Satisfactions et défis des médecins de famille

Enquête sur le web à l'aide de la technique Delphi

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RÉSUMÉ

OBJECTIF Identifier et décrire les principales satisfactions et les grands défis que vivent les médecins de famille albertains.

TYPE D'ÉTUDE Étude qualitative sur le web à l'aide de la technique Delphi.

CONTEXTE Province de l'Alberta.

PARTICIPANTS Vingt-huit médecins de famille pratiquant en Alberta.

MÉTHODES Le site web utilisé présentait une description du projet, des informations d'ordre éthique, un calendrier des événements et des informations préliminaires. Les enquêtes Delphi et les questionnaires démographiques étaient protégés par des mots de passe. Des enquêtes ont été menées à 5 reprises entre mai 2004 et janvier 2005. Les participants étaient avertis à chaque nouvelle enquête et relancés par courriel s'ils n'avaient pas répondu.

OBSERVATIONS Les participants ont identifié 8 satisfactions et 9 défis importants. L'équipe de recherche en a identifié 2 autres qui ont été validés par les participants. Par ordre d'importance, les principales satisfactions rapportées étaient: dispenser des soins variés et complets; fournir des soins préventifs; entrer en relation avec le patient et sa famille; être un témoin privilégié de la condition humaine; assurer la continuité des soins et en recevoir une rétroaction continue; avoir une flexibilité et un contrôle sur sa pratique et sa sécurité d'emploi; maintenir et acquérir des habiletés et connaissances; enseigner, partager ses connaissances, acquérir de l'expérience et faire du monitorat. Par ordre d'importance, les défis mentionnés étaient: la charge de travail et les contraintes de temps et de réunions; la nécessité de faire connaître les satisfactions de la médecine familiale à ceux qui envisagent cette option; les frais généraux, la rémunération insuffisante; l'obtention d'un plus grand respect de la part des spécialistes; la nécessité de s'assurer que les satisfactions identifiées ne sont pas menacées par la réforme des soins de première ligne; le manque de disponibilité des spécialistes et des techniques, examens et autres ressources; le fait de gérer la pratique comme une petite entreprise; la paperasse, les appels téléphoniques et les formulaires; le maintien et l'acquisition d'habiletés et de connaissances; les attentes des patients; et les questions médico-légales, formulaires d'assurance et réclamations médicales concernant les accidents de la route.

CONCLUSION Les satisfactions et défis rapportés par les participants illustrent les facteurs positifs et négatifs propres à la médecine familiale. Les défis identifiés pourraient faire l'objet de travaux additionnels.

POINTS DE REPÈRE DU RÉDACTEUR

- Le médecin de famille canadien fait face à plusieurs défis dans sa pratique, mais il connaît aussi des satisfactions. Cette étude qualitative identifie, décrit et classe les satisfactions et défis principaux rapportés par un groupe de médecins de famille albertains.
- Quatre des 8 satisfactions clés portaient sur la relation médecin-patient, incluant le sentiment d'être un témoin privilégié de la condition humaine.
- Parmi les 11 défis clés, la charge de travail et les contraintes de temps avaient la plus haute importance.

Cet article a fait l'objet d'une révision par des pairs.
Le texte intégral est aussi accessible en anglais à **www.cfpc.ca/cfp.**
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Rewards and challenges of family practice

Web-based survey using the Delphi method

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ABSTRACT

OBJECTIVE To identify and describe the important rewards and challenges that affect family physicians in Alberta.

DESIGN Web-based qualitative study using the Delphi method.

SETTING Province of Alberta.

PARTICIPANTS Twenty-eight family physicians practising in Alberta.

METHODS The study website presented a description of the project, ethical information, a calendar of events, and contact information. Delphi surveys and demographic questionnaires were password protected. Five rounds of surveys were conducted between May 2004 and January 2005. Participants were notified of each round of surveys and prompted by e-mail if they did not respond.

FINDINGS Participants identified 8 key rewards and 9 key challenges. The research team identified 2 additional challenges that were validated by participants. In order of perceived importance, key rewards were providing diverse and comprehensive care; providing preventive care; having relationships with patients and their families; being an immersed witness to the human condition; providing continuity of care and receiving ongoing feedback; having flexibility and control of practice and job security; maintaining and acquiring skills and knowledge; teaching and sharing knowledge and gaining experience and mentoring. The challenges, in order of perceived need to be addressed, were workload and time pressures and meeting demands; the need to promote the rewards of family practice to those considering joining the profession; overhead and income inequities; getting respect from specialists; the need to ensure that the rewards identified are not adversely affected by primary care reform; lack of availability of specialists, procedures, tests, and other resources; running a practice as a small business; paperwork, telephone calls, and forms; maintaining and acquiring skills and knowledge; patients' expectations; and medicolegal issues, insurance paperwork, and dealing with medical claims related to motor vehicle accidents.

CONCLUSION The rewards and challenges reported by participants outline the positive and negative factors in family practice. The challenges provide a focus for further work.

EDITOR'S KEY POINTS

- Canadian family physicians face many challenges in practice, but also experience rewards. This qualitative study identifies, describes, and ranks key challenges and rewards as reported by a group of Alberta family physicians.
- Four of the 8 key rewards centred on physician-patient relationships, including being "an immersed witness to the human condition."
- Workload and time pressure was ranked most important of the 11 key challenges identified.

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The 2003 results from the Canadian Resident Matching Service (CaRMS) showed that fewer medical students were selecting family practice as a career.[1] Reasons for this include the perception that family practice has a heavy workload and lacks the prestige and earning power of specialty programs.[1] Unfortunately, the difficulties of family practice extend beyond low enrolment and are not limited to Canada. In recent years, British and Dutch family practitioners have gone on strike to protest inadequate funding and poor working conditions,[2,3] while in Australia, general practice has been described as "soul-destroying."[4]

Several international surveys have attempted to identify and clarify why family practitioners suffer from severe stress and health problems[5-9] and job dissatisfaction,[7-11] and even consider ending practice.[5,12] Specific areas of difficulty include heavy workload,[5,8,12,13] too much paperwork and bureaucracy,[11-13] lack of control,[10,11] patients' demands,[9,13] lack of time to meet demands,[5,12] insufficient financial compensation,[5,11] and lack of balance in personal and professional life.[5,7,9]

To describe these concerns more accurately, some international studies have used qualitative methods.[14-20] Common themes among these studies include excessive workload[14-17] and difficulty balancing personal and professional life,[16-20] but most focused on specific groups, such as rural[16,18] or female[19,20] practitioners, and none examined Canadian physicians.

While some Canadian family physicians can relate to the concerns of their international colleagues, such concerns might not represent the key issues in Canada. Only 2 studies have addressed concerns here.[21,22] In surveys of the perceived effects of health care reform[21] and the National Physician Workforce Survey,[22,23] family physicians identified many concerns including inadequate compensation, time demands, workloads, negative effects on personal life, excessive paperwork, inadequate staffing, difficulty accessing medical services, stressful on-call schedules, and bureaucracy in medicine. Professional satisfaction was linked with intellectual stimulation and relationships with patients.[23] These studies provide insight into a few issues facing Canadian family physicians, but they were not designed to identify and develop consensus on how to manage the key issues encountered in family practice.

To address issues specific to family practice, we need to understand them. With so many concerns cited in the literature, it is difficult to determine which concerns are important. There might also be key issues that have not been described in the literature. What are the concerns, how important are they, and which ones need addressing? To answer these questions, we needed to allow family physicians to generate and report these concerns and ideas without influencing their responses. To that end, we conducted a Web-based consensus study using the Delphi method to identify, describe, and rank the important rewards and challenges experienced by family physicians in Alberta.

METHODS

Study design

A qualitative approach was used to allow family physicians to convey their personal concerns and ideas on key issues. The Delphi method enables development of consensus among experts through an anonymous iterative survey method.[24,25] Initial rounds are generative; subsequent rounds clarify, refine, and facilitate the emergence of consensus.[25] A Web-based Delphi survey allowed for timely participation from various locations and for participants to generate ideas in their own words, rather than having researchers assume an understanding of the important factors and simply ask participants to rate them.

This study used both a respondent group and a work group. The respondent group included the family physicians who participated in the Delphi surveys. The work group comprised members of the research team who analyzed and summarized data between rounds of the Delphi survey.

Participants (respondent group)

Participants were family physicians from throughout the province of Alberta with access to computers. Maximum variation sampling[26] was used to elicit a spectrum of opinion and identify important common issues from urban and rural, male and female, academic and non-academic physicians with a range of years in practice, varied volumes of practice, and many different types of patients.

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Recruitment of respondents occurred in 2 ways. First, potential participants were identified by the work group and through word-of-mouth. Second, information on the study and how to participate was e-mailed to members of the Alberta College of Family Physicians and also posted on its website. Twenty-eight family physicians agreed to participate and signed consent forms. Participation in the Delphi rounds was voluntary; each respondent participated in at least 1 round. Results from previous rounds were posted to inform participants who had missed a round. Of the 28 respondents, 18 (64%) participated in all 5 rounds, and 25 (89%) participated in at least 4 rounds.

Work group

The core work group comprised the principal investigator (family physician researcher) and 2 co-investigators (an evaluation researcher and a rural researcher) with experience in Web-based Delphi surveys. The remainder of the work group consisted of 2 researchers, 3 community family physicians, 1 rural family physician, and 2 academic family physicians. They assisted with overall project direction, recruitment, development of questionnaires, and pilot testing, and (as peers) checked interpretations.

Study procedures

The study website presented a description of the project, ethical information, a dynamic calendar of events, and contact information, all of which were publicly accessible. The Delphi surveys and demographic questionnaires were password-protected; respondents could not access other participants' responses. E-mail reminders were sent to all participants notifying them of each survey round, and 1 week before deadline to those who had not completed their surveys. Five rounds of Delphi surveys were conducted between May 27, 2004, and January 5, 2005. **Table 1** outlines the purpose and details of each round.

Development and analysis of surveys

The work group communicated with each other by e-mail, teleconferencing, and face-to-face meetings. For the analysis, collated results were reviewed by the work group after each round. Results were discussed, and consensus was developed on interpretations and on how to proceed with the subsequent rounds. The work group developed and pilot-tested the surveys.

Round 1 started with an open-ended question, "Describe both the significant rewards and the significant challenges you have experienced in practice." A large amount of information was generated and was collapsed into themes using thematic content analysis.[27] Members of the work group reviewed the information independently and then discussed it to develop consensus on 34 themes. Themes were presented to participants in round 2.

Round 2 generated broad descriptions and 53 themes. Saturation was reached because many of the later contributions were repetitive. Based on comments from participants, the titles of 4 themes were changed. The work group divided each theme into a reward and a challenge and selected quotes from participants to capture the breadth of their comments. This information was posted in round 3.

In round 3, each participant selected 10 rewards and 10 challenges. After reviewing the results, the work group decided that a minimum of 11 of the 25 respondents needed to select a given theme for it to be considered a key reward or challenge. Eight key rewards and 6 key challenges were identified in round 3 and were posted in round 4. The work group identified 2 additional challenges.

In round 4, participants rated how well the list represented key rewards and challenges on a scale of 1 to 5 (1—not at all, 5—very well). A mean score of 4.5 was obtained. When asked if "maintaining and acquiring skills and knowledge" could be collapsed into 1 theme with challenging and rewarding aspects, 17 of 25 participants chose to keep it as 2 separate items, a reward and a challenge. "Medical legal, insurance paperwork, and motor vehicle accidents" was also kept separate from "paperwork, telephone calls, and forms" because only 13 of 25 round 4 participants suggested combining them. Participants identified 3 new challenges to be considered key challenges.

In round 4, participants suggested new wording for 2 themes. In round 5, 22 of 24 participants selected the wording "rewards of maintaining and acquiring skills and knowledge" and "challenge of maintaining and acquiring skills and knowledge" when asked which wording should be used. All 24 selected the descriptor "medical legal, insurance paperwork, and motor vehicle accidents." When asked whether the new challenge should be considered a key challenge, 17 of 21 selected yes for "respect from specialists," 14 of 23 selected yes for "the challenge of running a practice—a small business," and 17 of 21 selected yes for "overhead and income inequities."

The study received ethical approval from the Health Research Ethics Board at the University of Alberta.

FINDINGS

We used purposeful sampling to obtain a heterogeneous sample of 28 family physicians: 11 women and 17 men from 7 of the 9 Alberta health regions. Sixteen physicians practised in urban areas, 4 in small towns, and 8 in rural areas. Years in practice ranged from 2 to 34. Physicians practised in a variety of settings, including private offices, community clinics, walk-in clinics, nursing homes, hospital inpatient units, emergency

Table 1. Procedures of the 5-round Delphi survey

DELPHI ROUND	PURPOSE	PROCEDURES
Round 1 posted for 12 days (86% response)	Identify and describe rewards and challenges	Participants were asked to do the following: • Complete a demographic questionnaire • Describe significant rewards and challenges they have experienced in practice • Include reasons for their choices
Round 2 posted for 37 days (96% response)	Clarify rewards and challenges and identify any new rewards or challenges	34 themes from round 1 were posted for review. Participants were asked to do the following: • Rate how well the theme reflected their comments (1—not at all, 4—very well) and comment • Rate themes' importance and effect on family medicine (1—not at all, 5—very important) and provide reasons for ratings • Review themes rated as important for "breadth and completeness" and "clarify" • Reflect on the breadth and completeness of rewards and challenges as described and add any others and rate them
Round 3 posted for 12 days (89% response)	Develop consensus on key rewards and challenges and obtain feedback	53 themes from round 2 were posted for review (divided into rewards and challenges). Participants were asked to do the following: • Select up to 10 key rewards and challenges each • Provide comments and feedback
Round 4 posted for 17 days (89% response)	Validate and clarify key rewards and challenges identified, develop a priority list of rewards and challenges, explore potential solutions including the role organizations could play, determine whether other rewards or challenges should be considered, and obtain feedback	Rewards and challenges chosen were posted along with the results of previous rounds. Participants were asked to do the following: • Rate how well the list represents the key rewards and challenges (1—not at all, 5—very well) • Clarify whether "maintaining and acquiring skills and knowledge" represents 2 separate issues or the same issue • Clarify whether "medicolegal issues, paperwork, and motor vehicle accidents" could be included with "paperwork, telephone calls, and forms" • Comment on proposed list and add any items that should be included • Select the 5 most important rewards and challenges and rank them on a scale of 1 to 5 relative to each other. Repeat this process to identify the least important items • Rate the need to address challenges (1—no need, 5—very strong need). Provide ideas for addressing challenges • Reflect on the key rewards and challenges and provide salient and concrete suggestions on the precise way specific organizations could assist • Provide any other ideas, comments, feedback, or suggestions
Round 5 posted for 27 days (86% response)	Obtain further clarification, determine whether new challenges identified in round 4 should be included, and obtain feedback	Summarized results from round 4 were posted, including 3 new potential challenges with descriptions of what could be done to address each challenge. Participants were asked to do the following: • Clarify the wording of "rewards of maintaining and acquiring skills and knowledge" and "medicolegal issues, insurance paperwork, and motor vehicle accidents" • Comment on and rate the need to address the new challenge (1—no need, 5—very strong need) • Decide whether the new challenge should be a key challenge • Provide ideas on solutions and the role key organizations could play • Answer the questionnaire soliciting feedback

departments, academic family practices, and palliative care and rehabilitation units. Types of practice included inner city; pregnancy, labour, and delivery; well-child; elderly; aboriginal; mental health; substance abuse; palliative care; sports medicine; developing world immigrant; anesthesia; and dependent adult. Methods of payment included fee-for-service, alternative payment plans, salary, and others.

In round 4, participants ranked rewards and challenges in order of importance (**Table 2**). Participants also rated the need to address key challenges on a scale of 1 to 5 (1—no need to 5—very strong need) (**Table 3**). Consensus was developed through rounds 3 to 5 on the key rewards and challenges that affect Alberta family physicians. These are illustrated with quotes aimed to capture the breadth and depth of participants' comments (**Table 4**).

Eight key rewards

Diversity and comprehensive care. This reflects the variety, breadth, and diversity of practice, the complex set of skills, specific technical skills, and so on: "This is the essence of family medicine and encompasses most of the reward."

Preventive care. "Most people still go to their family doc with questions ... we're the best people to do preventive care, at least on an individual basis."

Relationships with patients and their families. "The greatest rewards come from the personal relationships I have with my patients."

Being an immersed witness to the human condition. "I get to vicariously experience the extremes of life: birth, death, catastrophe, and almost every day I am inspired by the strength and ability ordinary people have to rise to the challenge that life has thrown at them."

Continuity of care and ongoing feedback. "Privileged ongoing relationship with patients provides satisfaction through feedback."

Control, flexibility, and security. "I highly value being able to choose my hours and my scope of practice."

Table 2. Overview of ranking (highest to lowest): *In Delphi round 4, 8 rewards and 6 challenges were ranked according to their level of importance relative to each other on a scale of 1 to 5 (1—least important, 5—most important)*

REWARDS AND CHALLENGES	MEAN RANKING (N = 24*)
REWARDS	
Diversity and comprehensive care	4.0 (n = 20)
Preventive care	3.8 (n = 4)
Relationships with patients and their families	3.5 (n = 17)
Being an immersed witness to the human condition	3.3 (n = 8)
Continuity of care and ongoing feedback	2.9 (n = 8)
Control, flexibility, and security	2.7 (n = 11)
Maintaining and acquiring skills and knowledge	2.0 (n = 2)
Teaching, sharing knowledge and experience, and mentoring	1.8 (n = 6)
CHALLENGES	
Medicolegal issues, paperwork, and motor vehicle accidents	4.0 (n = 1)
Workload and time pressure, meeting demands	2.6 (n = 17)
Maintaining and acquiring skills and knowledge	2.2 (n = 5)
Paperwork, telephone calls, and forms	2.2 (n = 6)
Availability of specialists, procedures, tests, and other resources	2.0 (n = 5)
Patients' expectations	1.9 (n = 8)

*24 of the 25 round-4 respondents completed this part of the survey. On the most important rankings, 23 of the 24 ranked 3 and 2 on the most important items; all 24 responded to the rest of the rankings.

Table 3. Ranking of the need to address challenges: *Mean scores as identified in Delphi rounds 4* and 5† (1—no need to address, 5—strong need to address)*

KEY CHALLENGES	MEAN SCORE (RANGE, MEDIAN SCORE)
Workload and time pressures, meeting demands	4.48* (3-5, 5)
Need to promote the rewards identified to those who might consider family practice as a profession	4.44* (3-5, 5)
Overhead and income inequities	4.27† (2-5, 5)
Getting respect from specialists	4.22† (2-5, 5)
Need to ensure that the rewards identified are not adversely affected by primary care reform	4.0* (1-5, 5)
Availability of specialists, procedures, tests, and other resources	3.88* (2-5, 4)
Running a practice—a small business	3.87† (2-5, 4)
Paperwork, telephone calls, and forms	3.72* (2-5, 4)
Maintaining and acquiring skills and knowledge	3.67* (1-5, 4)
Patients' expectations	3.63* (2-5, 3.5)
Medicolegal issues, insurance paperwork, and motor vehicle accidents	3.48* (1-5, 3)

Table 4. Rewards and challenges of family practice: *Number of participants ranking rewards and challenges in Delphi rounds 3* and 5.†*

REWARDS IN ORDER OF RANK AND CHALLENGES IN ORDER OF THE NEED TO ADDRESS THEM	NO. OF PARTICIPANTS RANKING THEM	ILLUSTRATIVE QUOTES
REWARDS		
Diversity and comprehensive care (reflects the variety, breadth, and diversity of practice; a complex set of skills; specific technical skills; etc)	22/25*	Broad range of knowledge; never boring; difficulty and complexity; one physician who can look at all aspects; patient assessed as a whole person
Preventive care	13/25*	Early, when it is relatively easy to educate patients, to effect change, and to focus on wellness; satisfying and fun; our most important role; integral to family medicine
Relationships with patients and their families	22/25*	Advocates, highly privileged position; personal ... intense relationship; experienced birth, severe illness, or death in the family; long-term relationships—generations; emphasized more in recruiting efforts; most significant reason for continuing
Being an immersed witness to the human condition	11/25*	Learn from observing; we grow from interacting; witness to the powerful moments of life; the church has the sacraments, [but] we usually are involved at some stage in the actual physical expression of them
Continuity of care and ongoing feedback	17/25*	Following patients; knowing they benefited; encouragement personally and professionally; enduring feeling ... done some good; I know my patients, ... a good thing for everybody
Control, flexibility, and security	19/25*	Flexibility in this occupation; being able to exert significant control over my client load, work hours, work style, and setting; type of medicine; ability to learn new skills
Maintaining skills and knowledge	13/25*	Stimulation and satisfaction; learn something new each day; modern technology; maintain an advanced skill, eg, endoscopy; constructive feedback from colleagues (family physicians, nurses, consultants); key to becoming an excellent clinician
Teaching, sharing knowledge and experience, and mentoring	13/25*	Bringing someone to valuing appropriately their skill and place ... is of great benefit; there are things we can teach that are not teachable in the classroom
CHALLENGES		
Workload and time pressures, meeting demands	19/25*	Never enough time to do anything well; meeting patient needs and demands; single largest frustration; feeling rushed; affected my family life to its detriment
Need to promote the rewards identified to those who might consider family practice as a profession		
Overhead and income inequities	17/21†	Family practice ... poorly paid relative to other specialties; affects our ability to take the time for paperwork [or] for extra training and with our patients; need to see enough patients to make the office ... cost-effective; cost of providing primary care is largely borne by family physicians, ourselves
Getting respect from specialists	17/21†	[Specialists] do not understand our role; [do not accept] telephone appointments and [offload] work onto our staff, undermining our credibility with our patients; negative comments about our specialty to residents and medical students reflect a lack of respect; in the past [we had] more opportunities to meet and work together
Need to ensure that the rewards are not adversely affected by primary care reform		
Availability of specialists, procedures, tests, and other resources	12/25*	Much time is spent either trying to access resources or patching up the cracks in the system; sometimes dangerous as we try to manage our patients in need; feeling powerless in the face of unacceptable delay; increases the "burnout factor"

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REWARDS IN ORDER OF RANK AND CHALLENGES IN ORDER OF THE NEED TO ADDRESS THEM	NO. OF PARTICIPANTS RANKING THEM	ILLUSTRATIVE QUOTES
CHALLENGES		
Running a practice—a small business	14/23†	Part... is overhead expenses, but running a practice is so much more: staffing, supplies, computer systems management, health information act; running one's practice efficiently (time and cost) and safely is a major challenge
Paperwork, telephone calls, and forms	18/25*	Bureaucracy intrudes on my ability to provide good patient care; hours of work to take home; biggest downsides to family medicine; other reports fall in our laps from specialists
Maintaining and acquiring skills and knowledge	14/25*	Expanding body of knowledge is daunting; frustrating to see colleagues ... not in keeping with the need to remain current; negative incentives and barriers; difficult in a rural practice ... low volumes; ever-changing goals and standards of care
Patients' expectations	12/25*	High patient expectations ... of what we should or can provide for them; a "free" service (as the public sees it) is expected to be available for anything and everything 24/7; limiting patients' "list," as it often takes them 2 weeks to come and see me
Medicolegal issues, insurance paperwork, and motor vehicle accidents	13/25*	Done in non-patient-care time; assist a process that inherently delays recovery of health; wasting good clinical time

Rewards of maintaining and acquiring skills and knowledge. "Development and maintenance of a highly valued skill set. I feel like I contribute to my society in a meaningful way."

Teaching and sharing knowledge, experience, and mentoring. "Keeps me up to date and excited about medicine."

Nine key challenges

Workload and time pressures, meeting demands. "Not enough time to do the kind of job I would like to do."

Overhead and income inequities. "Rising overhead forces us to try to see more patients in less time, compromising the rewards of practice and magnifying the challenges."

Respect from specialists. "The issue is more of a relationship issue than a one-way lack of respect. There is also a lack of respect from family physicians toward specialists." Working conditions and our behaviour might contribute to the problem because, "If we dump our complex patients on them with sketchy referral letters and inadequate preliminary workup we lose their respect." Also,

> The lack of opportunities to meet and work together distances us. Because I do only office practice, I have never met in person many of the consultants I refer to. Often specific questions I have asked in a referral letter go unanswered as the consultant generates his or her reply. Would there be a better rapport if we had different working conditions?

Availability of specialists, procedures, tests, and other resources. "[I have] difficulty accessing appropriate consults or tests in a timely fashion."

Challenge of running a practice—a small business. "We truly subsidize health care in a major way with paying for our own offices and running them very efficiently!"

Paperwork, telephone calls, and forms. "Paperwork! I rarely have a day that I don't have at least 2 hours of work to take home."

Challenge of maintaining and acquiring skills and knowledge. "Keeping up with the ever-expanding body of knowledge is daunting."

Patient expectations. "Patients today, compared to when I started practice, seem to expect almost instant relief of their discomfort without cost, side effects, or inconvenience."

Medicolegal issues, insurance paperwork, and motor vehicle accidents. "Least enjoyed aspects of medicine related to conditions in which lawyers, adjusters, and others manipulate the 'I am injured' patient population to perceive themselves as victims rather than to just move on in life."

Two other key challenges

The work group identified two other key challenges: need to promote the rewards identified to those who might consider family practice as a profession and need to ensure that the rewards identified are not adversely affected by primary care reform.

DISCUSSION

We have described a unique comprehensive consensus on the key rewards and challenges encountered by Alberta family physicians. While some themes identified are new, some provide new insights and a deeper understanding of themes found in previous research. The rewards appear intrinsic to the profession; most of the challenges seem related to external forces.

As reward 1, diversity and comprehensive care was rated as the most important reward and seen as "the essence of family medicine," an important finding that reflects our vital role as generalists. Our broad range of knowledge enables us to treat the whole person rather than treating patients by fragmenting them into diseases or systems. Treating the whole person might contribute to development of relationships.

Four key rewards provide a deeper understanding of the doctor-patient relationship and its importance, reinforcing the principle of family medicine that the doctor-patient relationship is central to the practice of family medicine. These "personal," "intense," and "long-term" relationships with patients and their families (reward 3) establish trust. Through these unique trusting relationships, preventive care (reward 2) can be offered, because we know the whole person and how best to approach that person.

A new finding, being an "immersed witness to the human condition" (reward 4) recognizes the unique nature of doctor-patient relationships. We are "witness to the powerful moments of life," and while the "Church has the sacraments, we usually are involved at some stage in the actual physical expression of them." These descriptions imply a sacred or spiritual component to the relationship. This important finding needs further study.

Finally, continuity of care (reward 5) is the means by which we come to know our patients thoroughly. Surveys done in 3 different health systems also support the importance of continuity of care; researchers concluded that, "Personal continuity of care remains a core value of general practice/family medicine and should be taken [into account] by policy makers… redesigning health care systems."[28]

Participants reported a strong need to address the challenge of respect from specialists. While participants thought the problem was "pervasive," they recognized that "the issue is more of a relationship issue." In the National Physician Survey,[22] 23% of family physicians were very satisfied and 47.9% were somewhat satisfied with their relationships with specialists, while 50.3% were very satisfied and 35.1% were somewhat satisfied with their relationships with patients. Our findings provide a possible explanation for the fact that family physicians are more satisfied with their relationships with patients than they are with their relationships with their specialist colleagues.

Duality of rewards and challenges

The apparent duality of some rewards and challenges highlights the unique and complex aspects of family medicine. Maintaining and acquiring skills and knowledge (reward 7, challenge 7) reflects a dilemma generalists face. While physicians enjoy the intellectual stimulation that results from professional development,[29] our study identifies the challenges they face in keeping skills up to date.

Relationships with patients and their families have been described as positive in surveys,[22] while patients' expectations (challenge 8) can represent a negative[9,13] aspect of practice. Unlike previous work,[9,13,22] this study provides a deeper understanding of conflicting themes. It is the "privileged ongoing" and "personal relationships" with our patients that are the "most significant reason for continuing." Despite this, it is important to recognize that some encounters will invariably present challenges, such as patients with "lists" and patients with high expectations of "what we should or can provide for them." Clearly, once the content and descriptors are considered, these themes do not conflict, but provide a richer understanding of patient-doctor relationships.

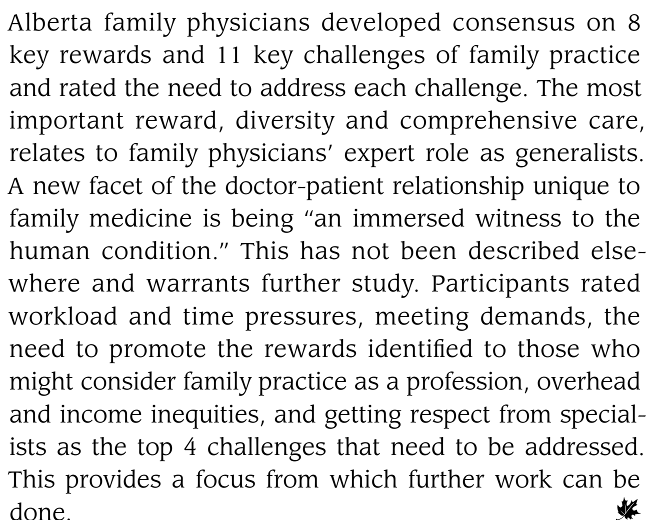
Workloads, time pressure, and meeting demands received the highest rating in terms of "need to address." Physicians described how "quality of patient care tends to be sacrificed" and that there is "not enough time to do the kind of job I would like to do." Canadian and international research has also identified concerns with excessive workload,[5,8,12,13] paperwork, and bureaucracy[11-13] and with time pressures.[5,12] While this study identified paperwork, telephone calls, and forms as a challenge (challenge 6), medicolegal issues, insurance paperwork, and motor vehicle accidents (challenge 9) were identified as a distinct and separate frustration. It was considered to be "the least enjoyed aspect of medicine," and concern was expressed about the negative effect on patients due to the "manipulation of patients" and the "wasting of good clinic time when one could be practising medicine."

Overhead and income inequities (challenge 2) have been reported in previous work[5,11,22,23] and arise from physicians' concern about "our ability to take the time we should with our patients." This challenge and others, like the availability of specialists, procedures, tests, and other resources (challenge 4), derive from the ultimate goal of improving quality of care for patients.

Control, flexibility, and security (reward 6) is a key reward resulting from physicians' perception of the "freedom to set my own hours" and the ability to "exert significant control over my client load." Family physicians in some countries do not have this luxury, and international trials describe frustration with the lack of control.[10,11] The National Physician Survey found flexibility and predictability to be the third most frequently identified reason for choosing a career in medicine.[29] Perhaps international research could compare practices

in Canada and abroad in the hope of improving this aspect of practice for our international colleagues.

Conclusion



Alberta family physicians developed consensus on 8 key rewards and 11 key challenges of family practice and rated the need to address each challenge. The most important reward, diversity and comprehensive care, relates to family physicians' expert role as generalists. A new facet of the doctor-patient relationship unique to family medicine is being "an immersed witness to the human condition." This has not been described elsewhere and warrants further study. Participants rated workload and time pressures, meeting demands, the need to promote the rewards identified to those who might consider family practice as a profession, overhead and income inequities, and getting respect from specialists as the top 4 challenges that need to be addressed. This provides a focus from which further work can be done.

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Contributors

Dr Manca *conceived and designed the study, developed the questionnaires, analyzed and interpreted the data, organized meetings of the investigators, and wrote the article.* **Dr Varnhagen**, **Ms Brett-MacLean**, *and* **Dr Ausford** *assisted with conception and design of the study, development of questionnaires, analysis and interpretation of data, and writing the article.* **Dr Allan** *assisted with conception and design of the study, the literature review, developing the questionnaires, analyzing and interpreting the data, and critically revising the article.* **Ms Szafran** *assisted with design of the study, developing questionnaires, analyzing and interpreting the data, and critically revising the article.* **Dr Rowntree** *and* **Dr Turner** *assisted with recruitment, developing the questionnaires, analyzing and interpreting the data, and writing the article.* **Dr Rumzan** *assisted with developing the questionnaires, developing the web pages, collecting data, e-mailing participants' reminders, and writing the article. All the authors reviewed and approved the manuscript submitted.*

Competing interests

None declared

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