

International exchange

Understanding issues in primary care: perspectives of primary care physicians

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ABSTRACT

Objective To explore and describe the perceptions of family physicians in a large urban centre regarding issues in primary care and to identify those issues that would impact provision of care in a primary care setting.

Design Cross-sectional survey using interviews.

Setting Urban centre in western Canada.

Participants Eighty-two family physicians located in the central core of a large urban centre.

Method Semi-structured interviews and thematic analysis were used to collect and analyse the data.

Main findings Physicians identified a number of interrelated issues in community family practice including high overheads, time, lifestyle and family commitments, staffing issues, lack of communication

among providers and between providers and the health region, and technology. These issues impacted their quality of work life, causing a sense of being overwhelmed, frustrated, isolated, powerless and disillusioned. The participants recommended changes that would benefit their practices, family medicine, and primary care reform.

Conclusion Family practice is at a crossroads and new models of team-based care and alternative funding strategies are the preferred methods of implementing primary care reform.

Keywords: family medicine, interprofessional and multidisciplinary health care provider teams, primary care, primary care reform

How this fits in with quality in primary care

What do we know?

We know that family physicians are changing their practices and medical students are choosing not to go into family medicine.

What does this paper add?

This paper reports on results of a study conducted to explore issues in family medicine.

Introduction

Background

Primary care reform is a major focus in health care.^{1–3} The health region in a large urban centre in western Canada chose to focus on a system of working in partnership with primary care providers to reform the primary care system.⁴ A blueprint was developed which included a primary healthcare focus, development of a healthcare system that supports effective linkages between institutionalised care and community-based care, a sustainable team of primary care providers, and formal partnerships between the health region and those providers.⁵

The family physician role in a primary healthcare team is as consultant, collaborator and leader.^{6,7} Quality of care and access to care have been identified as critical issues for physicians, other healthcare providers, and the public. Increasing workloads, work overload, and dissatisfaction have also been identified as major concerns for healthcare workers.^{8,9} The health region is seeking input and feedback from citizens and stakeholders, including health professionals.¹⁰ This communication helps to ensure an effective, respectful process and an understanding of primary care issues and solutions.¹¹

Research questions and objectives

The purpose of the research was twofold: to collect baseline data that would inform primary care renewal within the health region, and to establish collegial and collaborative relationships with family physicians. Physicians were asked to describe the current state of their practice, any near future changes being considered, and suggestions or recommendations for changes in the provision of primary care overall, and specifically in their geographic location.

Methods

All 167 physicians in family practice, urgent care centres and walk-in clinics in the central core were contacted; 89 responded for an overall response rate of 53.3%. A semi-structured interview guide was used with demographic information recorded. Interviews ranged from 10 min to 2 h. The majority of the interviews were conducted face-to-face, with a small number conducted over the phone. Physicians were offered an individual interview; however, in seven cases physicians working together in the same office preferred to be interviewed as a group. Interviews were audiotaped, or detailed notes were taken. Verbal or written consent was obtained at the time of the interviews.

Analysis

Audiotapes and interview notes were transcribed. All transcriptions were analysed using QSR N6 software with broad themes identified. Relationships among themes were analysed. Upon completion of the interviews, the final analysis included refining definitions, examining the interrelationships among issues, and systematically comparing and combining similar themes.

Results

The findings reported in this article ($n = 82$) exclude the seven participants from the 24-h urgent care centre located in the urban core because the work setting differs significantly from the usual family practice setting. Over 55% of physicians interviewed worked more than 50 h per week, with a further 27% practising for 40–50 h per week. Participants worked in a mix

of solo (24) and group (58) practices. Physicians were asked about the number of patients in their practice, but most were unable to provide that number because that information is not documented. Some of the participants did provide estimates that ranged widely, with the highest number of estimates being between 2001 and 3000 patients in their practice. Participants were also asked about working in shared care arrangements with other healthcare professionals such as home care nurses, chronic disease management staff, and mental health clinicians. Thirty-seven percent of the 73 physicians who responded to this question were involved in some type of shared care.

Changes in family practice

Twenty physicians were considering decreasing their number of hours.

‘I’d just like a little time for myself ... Work is consuming most of my time and I’d just like a better balance.’

Eleven were considering alternative forms of practice. Reasons included a more structured and regular schedule, or a practice that was more lucrative than family practice.

‘I have to commit to either the office or the Hospitalist Program ... I won’t be able to manage both ... A lot depends on the economics of it all.’

Eighteen respondents were considering retiring or closing their practice.

‘Leaving ... I feel like I’m on a treadmill. Huge expectations of people coming in, “Do this, do that” ... And if you spend the time you get no money for that. So I have done this 17 years and I’m ready to do something different.’

Issues in family practice

Interrelated issues identified by many of the participants were expenses, time, lifestyle and family commitments, staffing, and lack of communication.

Expenses were a major concern for the respondents. Office rent in the central core is extremely high. Office expenses must be paid when the practice is closed for vacation, maternity leave or continuing medical education.

‘A lot of family physicians ... [are] struggling with overhead and staffing. We can’t compete ... We’re already paying overhead out of our means.’

Respondents also cited lack of time as a result of patient loads, complex patients and paperwork.

‘The more complicated patients are getting more difficult to manage.’

Lifestyle and family commitments were sometimes compromised by the time required for family practice.

‘... a huge chunk of my family time. And I get paid for it but I would rather just be with my family and not be doing the forms and stuff ... It does take away from my personal time ... I’m usually busy until 10:00 or 10:30 most nights on the computer.’

Staff resources were another challenge for the physicians. They had difficulty hiring and retaining skilled staff due to more competitive salaries available elsewhere. Registered nurses or nurse practitioners, who could triage if working to scope, required remuneration higher than the physicians were able to offer.

‘You can’t afford to maintain the staff that you really should have to run a good family practice ... and then your job doesn’t get any easier, it gets harder.’

Most locums, if available, requested 65–70% of billings.

‘I had a locum but only partially. She was only able to cover me for two days a week.’

The lack of family doctors and the trend of fewer residents choosing family medicine as their focus of practice were mentioned by several of the respondents.

‘I understand though that a lot of the new graduates don’t want primary care so that is a big concern.’

Vacation or sick leave coverage for themselves and staff was also an issue.

Lack of communication amongst physicians and between family physicians and the health region was identified as a major difficulty. Physicians require patient information after referral in order to provide comprehensive care. However,

‘... can’t say as I feel like there’s a lot of two-way information.’

The relationship between family physicians and the health region was strained due to a lack of communication.

‘I think they need to appreciate the time and effort that it’s going to take to rebuild the camaraderie and the connectivity of the doctors in the region. I think they [health region] have dropped the ball.’

Quality of work life

These issues impacted the respondents’ quality of work life, and resulted in feelings of being overwhelmed, frustrated, isolated, powerless, and disillusioned.

Many of the respondents were overwhelmed by the workload.

‘You step on the treadmill at the beginning of the day and step off at the end of the day.’

This was one source of frustration, access to specialists was another. In fact, 89% of physicians interviewed had difficulties accessing specialists for their patients. Several respondents experienced difficulty with the specialist referral process.

‘The access to specialists is another big issue ... It certainly impacts on my life and the hassles I have to go through for it.’

Several of the participants were isolated but lacked the time and opportunity to meet with colleagues.

‘The really big problem that I see right now is that we’re all so isolated. And the very first need I would see is for a degree of collegiality.’

A sense of powerlessness and marginalisation was expressed by many of the participants.

‘A family doc was on the same level as a specialist ... There’s no question now that we’re at the bottom of the totem pole in every aspect of medicine.’

Disillusionment was not uncommon among the participants.

‘It’s not what I thought it was going to be.’

Despite these feelings, many expressed a sense of satisfaction.

‘I really like family medicine. I love that I have a great group of people in my practice ... And I think that we can make little bits of difference in people and big differences in a few people[’s] lives.’

Participants’ recommendations

The most common recommendation was to increase teamwork with multidisciplinary staff. Physicians were interested in working together with nurses and other allied healthcare professionals to create a team approach to patient care.

‘We need to help each other ... there’s a lack of interprofessionalism ... we used to work together, we used to talk.’

Another respondent suggested,

‘Definitely train nurses to do a bunch of the stuff that is really not, doesn’t require a physician to do it.’

Twelve respondents suggested a group practice, sharing office space and staff.

‘An office being provided where there is a group of doctors working, taking care of their practices and at the same sort of geographical area there are resources available.’

Some of the physicians also suggested alternative payment plans to better support family practitioners and encourage them to stay in their practice.

‘From an income point of view I think there has to be a different way to bill that is not just based on numbers.’

A number of recommendations involved continuing medical education which can encourage collegiality and informal working groups. Several of the physicians suggested increased financial and staffing support to assist them.

‘I think we should have more support for continuing medical education ... courses are really expensive. We don’t get reimbursed for taking time off.’

Many of the physicians would also like assistance with practice management issues.

‘Being taught practice management skills to try and reduce your overhead. Like reduce that income and expense ratio.’

Associated with the practice management issues were technology, computerisation and electronic medical records. Many of the participants discussed the need for online access to medical records, lab reports, X-rays, discharge summaries, emergency reports, and other relevant information.

‘We’ve had this computer system since ’96 so I really can see tons of advantages to have a fully computerised office and I would like to move that direction, but I will not until I can access at least my X-ray reports and my lab reports online.’

Many of the respondents had computerised their offices based on the health region’s decision to implement electronic lab results.

‘For us, one of the things that would make life faster for me is electronic lab results. There has been a big push with the POSP [Physician Office System Program] and everything to get office systems computerised. And yet we can’t access.’

Discussion

Interviews were conducted with a large group of community family physicians to collect baseline information on primary care practice. These interviews also provided the physicians with an opportunity to propose recommendations for primary care reform. Their responses were not surprising in light of the published literature.

The physicians interviewed identified key issues including expenses, time, workload, lifestyle and family commitments, staffing, and lack of communication among providers and between providers and the health region.

Numbers of patients seen, complex patients with numerous problems, and amounts of non-clinical

work all contribute to increasing workloads and time spent in their practice. In fact, over 80% of the study physicians practiced 40 h or more each week. They had problems hiring and retaining qualified staff. Coverage for vacation, sick leave and locum was problematic. Overhead costs continue to rise. These issues are nationwide.¹² Some of these respondents, corroborated by other research, prefer alternative payment options and continuing medical education (CME) support.^{7,13}

Another concern was the predicted future shortage of family physicians. Medical students cite lifestyle as a factor for not choosing family medicine, and many prefer a more balanced life, working 30–40 h per week.^{14,15} In a recent study only 20% of students chose family medicine as their first career choice.¹⁴ Nationally, in the last 10 years, there has been a 19% reduction of medical students choosing family medicine residency as their first choice.¹⁶

Communication among providers and between physicians and the health region was of particular interest. Electronic access to medical records should facilitate patient care. Despite their interest, physicians were concerned about the time, expense and resources required to initiate this access. This was also the case in other jurisdictions.¹³ This concern is warranted, given the small gains in efficiency evidenced in the connectivity pilot.¹⁷

These issues impacted their quality of work life, resulting in a sense of being overwhelmed, isolated, frustrated, and disillusioned. Changes considered for the near future related to quality of life included decreasing hours worked, practising alternative forms of work, or closing the practice. These are also reflected in the literature.^{8,9,13,18}

Since just under one-third of the participants in the study belonged to solo practices and were isolated from one another, group practice, which allows for shared responsibilities, workloads and resources, is being considered by some of the respondents and has been identified in other studies as being potentially beneficial.^{7,13} While in some areas working together is a natural phenomena (e.g. after hours call, urgent care), physicians also voiced concerns about losing their independence. In order for a group of physicians to effectively work together, a number of principles and resources may need to exist: the ability to maintain independent practice; consensus decision making; a business manager; and other appropriate resources to support the group.

New models of care such as interprofessional multidisciplinary teams was the most frequently recommended change, which coincides with the findings of other studies.^{7,18,19} These non-traditional models have the potential to begin to address many of the respondents' issues concerning their practice (e.g. workload, time, lifestyle) and to facilitate care for

patients. Working in shared care with other healthcare professionals improved co-ordination of care, decreased gaps in follow-up, provided better access to expertise, information and specialists, and increased job satisfaction for team members. Additional time required to work as a team, and space for other team members are concerns for physicians in their day-to-day practice. Interprofessional team models also provide solutions to health regions faced with rising healthcare costs but reduced patient and provider satisfaction.

Conclusion

Community family practice appears to be at a crossroads where desire for change is apparent and the necessity of change is critical for family physicians and citizens to maintain the delivery of high-quality care in the community. Change should be built on the strength of a strong patient–physician relationship developed over time, and sustaining and improving access to first-contact care by teams. Building on and promoting the values of primary care can enhance the quality of work life for the physicians and communicate positive expectations to the public. The goal of family physicians is to deliver high-quality care in the most efficient manner. Focusing on and enhancing high-quality, efficient, accessible care teams, while attending to physicians' personal lifestyle needs, will be relevant to physicians and patients alike by increasing access to first-contact team-based care. Communications to the public with respect to these goals of primary care renewal will be important messages for programme planners and policy makers to deliver. Primary care will look different in the future if the recommendations of these physicians become a reality.

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CONFLICTS OF INTEREST

None.

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