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EDITORIAL

Time is on my side, yes it is

The Icelandic College of Family Physicians (FIH) celebrates its 30th anniversary this year. In those 30 years family medicine in Iceland has grown and matured and established itself. But even if we believe that family medicine is and should be firmly established as the central discipline of medicine in our society the majority of physicians in Iceland are trained as specialists in various specialities other than family medicine. Our task is to change this and I believe we must do everything in our power to attract young doctors and grow to be one of the most respected fields of medicine.

We have come a long way in those years and FIH has fought many battles but maybe not won the war – not yet. One of the big battles we have won concerns the academic status of family medicine, the professorship, and other teaching positions as well as the recognition of family medicine as a speciality and family physicians as specialists. Later came continuing professional development and the establishment of a biennial family physicians' scientific conference as well as the first continuing professional development documentation system for family physicians. The College also published a standard for family physicians' offices and daily practices as well as an IT standard in 1985 and a curriculum for family medicine in 1995. The curriculum has been under revision for the last four years and will be re-published now as we celebrate our 30 years. I believe that this revision of the curriculum is one of the major achievements of our College and something we should be very proud of.

Ólafur Mixa was the first among Icelandic family physicians to be certified as a specialist in family medicine in 1971. In his footsteps came several young men and women eager to work towards making family medicine a stronghold in Icelandic healthcare. Most of them had been influenced by discussions and debates in the Nordic countries and the UK at a time when the '68 generation was preoccupied with messages about solidarity and equity. The ideology of family medicine built on ideas that primary care would become the foundation of a good healthcare service, an inexpensive, high-quality service for everyone, always and everywhere. In many ways this goal has been reached and today family physicians are probably the most socially concerned doctors and regard themselves as patients' advocates as well as guardians of the welfare system [1].

Needless to say, for a small country like Iceland it has been of great value to be able to participate and bond with the other Nordic countries. We have also been very open towards ideas from other sources and our family physicians have trained in for example Canada, the USA, and UK as well as in the Nordic countries. This mixture has at times been very interesting as our family physicians bring home different ideas and expectations. We have also been grateful for the Nordic Congresses since they started in Copenhagen in 1979 [1]. This Nordic forum for family physicians enabling them to share their experiences and scientific work has had a great influence on family medicine in Iceland. The 16th Nordic Congress will be held in Copenhagen 13–16 May 2009 and we should all make a mental note to attend and celebrate our common values and heritage.

Today we base our primary healthcare on over 30 years of experience and our main goal continues to be to provide personal, comprehensive, continuous care where the relationship between the patient and the family physician is at the centre and is the guiding light. Continuity of care is probably the most important part of quality primary care and can still be improved [2], and we all agree that too much fragmentation should be avoided [3]. Family physicians are also supposed to guide patients through the ever more complicated system of healthcare but have never truly served as gatekeepers since there has always been relatively open access to subspecialists in Iceland.

The challenge we face today is the growing population of older people with chronic and complex problems. These facts are very well illustrated in our research activities published recently in this journal [4–6]. The increasing comorbidity is very challenging and fits well with the ideology of family medicine where the focus is on the patient and the continuity of care but not on a single disease. Even if we like the challenge of more efficiency in our practice we have to defend our time with the patient

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since our relationship builds on trust, which is difficult to create without ample time. We also need to embrace teamwork, multidisciplinary care, and long-term management for our more complex patients, and promote and support to a greater extent patients' self-care and self-management. Lastly, we will have to start spending more effort and money on technology to support our care for the chronically ill and telemedicine will probably have fundamental implications for our healthcare system in the near future.

The bottom line is that we need good people and in order to attract young doctors we must ensure that our family physicians get the best education possible. We must also create a scientific base of family medicine with research and quality assurance. Family physicians also deserve the same respect as other specialists and needless to say the same salaries. Somehow this seems to go hand in hand. For many, many years Icelandic family physicians were worse paid than other specialists. This changed after a difficult dispute with the Ministry of Health in 2002 and with the correction in financial compensation enthusiasm for the discipline has risen.

The recent change of government in Iceland in the spring of 2007 brings new challenges as well as opportunities. The current Minister of Health seems interested and willing to make changes towards increased emphasis on information technology and privately run healthcare facilities, albeit governmentally funded with universal access assured. If these ideas come to fruition the opportunities for family physicians to have more control over their practice will increase, bringing more job satisfaction, it is hoped, and consequently better recruitment to the field of family medicine resulting in better patient access and contentment.

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