More hours, more tired, more to do: results from the CMA's 2002 Physician Resource Questionnaire

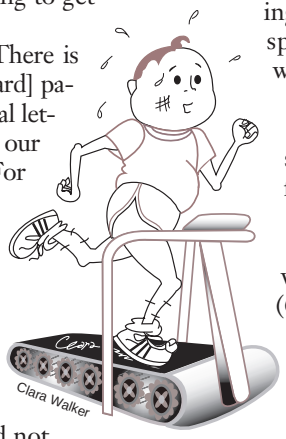
Although the emphasis of the CMA's annual Physician Resource Questionnaire (PRQ) is always on the tracking data it provides about the evolution of medical practice in Canada, it also offers several thousand physicians a year a chance to vent or rejoice about their profession. In 2002, there was a lot of venting (see sidebar).

Many of the complaints concerned the unrelenting demands of medical life. In the 2002 PRQ, respondents were asked for the first time whether their method of practice had changed significantly in the past 2 years, and one-third said it had. Nine percent indicated that they had increased call responsibility, with physicians in the under–35 and 35–44 age groups being somewhat more likely (11% and 12%) to have taken on more call responsibility than physicians in the 55–64 and ≥ 65 age groups (7% and 4%). Conversely, physicians aged 55–64 and ≥ 65 were more likely (13% and 15%) than those under 35 or aged 35–44 (3% and 8%) to have decreased call responsibilities or to have stopped taking shared call in the previous 2 years.

"Too many hours, too many patients, feels like fast-food medicine"

Of the more than 2900 physicians who completed this year's Physician Resource Questionnaire, 300 supplied verbatim comments about the condition their profession is in. Only 4 of the comments reflected positively on the state of medicine. Here's a sample.

- "Health care in Canada is like the story of the *Titanic*. The boat has already hit the iceberg and the ship is going down. It is going to get very bad over the next 5 years."
- "We are totally overworked, especially administratively. There is increase load of WSIB [Workers Safety and Insurance Board] papers, accident papers, insurance papers, office clients, referral letters to specialists and now even charting temperatures on our fridge for vaccine storage as requested by public health. For this amount of work I feel used, abused and underpaid."
- "I find the cost of running the office very expensive (computer, software, etc.) However, the government does not have any subsidies available for doctors' offices to keep up with the technology."
- "Too many hours, too many patients, feels like fast-food medicine."
- "The practice of family medicine on my own from 1980 to 2000 led to work overload, was always stressful and did not allow me to live a normal life. I therefore opted for asthma and allergies. I love it, because it allows me to become thoroughly immersed in these fields, as regards both the scientific and *human* aspects."
- "I have less and less time and energy for personal activities. Once my day off was 90% nonmedical, now it is catch-up time for paperwork, office management, house calls, etc., which fill approx. 75% of the day — i.e. 25% off."
- "I hope to retire by age 55 yr. I hope to retire completely from medicine and anything related to it."
- "Feel like a mouse on treadmill."
- "I still love the work I do — I'm just tired."
- "I enjoy my work in office and hospital. Great colleagues; excellent facilities. The pay is a bonus."



And a number of doctors appear to want off the "medical treadmill." Although 5% of respondents indicated that they had expanded their scope of practice in the past 2 years, almost twice as many (9%) were moving in the opposite direction. "I resigned my hospital privileges and stopped obstetrics so that I can have a reasonable life," one doctor wrote. "Never again will I work ≥ 90-hour weeks." Those aged 55 to 64 and ≥ 65 were more likely to have reduced their scope of practice (12% and 17%) than physicians in the under–35 and 35–44 age groups (7% and 8%).

The 2002 survey also raises questions about whether rising debt loads will allow young doctors to take an early step off that treadmill. For the first time, the PRQ asked doctors about the debts they carried following postgraduate training. Those under age 35 and aged 35–44 were the most likely to have carried a debt load (79% and 66%); only 28% of those ≥ 65 and 42% of those aged 55–64 had a debt load after postgraduate training. The average debt load for surgical specialists was $39 228, compared with $32 641 for medical specialists and $29 016 for GP/FPs. The results support data from a recent study of the impact of rising tuition fees on medical students, which found that first-year medical students in Ontario expect to graduate with a median debt of $80 000 (*CMAJ* 2002;166[8]:1023-8).

Many of those medical students will eventually receive fee-for-service (FFS) payments, but the proportion of physicians who receive 90% or more of their professional income in this manner continues to decline, from a high of 68% in 1990 to 59% in 2001 and 58% in 2002. Physicians in the 55–64 and ≥ 65 age groups are more likely to be in FFS arrangements (63% and 73%) than their younger colleagues (55% to 56%). Three-quarters of surgeons receive the bulk of their income from FFS, compared with 59% of GP/FPs and 52% of medical specialists.

Thirty-seven percent of respondents cited FFS as their *preferred* mode of remuneration, down from 50% in 1995,

while 23% would prefer a blended remuneration structure and another 26% would prefer to be paid by salary. "A salaried position with pension would certainly afford a better lifestyle and increased security after retirement," one respondent suggested.

Regardless of how they're getting paid, the proportion of physicians who reported increases to their net income in the previous year has more than doubled in the past 5 years, from 13% in 1997 to 29% in 2002. Seventy-nine percent of those with increased net income also reported an increase to their workload in the last 12 months, compared with 55% of those who did not report increased income.

To earn their money they worked an average of 53.8 hours per week, excluding on-call activities, compared with 53.4 hours in 2001 and 52.9 hours in 2000. "I'm very dissatisfied with my lifestyle," wrote one doctor. "My workload is enormous, my patients are demanding and I have too little time for my family."

As usual, male physicians tended to work longer than females (56.0 hours per week v. 49.1), and GP/FPs worked fewer hours (51.6) than medical specialists (55.3) and surgical specialists (58.6). Following a pattern evident in previous years, those in the under 35 and 35–44 age groups tended to work fewer hours per week (52.8 and 52.0) than their colleagues in the 45–54 and 55–64 age groups (56.4 and 54.3). Respondents aged ≥ 65 worked an average of 46.6 hours per week.

The PRQ is Canada's largest annual survey of physicians' professional activities. It first started tracking physician practice trends in 1982 and has been conducted annually since 1997. The 2002 survey was mailed to a random sample of 7693 doctors and the response rate was 38%. Results at the national level are considered accurate to within ± 1.9%, 19 times out of 20. Detailed results from the 2002 PRQ are available at **www.cmaj.ca** with the online version of the Sept. 3 issue. — *Shelley Martin*, Senior Analyst, Research, Policy and Planning Directorate, CMA

US drug industry bans expensive freebies for MDs, Canada raises fines

The new marketing code of ethics for drug detailers in the US has outlawed a battery of expensive giveaways, while the revised Canadian code has simply expanded on what giveaways are allowed and increased potential fines facing drug companies.

The new voluntary code from the Pharmaceutical Research and Manufacturers of America (PhRMA), which went into effect July 1, states that all interactions between physicians and detailers must be focused on information. This means that tickets to sporting events and Broadway plays, free music CDs, rounds of golf or expensive dinners are now forbidden, while pizza lunches or other modest meals are acceptable as long as the gatherings also deliver benefits to patients and cost under US$100. The code also spells the end of free travel to medical conferences (except for speakers) and of payment for time spent at CME events.

The changes are at least partly in response to public objections to free items or benefits for doctors, says PhRMA spokesperson Dr. Mark Horn, the director of medical alliances in corporate affairs at Pfizer. *Adbusters*, *W-FIVE* and the *New York Times* have drawn attention to the close relationship between the drug industry and physicians. The new code "clearly recognizes that there were a lot of actions under the rubric of education that weren't. We need, as an industry, to get back to basics."

This is PhRMA's first code — previously it followed American Medical Association (AMA) guidelines.

US pharmaceutical companies spend about $16 billion annually on drug promotion.

Dr. Bob Goodman, director of the watchdog group No Free Lunch (**www.nofreelunch.org**), says the US code is a public relations exercise that may, inadvertently, be effective because the public has taken over the role of watchdog from the industry. He praises PhRMA for "taking the higher road because the AMA hasn't been a leader in ethics for us."

In Canada, a revised code for members of Canada's Research-based Pharmaceutical Companies (Rx&D) doesn't limit freebies but it does get more precise about limits. For example, it spells out how to pay physician consultants and fund physician travel to international health education events. The maximum penalty for violating the Canadian code has tripled to $15 000, and there are now only 3 levels of violation instead of 4.

Jacques Lefebvre, Rx&D's executive director of communications and public affairs, says the latest revisions to the 10-year-old code are "a bit more precise. We don't want grey areas." He said the changes are an effort to "ensure best possible marketing practices" and "respond to the environment," but he declined to define "environment" or to comment on the new limits imposed by the US code.

Maximum fines in the US are $15 000, which Horn admits isn't much of a deterrent — Pfizer had sales of US$32 billion last year. "But we care deeply about our reputation, and that's the driver here."

Industry watchdog Joel Lexchin, an associate professor at the University of Toronto, doesn't think any code set and monitored by pharmaceutical associations without public input can be effective. "I don't think industry should be monitoring its own promotions," he argues.

Lexchin, who says industry marketing should be governed by an independent body with legal status, advocates a meaningful, escalating series of sanctions. The maximum sanction would be a ban on the promotion of individual products for a year "so that if companies keep violating, they will suffer substantially."

He estimates that Canada's research-based companies spent $1.2 billion promoting their products in 2000. — *Barbara Sibbald*, CMAJ