Family physicians—looking in the mirror

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I am worried about the state of family medicine. Over the past several years, concerns have been increasing about family medicine[1,2] as we practise now and in the future.[3] I have met with many family physicians in Saskatchewan over the past 18 months. Feedback is consistent in identifying issues, such as workload, on-call duty, income, group practice, desire to practise good-quality family medicine, health promotion and disease prevention strategies, and providing care to patients with chronic diseases. Doctors echo concerns about information technology and electronic medical records.

The challenges

In Saskatchewan, 62% of family physicians now practising are from outside North America.[4] We have been able to recruit good family physicians, but the challenge now facing the province is that overseas physicians are no longer as available. We have been able to retain 70% of family medicine residents after graduation (22 residents yearly), but this number will not meet the needs of the province.

The average workload for a Saskatchewan family physician is 80 hours weekly with an average of 142 patients weekly. Both statistics are the highest in western Canada.[5] Saskatchewan family physicians have acknowledged that 74% of their practices are closed to new patients; 56% report their patients have issues with accessibility.[5] We are also aware that 50% of family physicians are 50 years or older.

The 2003 Canadian Residency Matching Service revealed that only 24% of graduates made family medicine their first choice.[6] In Saskatchewan, 45% of positions were not filled in round 1. In the United States, only 42% of family medicine positions were filled by American students. This is the lowest percentage in decades.[7]

Articles by Rosser[3] and Sullivan[6] identified key reasons why interest in family medicine has declined. Reasons include the perceived glamour of specialty medicine; misunderstanding of family medicine; and ongoing concerns about workloads, undefined roles, information overload, and low pay voiced by family physicians.

What do our patients think?

Three articles in this issue of *Canadian Family Physician* look at the care provided by family physicians. Boon and colleagues (page 1481) compared patient visits to family physicians and naturopathic practitioners. Patients seeing naturopathic physicians were more likely there for advice about health maintenance, had longer visits, and were new patients. Patients visiting family physicians stayed approximately 15 minutes, and interactions were very much symptom specific. Why did patients see naturopathic physicians for counseling? Is it because naturopathic physicians have more time or expertise or because family physicians do not have the time?

Frank et al (page 1490) looked at older patients' perceptions of their medical care before admission to geriatric rehabilitation programs. Access to family physicians was clearly important to these patients. They reported difficulty in getting appointments and difficulty covering all their concerns during visits. Patients reaffirmed that doctor-patient relationships are crucial to medical care.

Mathews and Barnsley (page 1498) conducted a survey on the behaviour of patients with acute illnesses. Why do they not see their regular physicians? Access to family physicians was an issue in this study, especially for patients seeking care outside regular office hours.

In all three articles, patients identified the doctor-patient relationship as crucial. Access to their family physicians is also an important issue for patients. The Commission on the Future of Health Care in Canada dedicated a section to primary health care. In its report, the commission states it found relevant themes during the public consultation process. These included improvement in health promotion and prevention, a strong and accessible primary health care service, and the public's desire to have long-lasting

and trusting relationships with health care professionals.[8]

What can we do?

I am on a 3-year secondment to primary health services in the Department of Health in Saskatchewan to move primary health care forward. I see this as one way family physicians can change the way they practise and overcome some of their frustrations. An Action Plan for Primary Health Care was developed in Saskatchewan in 2002.[9] Similar plans have been developed in most provinces. Saskatchewan's plan identifies a framework for primary health care. A key recommendation is the development of primary care teams. Family physicians and nurse practitioners would be core team members with other health professionals, such as mental health workers, public health nurses, therapists, and pharmacists, depending on community needs and human resources.

There is increasing evidence for the role of nurse practitioners in working with family physicians in primary care.[10] These teams would help relieve some of family physicians' workload and on-call hours and allow both physicians and nurses to look at other activities, such as enhanced chronic disease management and health promotion.

Evidence shows that teams can provide primary care successfully.[11] We see teams initially focusing on patient care, health promotion, and chronic disease management. The team approach will allow family physicians to do what they do best: diagnosis and follow up. Longer-term plans include working with intersectoral partners on community issues.

One of the concerns raised by family physicians contemplating working in teams is the effect teams might have on physician-patient relationships. Answers to this question are not all in, but evaluations done to date suggest teams do not affect them negatively. In fact, I believe the focus on chronic disease management, health promotion, and prevention will enhance relationships for patients and family physicians alike.

Other key initiatives in the plan include setting up a 24-hour telephone advice line; having a provincial information technology strategy with a focus on primary health care; integrating and coordinating services, community participation, and development; and redefining access and core service standards. The plan highlights alternative methods of payment for family physicians.

Saskatchewan has had experience with a number of demonstration sites (21 to date). Family physicians involved in such sites are on alternative funding arrangements by contract, not salary. Interim evaluations have been done on four of the sites and are positive in terms of team effectiveness and patient satisfaction. Aspects of continuity of care have been evaluated and are also positive.

I am worried about family medicine, but I believe there are approaches that can mitigate the concerns of family physicians and students. Primary health care provides an opportunity for family physicians to move forward in such areas as health promotion and prevention and improve access and continuity of care for patients.

We need family physician leaders, medical associations, and the College of Family Physicians of Canada to work with provincial primary health care branches to further define the role of family physicians in primary health care, address the concerns of family physicians, and create new options for our students who wish to practise family medicine.

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