Affiliates

Family physicians deserting hospitals, says retiring CFPC president

EVELYNE MICHAELS

The retiring president of the College of Family Physicians of Canada (CFPC) says too many family doctors are dropping out of traditional areas of family practice.

In a speech to the college's 25th annual scientific assembly, held recently in Toronto, Dr. Robin Krause said that family physicians are "abrogating their rights" in the areas of in-hospital patient care, obstetrics, and the care of patients in the emergency department. In an interview with *CMAJ*, Dr. Krause, currently director of undergraduate education in family medicine at the University of Manitoba, said this withdrawal is largely an urban phenomenon. "In smaller centres we see the family doctor still very much involved in all aspects of primary health care", he said.

Dr. Krause said he believes the family doctor is not necessarily being pushed out of the urban hospitals, but is in fact "deserting" them voluntarily for a number of reasons. First, he says, doctors are electing to spend more time with their own families, unlike the older generation of physicians. Also the pressures of a busy practice leave the average family doctor little free time to visit in-hospital patients.

Dr. Robert Bourret, the newly elected president of the college, said Medicare has been largely responsible for family physicians' withdrawal from hospitals, especially in Quebec. "I can recall 20 years ago I had maybe 15 patients in hospital I had to visit each day", he said. "Then the patient was under our names, with the surgeon or specialist in a consulting capacity. Now the government doesn't want to pay two doctors on one case — so the specialist is it, and our visit is on a courtesy basis for the most part." Also, said Dr. Bourret, current fee schedules may actually discourage involvement by family doctors who can be paid less for a hospital visit than an office consultation.

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Dr. Bourret, who works in a private clinic in Verdun, Que., and teaches part time at l'Université de Montréal, says a number of changes introduced by the college may help to reverse the current trend away from hospitals. Family physicians can now be certified in emergency medicine for the first time, and diplomas in obstetrics/gynecology and geriatrics for family physicians are also being actively considered. Such specialization is not meant for the majority of family doctors, he emphasized, but for a few interested and capable people who might eventually go on to teach that aspect of family practice to students.

The next year could bring other significant changes in the education and practice of Canada's family physicians. Two task forces, established to study how primary care doctors are trained, are expected to make their recommendations by the end of this year or early in 1984.

The Canadian Medical Association task force on education for the provision of primary care services was set up with a broad mandate to study the content, strengths and weaknesses of pathways currently available to physicians preparing for primary care practice. The CMA task force has visited most family medicine residency training programs and rotating internship programs in Canada. An interim report may be presented at the CMA's General Council when it meets in Montreal on Sept. 30 and Oct. 1 of this year.

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Patient education: an essential part of medical care

Family doctors must do more than simply diagnose and treat their patients' illnesses — they must promote their patients' good health. While such a goal sounds fine in theory, can Canadian physicians realistically practise this ideal? Critics of health promotion have argued that such preventive medicine is neither time-effective nor cost-beneficial to the busy practitioner. And, they hasten to add, the patient actually *expects* a prescription or a procedure from the doctor, not another lecture on the hazards of smoking or of being overweight.

Not so, says Dr. W. Lawrence Green, a professor of family practice and community medicine at the University of Texas medical school in Houston. Dr. Green says that patient education is gaining respectability and force among doctors and health consumers as "an essential component of medical care".

Both the US Surgeon General's report (1979) and then Health Minister Marc Lalonde's "A New Perspective on the Health of Canadians" (1974) have recognized the important link between lifestyle and disease. The Lalonde report introduced the "health field concept" consisting of four elements — human biology, environment, lifestyle and health care organization — all of which affect the level of health in the population. The lifestyle category includes those decisions of individuals that affect their health and over which they have some control. The US report pointed out that "it is the controllability of many risks — and often the significance of controlling even a few — that lies at the heart of disease prevention and health promotion".

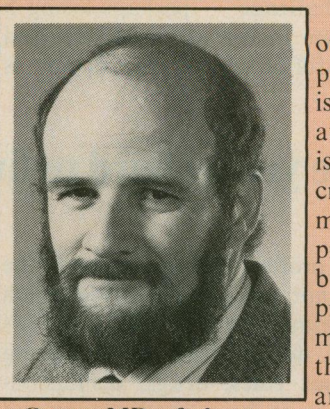
Other studies such as the Alameda, Calif. series (1972) showed a substantial increase in life expectancy for people who exercised regularly, kept their weight normal, ate breakfast regularly, avoided smoking, limited their alcohol consumption, and slept 7 hours to 9 hours each night.

Says Dr. Douglas Wilson of McMaster University's department of family medicine: "If lifestyle is, in fact, an important determinant of health, then it becomes essential to develop tools for measuring lifestyle in the individual."

Specialists in the field of health care promotion have made progress in this area — but what place is there for such concerns in the practice of the average family physician? Dr. Green says the concept of health promotion as an important part of daily practice has increased in popularity among doctors who are far more aware today of the lifestyle component in health and illness. "There are just fewer diseases that physicians can intervene upon without the cooperation of the patient", he said in an interview with *CMAJ*.

There have been some problems in the past — for example, until recently most patients have demanded active treatment from their physicians. But, says Dr. Green, the average patient is more sophisticated today about health and does not want to remain passive in his or her treatment.

Another difficulty has been that physicians are not properly equipped to do lifestyle counselling: "In fact, part of their training conspires against effectiveness in this area", says Dr. Green. "Their training is designed to make them feel *extra* responsible, so they have difficulty transferring responsibility to the patient when it is appropriate."



Green: MDs feel *extra* responsible.

A third criticism made of health promotion in private practice is that it is not efficient — a situation that Dr. Green says is already changing: "Increasingly as patients demand a lifestyle approach, it will be good business for the doctor to provide it. And there are methods of incorporating this kind of investigation and counselling in a stepped approach way, without entering a bottomless pit of greater physician involvement in non-medical activity."

One lifestyle questionnaire currently being studied at McMaster University is called FANTASTIC (the letters stand for Family and friends, Activity, Nutrition, Tobacco and toxins, Alcohol, Sleep and seatbelt use, Type of personality, Insight, and Career). So far the questionnaire has been an effective tool for teaching health care professionals. Dr. Wilson believes the individual practitioner may also find FANTASTIC useful in collecting data from patients, especially in wellness assessments, during life crises, or for patients with stress-related diseases such as hypertension. The questionnaire is easily completed and can be combined with a tailored prescription and follow-up for each patient.

Because they maintain contact with the individual and his family over time, family physicians are in an ideal position to assess and educate patients for lifestyle habits, says Dr. Wilson: "Initial health beliefs, health behaviours and health resource-seeking behaviour for care and cure are learned in the family setting" and the alert family doctor can have some influence, especially with new parents.

But is the doctor's word enough to make the average person change destructive habits affecting his or her health? The 1979 US Surgeon General's report showed that patients *said* they would alter their behaviour if advised to do so for health reasons by their physicians. But other factors are important to guarantee success. The patient, faced with a

challenge to quit smoking, cut down on alcohol or drug consumption, lose weight, exercise regularly, or slow down at work, can react three ways: he can reject the doctor's information and advice; he can change his lifestyle habits; or he can accept the doctor's word but still not change his behaviour. Studies have shown that threatening the patient with dire consequences if he does not change his ways is of questionable value, since too much fear arousal can immobilize the patient and produce added stress which may be more damaging than the original problem. Doctors should also be aware that if a number of behaviours need changing, as with the obese patient who smokes, the patient should start with the least difficult challenge — perhaps losing 5 kg. A small success can increase confidence and self-esteem. Supportive follow-up by the doctor is most important, as are the support of the patient's family, and even written contracts between the doctor and patient.

But before health promotion is itself widely promoted in medical education and among a majority of doctors, more research into its actual benefits will have to be done. As one expert in the field, R.B. Taylor, has remarked: "The literature base is comprised of intuitive generalities derived from retrospective studies confounded by a host of inescapable experimental biases. Is it any wonder that the established medical specialties have been cautious in adopting its principles?"

Dr. Wilson concludes that the traditional biomedical model will have to be modified as physicians incorporate techniques of health promotion with diagnosis and treatment of their patients' diseases.

Doctor, why are you so hard to live with?

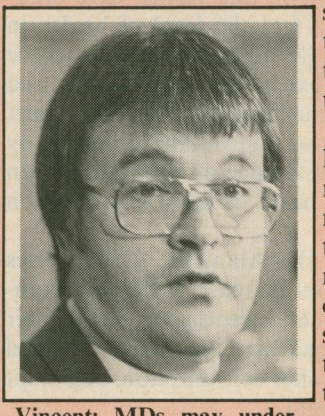
Fee disputes, dwindling professional self-esteem, the increasing pressures of not enough time, too much knowledge, and overwhelming responsibility — it's not easy to be a good doctor these days. Rising divorce rates, shifting sex roles, drugs, disillusionment — it's also not easy to be a good spouse and parent these days. And, according to Dr. Merville Vincent, it is downright difficult, if not impossible, to function well in both these complex systems simultaneously.

Dr. Vincent, the executive director of the Homewood Sanitarium of Guelph, was one of a number of health care professionals who participated in a seminar on "The Physician and his Family" at the recent assembly of the College of Family Physicians of Canada. It was there, said Dr. Vincent, that speakers tried to "explain the unexplainable, to answer the question every doctor dreads: How come you are so hard to live with?"

The subject of doctors and their families is of some interest, not only to the spouses and children of physicians, but also to physicians themselves who have only recently come to see that they are not immune from — and may even be predisposed to — a host of health and social complications. An article in the *Mayo Clinic Proceedings* of January 1981 reported that depression, drug and alcohol dependency, and marital conflict are the personal difficulties most frequently faced by physicians.

Of course it should be recognized that physicians' families are not alone. The families of airline pilots, shiftworkers, the unemployed, and even garden variety professionals and nonprofessionals, are also suffering from the stresses of the times.

But in some ways physicians are especially vulnerable to marital difficulties and parenting problems, says Dr. Vincent, who offered as reasons for this the following contrasts: A good doctor can control feelings; a good spouse–parent can express feelings. A good doctor works hard and spends time with patients; a good spouse–parent is available when he is needed. Patients want a doctor who is available, helpful and good humoured; so do families. Thus, says Dr. Vincent, "the two systems compete for the physician's energy, time and attention".



Vincent: MDs may undervalue human relationships.

Part of the problem, he says, is that it is still much easier to get into marriage and parenthood than it is to get into medical school. Physicians who succeed in school and later in practice are capable of sustained effort without immediate reward, and they have demonstrated the ability to set relationships aside to succeed.

"The result is that the physician often emerges from this process overly impressed with medical science, and undervaluing human relationships", says Dr. Vincent. Then when marital tensions develop, as they normally do in all marriages, the system of medical practice with its "infinite demands and absence of clear-cut limits of responsibility" gives the frustrated physician–spouse an acceptable and easy "out".

Both Dr. Vincent and Dr. Jean Wilkins, a pediatrician in Montreal, believe the stress on doctors is increasing today as their traditional authority within the society decreases. "Many doctors find it difficult to adjust to these new situations", says Dr. Wilkins. "Many react within the familial environment by becoming even more controlling."

Dr. Wilkins, who treats mainly adolescents, sees many doctors' teenagers and is himself the father of three children. He says being a "doctor's kid" can have its disadvantages. The doctor–parent is often absent from the home for long periods of time, and the nature of his work — helping others — is least open to challenge. Doctors' children are often closely watched from birth for a symptom or sign of illness to occur. If the doctor's child, or spouse, does in fact get sick, the doctor may either deny it and wait too long before seeking treatment, or else immediately overinvestigate.

While the financial, academic and social environment of doctors' kids is usually very secure and advantageous before adolescence, says Dr. Wilkins, the changes wrought by puberty may be especially traumatic in the doctor's family. Usually doctors are more controlling, protective and authoritative with their children than most parents; they have high expectations of themselves and others, and tolerate failure poorly. If the doctor–parent cannot relinquish control to the rebelling teenager, many serious problems can occur including drug abuse, social and academic withdrawal, and even suicide attempts.

Dr. Wilkins says he thinks too many doctors choose to have their children at the beginning of their medical studies or careers, when work requires all their time and energy. Thus, the spouse effectively becomes a single parent which can lead to more marital distance and resentment. In the doctor's absence from the home the spouse may also tend to idealize him to the children, and this attitude can interfere with the normal parent–child relationship.

Career choice often becomes a focus of conflict, says Dr. Wilkins — many doctors' kids may feel pressured to choose a medical career, or at least one of equal professional status, even if they are attracted elsewhere.

Dr. Vincent believes that satisfying, intimate relationships between doctors and their spouses and families are quite possible and do exist — but such success takes an awareness of the risks and much hard work. The threat in many medical families has been that the doctor's wife would not achieve a sufficient sense of personal fulfillment — but as more women enjoy careers and interests outside the home this risk is decreasing. This trend, as well as the growing number of female physicians, has meant that many doctors' families are now coping with the strains imposed by two careers — a phenomenon that is by no means limited to medical families.

The ultimate problem is when the career is given pre-eminence, says Dr. Vincent. Doctors may be especially vulnerable to this tendency because the current fee-for-service system in Canada gives them a credible rationale for extremely long working hours at the expense of time at home. But more and more younger doctors — particularly women — are learning to combine medical practice with family life and thus reduce the risk to their marriages and their children. It is a trend that will likely produce happier and, therefore, more effective physicians.

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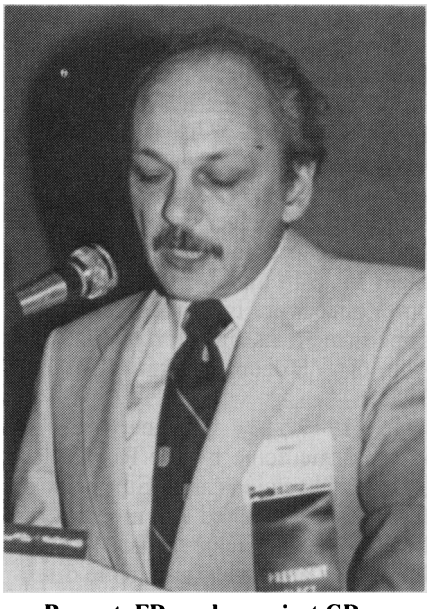
The second task force was set up by the college, under the chairmanship of Dr. Don Rae, to review the appropriateness of the current core curriculum for teaching family physicians. Dr. Krause told *CMAJ* that disagreement over rotating internships versus family medicine residency programs persists. He says some of the current rotating internship programs are quite effective, but, he adds: "It's really quite difficult to accept the fact that you should train someone for community work in a hospital." As for the re-evaluation of the existing core curriculum, Dr. Krause believes more input from family medicine is needed at the undergraduate level.

Dr. Krause reflects that in some ways current fee schedules across the country militate against effective family practice. "Most fees are still procedure-oriented", he says. "Manual dexterity gets paid. Counselling and talking to the patient, which may not seem dramatic but are very important, do not get paid." Dr. Bourret agrees that the college, which has been reluctant to become involved in medical economics, may ultimately have to do so. "Sometimes the dollars and cents interfere with your practice, which ends up being dictated by someone else", he says.

Dr. Bourret, who was president of the college's Quebec chapter in 1979 and 1980, says he hopes to attract more members from Quebec. There are about 5000 family doctors in that province, but only 750 have joined the college — a low proportion, but one that has already tripled in the past few years.

Dr. Bourret speaks passionately about the attraction of family medicine itself and about the college's philosophy in promoting family practice: "Our practice is the most global, the most comprehensive, a way of talking to patients and treating them which is not now taught in the medical schools. We come to see the patient as a whole person in his own milieu — the surgeon, perhaps, does not have to go that far."



Bourret: FPs no longer just GPs.

Dr. Bourret says the college exists and will flourish because the average young family doctor now accepts that he or she is no longer "just a GP", but has in fact made a commitment to the specialty of family medicine. ■

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