with resources available online

3. Methods/Plan:

- Review literature: “training specialists to train family physicians in LMIC”
- Develop workshop content
- Pilot workshop content within group partners
- Publish findings/experience—Besrouer paper?



4. Working group participants:

*Dr Mulyadi, Syiah Kuala University (Indonesia)*  
*Dr Tita, Syiah Kuala University (Indonesia)*  
*Dr Nurjannah (MPH), Syiah Kuala University (Indonesia)*  
*Dr Jing Ding, Capital Medical University (China)*  
*Dr Clayton Dyck, University of Manitoba (Canada)*  
*Dr Lynda Redwood-Campbell, McMaster University (Canada)*  
*Dr Ryan McKee, McMaster University (Canada)*

5. Timeline:

- 1. December 16, 2013: Teleconference 9 pm EST*
- 2. December 16, 2013: Review of literature – performed with Canadian (CFPC) information technology resources*
- 3. March 2014: Workshop content draft*
- 4. June 2014: Pilot workshop in Indonesia*
- 5. September 2014: Draft of written findings/experience*

6. Resources needed:

*Library information technology resources for literature review*

- Administrative support for coordinating meetings, liaison with library services*
- Online space for sharing resources and interactions between partners*
- Expert support in areas of online module development*
- Funding for face-to-face meeting of working group (spring 2014? To share and refine content prior to pilot)*

## Panel response

The panel summarized the working groups' plans into five succinct deliverables. What was clear was that all five groups honed in on a single overarching topic: *demonstrating the value of the family physician to the health system.*

### Deliverables:

1. A paper on the impact of family medicine training
2. The development of tools that collect community voices and express the narratives found among patients
3. The development of a collection of narratives and a tool to search them
4. A tool to inform, educate, and advise the target audiences on the benefits of, and the need for, family medicine. These tools would vary in order to meet the needs of different audiences
5. A workshop to teach specialists how to teach family medicine

*What was clear was that all five groups honed in on a single overarching topic: demonstrating the value of the family physician to the health system.*

There was talk about possibly combining groups at this stage, given the overlap of work. However, delegates decided that the group leaders would be invited to meet on a regular basis to ensure alignment and to capitalize on synergies among the working groups.

It was also noted that all groups would have a place available to them on the Igloo website, and that all participants would be sent instructions about how to access the site.

The participants agreed to start small, with delegates and CFPC's Global Health Special Interest or Focused Practices (SIFP) group as initial audiences for the work being developed. There was further dialogue about the level to which WONCA could be integrated. While most people felt it was a good idea, the group agreed to start small and to expand as work evolved.

### ***“What I have seen and heard” – Dr Mulyadi (Indonesia)***

Over last three days much has been learned about family medicine. A clear picture of family medicine has developed, one that Dr Mulyadi hopes to use to start developing family medicine programs in Indonesia. He noted that he looks forward to continued collaboration and offered thanks to the Besrouer Centre and the CFPC for their past and ongoing support of the work completed.

### ***“What I have seen and heard” – Dr Robert Woollard (Canada)***

Dr Woollard began his summary by noting that the idea of the Besrouer Centre is a powerful one that—had it been an easy process—would have been accomplished long ago. He went on to highlight the complexity of both the work and the relationships that have been established by these Besrouer Conferences.

Dr Woollard noted that spending the last few days hearing about the skills possessed by the generalist family physicians has bolstered the group's confidence and inspiration in working together. Without a

degree of confidence in each other, the challenging tasks of creating working groups and establishing a plan to move forward would not have been possible.

## Concluding Remarks

Delegates have proven to be highly ambitious and have understood that the work they are undertaking is built on a strong foundation. It is with this strong foundation that they have also been able to recognize and respect the differences in approach presented by international colleagues.

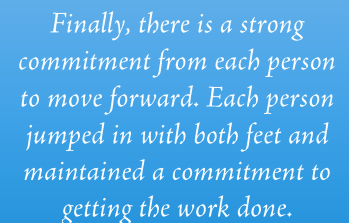
The group has also come to learn that relationships and narratives are of paramount importance. Narratives of success were shared from Brazil and the Northern Ontario School of Medicine and narratives of progress were highlighted from Uganda and Tunisia. It was the sharing of these stories that allowed the delegates to understand each other's experiences and the variety of cultures that came to the Besroul Conference.

The delegates focused heavily on what evidence was required to support family medicine as a chief component of primary care. They learned about the community basis for the discipline and the importance of community involvement in curriculum.

Joint tasks were defined from both the perspective that the future of family medicine is complex and from the desire to build together and work together. The five working groups developed from this conference will set the foundation for the next year by focusing on the critical elements identified over the three days.

Finally, each delegate demonstrated a strong commitment to move forward. This commitment will carry the Besroul Centre and the work of the 2<sup>nd</sup> Besroul Conference forward.

Heartfelt thanks goes to Dr Besroul, the CFPC, and the Global Health Committee for their dedication and passion.



*Finally, there is a strong commitment from each person to move forward. Each person jumped in with both feet and maintained a commitment to getting the work done.*