Time, change, and family practice

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The two reports by Woodward and colleagues in this issue (pages 1404 and 1414) raise important questions about the future of family practice. Changing attitudes to life and work are clearly demonstrated in the trends between 1993 and 1999 in the same cohort of family physicians.

The hours worked per week decreased slightly for all physicians, both men and women. Preferred hours of work in 1999 were 37.2 for men and 31.0 for women. Preferences for hours worked and satisfaction with the balance between work and home life were important in predicting hours worked. Those who were satisfied with the balance in both 1993 and 1999 worked 35 hours a week in 1993 and 33 hours in 1999. Those who thought the balance was not good at either time were working 48 hours in 1993 and 47 hours in 1999. Physicians without children and women with physician spouses or with children younger than 6 years worked fewer hours. Women with all children at school worked longer hours.

We do not know what part economics played in physicians' decisions about working hours. Physicians with debts to pay and children to support and educate might not be able to reduce their hours, no matter how much they want to. Lower income needs might explain why women with physician spouses and physicians without children worked fewer hours. The higher debt loads for physicians graduating today and higher tuition fees in the future for their children could increase the gap between hours worked and hours preferred.

Why shorter work weeks?

The trend toward a shorter working week could be interpreted in two ways. We could see it as withdrawing from commitment, wishing to have one's life and work in watertight compartments, or viewing medicine as just another job rather than a vocation. On the other hand, we could see it as taking our role as healers seriously, making time for our own inner lives, and trying to balance an active life with a more contemplative life.

One of the two services that substantially increased between 1993 and 1999 was counseling. Considering the complexity of so many of the health problems seen in family practice—chronic pain, occupational traumas and stresses, the so-called somatic disorders, family dysfunction, and anxiety and depression—this is encouraging, especially if it signifies taking more time with patients and improving counseling skills. Counseling can be shared with nurses, social workers, and other more specialized counselors. But in the assessment and therapy of complex disorders, counseling skills are clinical skills.

It is also notable that most physicians in both surveys offered psychotherapy. We do not know what form this takes, but it does suggest that respondents regard it as important to family practice. There will be some that do not welcome this trend. I urge them to think again. Family practice can show all fields of medicine how to transcend the artificial division between mind and body, which runs through medicine like a fault line. It is the kind of relationship we have with patients that distinguishes us more than anything else, and psychotherapy might be another word for the emotional intelligence we need in our relationships and in our clinical judgments.

There are two ways to reduce working hours. One is to reduce the services offered to patients; the other is to offer the same services to a smaller number of patients. To avoid confusion, we should make a clear distinction between two categories of service. Services such as home visits, hospital and nursing home visits, full or shared obstetric care, and a responsible 24-hour on-call deputizing system, are those we offer to patients in our own practice. Shift work in emergency departments, anesthetic lists, industrial medicine sessions, and work in sports medicine or cancer clinics are services for a very different population. If we happen to see one of our patients during one of these activities, it is coincidental. In an urban area it is unlikely. Services in the second category are important contributions to our communities, and some are

essential in rural areas. But it is an error to use them as universal criteria of comprehensiveness.

Using the first set of criteria, the two surveys do not show a great reduction in comprehensiveness of practice except in obstetric deliveries, which agrees with other surveys.[1] Much will depend on whether this is a continuing trend or if the proportion of family physicians doing deliveries will level off or increase. The number of physicians offering shared prenatal care increased substantially.

Apart from the figures for obstetric practice, the picture of comprehensiveness we get from the surveys is at variance with the widespread impression of a withdrawal from hospital, nursing home, and home care, and an increase in the number of doctors with "office only" practices. I suspect that the cohort is atypical in this respect. When the pressure of demand increases, it is understandable that physicians tend to withdraw into their office practices, especially when comprehensiveness is so poorly recompensed.

My own observation, however, is that withdrawal from comprehensive practice began before the physician shortage. At a time when shorter hospital stays, scarce beds, and portable home technologies were making home care increasingly important, many physicians were unwilling to accept responsibility for their patients when they were sick in their homes. In urban areas, commercial deputizing services were often provided by physicians without hospital affiliations, unable or unwilling to do home visits, and without access to patients' records.

Family physicians' withdrawal from comprehensiveness has been felt, especially by patients requiring end-of-life care in their own homes and by their family caregivers. This is sometimes explained as "not doing palliative care," as if palliative care were a specialty like surgery, rather than an obligation of physicians to care for their dying patients, sometimes in consultation with a colleague who has special skills. What does it mean "not to do palliative care?" When is the physician-patient relationship terminated? When active treatment is discontinued? When things get too complicated and time-consuming? When the patient can no longer come to the office?

We need to agree on what it means to be a family physician, what services are essential to the role, and then to give a proper recompense to those who are providing them. Woodward and colleagues report that 11% of the cohort "… had chosen to restrict their practice within family medicine to such areas as sports medicine, emergency medicine, geriatrics, counseling, and psychotherapy." It is important that we do not describe these doctors as family physicians. By restricting their practices, these 31 members of the cohort had ceased to do family practice. Many family physicians do develop special interests as well as continuing in family practice, for example, in children with disabilities, in eating disorders, in endoscopy, in wound management, or in acupuncture. In doing so, they enrich their experience and can be consultants for their colleagues as well as generalists for their own patients.

A perspective on change

Physicians have always had to adapt to change. Those in highly specialized fields are vulnerable to fluctuating demands for their services due to technologic advances and to rising or falling morbidity rates. In the early 1950s, a whole service, with its own specialists, clinics, surgical units, and hospitals had to be dismantled when antituberculosis drugs accelerated the declining incidence of tuberculosis. Physicians in general fields are vulnerable to increasing specialization and technologic advances.

I am old enough to remember the disappearance of major surgery from all practices except isolated ones. When the National Health Service was introduced in Britain, general practitioner surgeons had to become either surgeons or general practitioners. With few exceptions, they could not be both. A few years later the same change took place in Canada. There was a good deal of sadness over this, and morale was low for several years. But it forced us to think about what was essential to being a family doctor and what was not.

Eventually, general practice was reborn with a clearer self-concept and an articulated body of knowledge. We are now at a similar time of rapid change and need to look again at what is the essence of family practice. In a time of fragmentation, there is a need to define—for ourselves, our colleagues, and our patients—what commitments can be expected of family doctors.

It is paradoxical that fragmentation is occurring at a time when individualized care by a doctor who knows the patient has never been more necessary. The health status of each patient is "a unique outcome of the interaction between genes, development, and environment, with roots in the past and potent implications for possible futures."[2] Every patient has his or her own disease.

Whatever the outcome, I doubt whether it is possible to be a professional and to work strictly by the clock. Even when there are defined shifts,

there will always be exigencies that require us to make moral choices between conflicting obligations. When work is a labour of love, we do not leave it behind when the day is done. I doubt also whether it is desirable to separate personal life and work in such watertight compartments. Medicine, especially family medicine, teaches us about life, and life teaches us about medicine. As Wendell Berry wrote: "If we do not live where we work, and when we work, we are wasting our lives, and our work too."[3] If a profession ceases to be a labour of love, we should be concerned.

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