

Physician Heal Thyself

An Inquiry into Physician Satisfaction and the Structure of Family Practice in BC

A project of the Institute for Health System Transformation and Sustainability

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About IHSTS

The Institute for Health System Transformation and Sustainability (IHSTS) gathers, develops and shares evidence about British Columbia's health care system to inform decisions that impact health care quality, cost and sustainability.

IHSTS is a not-for-profit organization collaborating with many partners in health care delivery, including health authorities, clinical and community leaders, policy makers and government. We bring together research expertise with local experience to understand complex issues in health and health care from a BC perspective.

IHSTS projects adhere to rigorous methodologies and a standard project process. Our goal is to create credible, robust evidence that illuminates practical solutions for making BC's health system better and more sustainable.

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Executive Summary

The Challenge

Increasing evidence shows that the currently dominant models of sole/small group family physician practices, remunerated through fee-for-service, may no longer be the best way to serve physicians or their patients in British Columbia.

Family physicians in BC report dissatisfaction with their work life and their overall quality of life, some saying that they are overworked and suffering from serious stress. Young physicians express needs and wants different from more senior practitioners. Further, many British Columbians are not attached to a family practice and depend on walk-in clinics and hospital emergency rooms to take care of their needs.

Ample literature demonstrates that interdisciplinary family practice with integrated care teams is a good model for physicians and other health care providers – and especially for patients – but very few practices in BC use this model.

After hearing the concerns of several physicians, IHSTS launched a project to help BC's health system better understand:

- The professional and personal needs and interests of family physicians;
- How to meet those needs; and
- How to do this while at the same time providing high quality primary care for BC residents.

Methodology

IHSTS engaged Mark L. Winston, FRSC, Professor and Senior Fellow at Simon Fraser University's Centre for Dialogue, to lead the project, entitled: Physician Health Thyself; An Inquiry into Physician Satisfaction and the Structure of Family Practice in BC.

Data gathering involved a series of small-group dialogues or individual interviews with 30 family physicians working in different practice formats and at different stages of their careers to probe the following themes:

- The nature of their practice
- Areas of satisfaction and concern
- Remuneration
- Suggestions for how to structure the future of family medicine in BC

Findings

Nature of practice

- Physicians reported working in individual and group practices, integrated care teams, walk-in clinics, locum placements and hospitalist positions. Most participants worked on fee-for-service.

- Almost all preferred teams in which their patients received continuity of care, although a few preferred walk-in models or hospitalist postings because they could earn higher incomes, arrange hours of work, be relieved of administrative responsibilities and leave the job behind when they went home.

Areas of satisfaction and concern

- Physicians told us that they chose to go into family practice for two primary reasons: they wanted to build strong interpersonal relationships with their patients, colleagues and community, and experience the wide variety of patient health issues found in a generalist practice. Most reported having achieved these goals.
- The most consistent and vexing concerns we heard about the business of being a family doctor revolved around the administrative burden. Excessive forms and complex billings under fee-for-service were widely decried, reflecting that the level of paperwork required in their practices seriously detracted from the quality of patient care they were able to provide. Financial issues also were a major source of stress, particularly meeting high overhead costs for those with sole or group practices, and paying off student loans for younger physicians. In both cases financial issues lead to diminished quality of patient care; physicians feel forced to put in long hours at work and see too many patients in too-short visits. The lack of support services for patients and doctors was also seen as a problematic issue in family practice. At a minimum the participants felt that nurses, nurse practitioners, mental health workers and administrators were critical missing elements in their current practices.
- The physicians we spoke with generally were critical of walk-in clinics. The lack of health records, pressure to see too many patients, loss of physician-patient continuity of care and an overly simplified approach to patients who often have complex problems were noted as being damaging to the quality of patient care. Walk-ins can be profitable for the physician and clinic owner, but do not provide good primary care for patients.

Remuneration

- Participants preferred remuneration through blended models rather than fee-for-service. They suggested experimenting with salary based models where compensation could be adjusted depending on complexity of care, number of patients, their age and gender, call/weekend/evening hours, and other factors. Benefits such as vacation pay, medical coverage and pensions would be highly desirable, as well as reduced medical school tuition. The younger physicians we spoke with indicated they would be willing to trade reduced salaries for these added benefits, particularly if their work/life balance was positively affected and if reduced financial pressures enabled them to be employed in practices that provided continuity of care.
- Fee-for-service was seen as the most lucrative compensation model, but overhead costs and student loan debt drives family practitioners to cycle high numbers of patients through short office visits that focus on single health issues rather than overall patient

health, diminishing the quality of patient care. Another major disadvantage of fee-for-service was seen as the paperwork required, with complex billing codes and paperwork occupying their late evenings and weekends.

- Mid-career and senior family physicians consistently expressed concerns about attracting younger physicians into traditional practice models. Young doctors are caught between the need to earn high incomes to pay down debt and wanting a healthier work/life balance than previous generations. The result of these pressures is for young doctors to gravitate towards walk-in clinics and locum work, although they also expressed a sense of loss in not developing the long-term relationships with patients that were the primary reason they entered family practice in the first place.

Suggestions for how to structure the future of family medicine in BC

When asked to imagine their ideal practice, participants described working in a group practice or an integrated health care team, with specific characteristics that included:

- A roster of about 1,500 patients per physician, but adjusted downward for practices with high numbers of complex care patients
- Compensation through a blended model that included salary, benefits, and pensions, that could be adjusted based on workload, with ceilings on the maximum allowable workload and compensation
- A norm of 15 – 20 minute slots for office visits
- Each patient has their own doctor and an alternate
- A funded position for an administrator to manage the business end of practices and the paperwork
- Integrated team care was a popular model, to include family doctors with appropriate blends of specialists, nurses and nurse practitioners, mental health clinicians, other allied health professionals, house calls where appropriate and capacity to perform common laboratory tests. However, they expressed frustration that the rhetoric around integrated teams has not been realized, and won't be until tangible issues including credentialing, patient privacy, liability, practice structure, clinic design and especially funding are addressed.
- Disease prevention and health education should be key components in all practices, as well as the capacity to address non-medical issues that impact health, but family physicians are not provided the resources or training to include these elements in their practice.

Summary

Overall, family doctors today are practising in increasingly outmoded models, leading to decreasing job satisfaction and diminished quality of patient care.

The ideas presented during our study suggest future directions for family practice in BC that could be realized through creating a blended compensation system and new organizational structures that allow for integrated care with allied professionals and improved work satisfaction for physicians.

A series of financial and work place incentives for physicians, coupled with policies that would steer family practice towards integrated teams and group practices delivering continuity of patient care, would be desirable and healthier for doctors and patients alike.

Physicians were confident that desirable changes could be accomplished within the boundaries of current health care funding, through an overhaul of compensation models, deeply reduced administrative burdens on doctors, shifting of some physician roles to less costly allied health professionals, efficiencies from concentrating health care in comprehensive clinics, and improvements in patient health that could diminish overall health care spending.

Introduction

Effective primary care is an essential component of our health care system. There are many ways family practice can be structured and physicians compensated, but there is increasing evidence that the currently dominant model of sole/small group family physician practices remunerated through fee-for-service may no longer be the best way to serve physicians or their patients.

Ample literature demonstrates that interdisciplinary family practice with integrated care teams is a good model for physicians and other health care providers, and especially for patients, but very few practices in BC use this model. As well, many British Columbians are not attached to a family practice and depend on walk-in clinics and hospital emergency rooms to take care of their needs.

These observations and surveys of predominantly younger family physicians (see, for example [*Practice and payment preferences of newly practising family physicians in British Columbia*](#) in Canadian Family Physician) suggest that the usual model of primary care is not meeting the needs of doctors or patients. Family physicians in BC report dissatisfaction with their work environments and overall quality of life, characterized by overwork and stress. Further, young physicians express needs and wants different from more senior practitioners.

This project was initiated by the Institute for Health System Transformation and Sustainability to bring physician voices to this conversation. Its focus is on how we might understand the professional and personal needs and interests of family physicians, meet those needs, and at the same time provide high quality primary care for residents of BC.

Our Approach

Our intention through these conversations and this report was to stimulate a reflective conversation about the future of primary practice in British Columbia. This project was not intended to be definitive, but rather to lever dialogue and encourage thoughtful discussion about how family physicians practice medicine and how general practice might evolve in ways consistent with high-quality patient care.

We held small-group dialogues and individual interviews with 30 family physicians from different practice formats and at different stages of their careers. Each group or individual was asked to reflect on their choices of practice environments, their perceptions of effectiveness in providing quality care for their patients and how patient care might be improved. We also probed their life satisfaction with career choices.

Participant profiles covered a wide range of ages and practice experience, but all were active practising family physicians who were not in political or leadership roles with organizations representing physicians or in government. Roughly half were female, and the participants ranged from current residents, those in newly established practices, experienced senior physicians and a few who are semi-retired. Geographically their current practices cover the Lower Mainland, Vancouver Island and the Sunshine Coast, although many had experience from

other countries, elsewhere in Canada and in various regions of British Columbia. The most significant gap in our study was the lack of family physicians currently practising in the interior of BC, as we were not successful at arranging interviews or group dialogues in that sector.

Eight of the physicians were interviewed one-on-one, either in person or by phone, and the others participated in three-hour dialogue sessions of six to eight physicians each. Three dialogues were conducted:

- Vancouver: A group of physicians from the Lower Mainland and the Sunshine Coast were recruited through IHSTS's network of physicians who suggested names to invite and shared the invitation widely via email.
- Vancouver: A group of Vancouver physicians was recruited through short presentations to the departments of family practice at Providence Health and Vancouver General Hospital.
- Nanaimo: This session was organized in partnership with the Nanaimo Division of Family Practice, and included family doctors from Nanaimo and nearby towns.

Our dialogues and interviews were conducted by [Chatham House Rule](#), under which participants are free to use the information received, but the identity of any participants can't be revealed.

The project was guided by the following categories/questions:

Reasons for becoming a family physician

- Why did you become a family physician?
- Has your career been satisfying for the reasons you became a family physician?

Practice: past, current and potential

- Describe your past experience and the structure of your practice.
- Are you satisfied with your current practice?
- Imagine you're starting from scratch. Of all the family practice models you are aware of, what would work best for you? Why?
- What is the most significant challenge impeding the way you would like to practice medicine?
- What would you do to attract more young doctors into family practice in which they have long-term patient relationships? (This question was added after our first group dialogue, because senior physicians expressed concern about the lack of interest among residents in entering practices characterized by continuity of patient care).
- Integrated Teams: Do you currently distribute some of your workload to other non-physician health care professionals (see the BC Ministry of Health's policy discussion paper [Primary and Community Care in BC: A Strategic Policy Framework](#))?
- If not, what are the barriers?
- Would you welcome a team model? If so, how might that be organized/structured, and who would take team leadership?

Organizations

- Are there administrative concerns that detract from your ability to practice medicine, and if so how might they be improved?
- Does the current structure of government oversight, Doctors of BC and Divisions of Family Practice contribute positively, are they neutral or do they impede the way you practice medicine? What would you change?

Compensation

- How are you compensated?
- How do you think about financial remuneration:
 - What criteria do you use to decide how much is reasonable?
 - What are your comparator groups?
 - What are reasonable trade-offs: time/responsibility vs. income, for example?
- Are there improvements in how you are compensated that would result in a more satisfying practice and work/life balance?
- What compensation mode would you prefer?

Moving Forward

- Considering everything we've discussed today, propose one first step that would improve family physician satisfaction while maintaining or improving quality of patient care.

Results

Reasons for becoming a family physician

The most significant reasons cited for choosing family practice were the opportunity to build strong interpersonal relationships with patients, colleagues and community, and a desire to experience the variety of health issues faced in a general practice compared to a specialty.

Family doctors value both long-term patient relationships and community interactions. A few quotes illustrate their passion for continuity of patient care:

"I value being in a rural community, now delivering babies of women I delivered twenty years ago."

"There was a lot of loyalty, you had a patient they stayed with you."

"It's a nice cuddly feeling, they trust me."

Long-term relationships were a major source of satisfaction, both those developed with patients and those with colleagues. A number of the senior physicians we met with mentioned how much they valued the stories their patients have shared, and the generation overlap when they have treated three and sometimes four generations of patients' families. Stories and narratives, the whole person, were important; one family doctor was inspired as a medical student by a GP

who was able to listen to a patient talk about underlying marriage issues while being treated for a cold.

They also expressed satisfaction from their role in belonging to local communities, and making those communities healthier: *“That sense of when you go to a store, you see all your patients . . . you see what their whole life is like, not just ten minutes in the office. You know everybody.”* There was considerable satisfaction articulated from seeing the difference they can make in a community, particularly for those in rural practice.

Another common reason our interviewees chose family practice was the opportunity for variety by being a generalist rather than specialist, due to the breadth of knowledge and issues covered through family practice. Treating the whole person, not just symptoms, combining mental and physical aspects of health and taking care of people rather than focusing on a problem were common themes. In their words:

(I enjoy) “figuring out what people have instead of knowing what they are coming in for.”

“Every day is different, and I love that. I wouldn’t like to have a 9-5 or just look at eyeballs all day.”

“I didn’t want to get pigeon-holed into a really narrow area.”

“You get to know people as more than diseases.”

They also noted that they used a broad range of their expertise within general practice, especially obstetrics, psychiatry, geriatrics and pediatrics, providing the opportunity to address a range of health care issues. And every day brings great variety through their doors.

Expediency of moving forward with their careers and their personal histories/situations also were important factors in choosing general practice. Family medicine has a shorter residency time, and provides a good income faster than a specialty. A number of the physicians mentioned being exposed to an influential friend or family member who was a GP, and becoming interested in that way. The father of one doctor we spoke with was a plastic surgeon, who inspired her towards medicine but not that specialty. Another physician was sick as a child, in and out of hospitals, and medicine attracted him as a profession due to that exposure. Some were seeking a job with good revenue, while for others the income was not a factor.

Lifestyle and family considerations were important motivators. Flexibility, stable hours, work-life balance, and working for themselves were mentioned by some as reasons they entered family practice, although these physicians had also structured their practices specifically to achieve those outcomes.

Another theme was curiosity – a fascination with science and a broad interest in finding out more about the world. We heard often that there’s always something new to learn about in general practice, and you never know what you’ll need to pursue for your patients.

A few of our interviewees expressed a strong interest in social justice, and their primary reason for choosing family practice was a passion to create social change through medicine. For one physician, medicine was a career in which she could be a professional and advocate for social justice through her work. Another wanted to help marginalized individuals, and family practice seemed the best way for him to do that.

Finally, some doctors were drawn to family medicine through a passion for preventative health care. One was interested in *“what makes populations healthy,”* while another noted *“You see a lot of failures and I wanted to practice medicine from the other side of the coin and try to prevent those people from falling through the cracks.”*

Have these various motivations been fulfilled? Almost all expressed satisfaction with how their motivations have been implemented in practice. Some of the residents we spoke with were not quite there yet, primarily because they have not been able to build long-term relationships with patients during their residency training. One had been disillusioned during residency, but is now integrating Ph.D. studies with her family practice residency, which is improving her satisfaction with family medicine. Another more senior physician said that to some extent she has lost her love of doctoring, in part because she now works at a university clinic and doesn't have the same cradle to grave range she did when part of a group practice.

Some of the family physicians we spoke with have specialized within their family practice, but feel they still see a broad range of patient issues in their practice and maintain the long-term relationships they value. Two focus exclusively on frail elderly care, one specializes in general practice on patients with disabilities but also sees non-disabled patients, while a third works half-time in his general practice and half-time in palliative care.

Practice: past, current and ideal

Past and current practice

The physicians we spoke with have experienced a number of practice structures, with some currently practicing in more than one format. Almost all of the physicians except for residents had participated in a group practice at some point in their careers, usually comprising three to eight family doctors in total. They expressed many positive elements from the group practice model. Relationships with colleagues were the biggest positive factor; in an emotionally tough job, supportive colleagues were vital to their job satisfaction. One described a shared lounge area where members of her practice would meet informally and bounce ideas off each other. Also, a collaborative environment allows the flexibility of colleagues covering for vacations, conference attendance and personal or family illness, and helps avoid burnout.

Physicians also appreciated the option of rotating call and hospital visitations, as well as having someone familiar to see their patients when the primary physician was away. Sharing costs was seen as another advantage to group practice, as well as the opportunity to hire communal support staff.

However, group practice models also present some challenges. Some described considerable stress with colleagues when the individuals associating together were not compatible, and difficulties in getting the other doctors in their practice to cover absences because they are already overworked. Locums can be difficult to arrange as well, and one woman mentioned considerable pressure from her practice partners to not take maternity leave.

The business side can be challenging, with financial and personnel disagreements creating strained working environments. There are high costs associated with group practices, and generally each physician must see five to six patients per hour to support the practice; one dialogue group agreed that they work more than 60% of their week just to meet overhead. We heard frequently that funding should be provided by government specifically for administrative costs outside of the fees provided for seeing patients; the extent of paperwork and form filling was universally decried during our interviews and focus groups.

Financial pressures and high administrative loads favor short visits with patients, with ten minutes per patient being the standard, and long days with high patient loads and considerable time spent dealing with administrative rather than patient issues. Workdays of seeing patients, followed by evenings/weekends doing paperwork or call/hospital visits, were typical for the group practices described by the doctors.

Senior physicians complained that finding young doctors to join their practice has become increasingly difficult, because young physicians don't want to work the extended workdays that were acceptable to previous generations of general practitioners. It's also become difficult to find locums, who have been gravitating to walk-in clinics or hourly positions, where their income is better and workload lighter, with more predictable hours. Group practices would be improved considerably if physicians could employ a nurse or nurse practitioner, but most can't afford that option under the fee-for-service models under which general practitioners are compensated.

Integrated team models/community health centres were other practice environments experienced by our respondents. These included clinics focused on marginalized populations, some general-practice integrated teams, and practices focused on specific health issues such as pain management and frail elder care. Various mixes of family physicians, specialists, nurses, nurse practitioners, mental health workers, social workers, physiotherapists, nutritionists and others worked collaboratively in these clinics. One physician we interviewed who specializes in disabled patients has two group practice offices that work closely with physiotherapists, chiropractors, pharmacists and ophthalmologists in their buildings, but they are not organized into an integrated team and don't bill collectively.

This report discusses integrated care teams in more detail [below](#), but generally their physicians work on a mix of salary and fee-for-service payments, and benefit from separate financial support for clinic overhead and to employ allied health professionals. These integrated team models were highly favored by those working in them, and we heard few concerns from our interviewees about practicing in integrated teams.

A number of the family physicians we talked with have worked in walk-in clinics. They and most of the other doctors we interviewed had few positive comments about their experiences beyond the opportunity for increased income. Most felt that walk-in clinics provide quick money without the responsibility. A few with active continuity-of-care practices mentioned that walk-ins are a welcome relief from seeing chronic problems, and they welcomed the opportunity to hone their diagnostic skills on unfamiliar patients whom they don't have to see again. Also, they found their walk-in colleagues cooperative in taking turns covering evening and weekend shifts.

The most-mentioned negative aspect of walk-in clinics was that the lack of long-term patient care is detrimental to patients, termed "*shopping mall medicine*" by one doctor. Walk-in models lose the continuity of care that is critical to quality health care delivery. Doctors in walk-ins have no medical records to work with and slim background health information for clinic patients. There is pressure to see too many patients. Mistakes get made in haste. One physician in a group practice mentioned that he sees many patients who received inappropriate care at walk-ins because staff are under great pressure to maximize patient visits.

Patients themselves fractionate care, switching doctors and clinics often. Many physicians mentioned that walk-in doctors do the easy stuff and make more money than family doctors, often billing for complex care even though they are not providing continuity of care. Finally, most family physicians prefer the independence of having their own practices, and although they may have chosen to work in a walk-in they still decry their lack of autonomy.

Some participants had worked in university clinics. They see some patients who require continuing care, but largely service a walk-in population. Their patients are mostly students who are transitory, although they do see some faculty and staff for whom they provide primary and ongoing care. Some university clinics work as integrated teams, with associated psychologists, nutritionists, physiotherapists and/or nurses. One physician worked exclusively in a university clinic, but most physicians who work in that environment also have outside private practices.

University clinics provided strong satisfaction to the family doctors working there. They cited a regular salary, defined paid holidays, pensions and benefits such as extended medical care as some of the financial advantages. The physicians we interviewed were consistent in describing excellent collegial interactions. One concern we heard expressed was missing the continuity of care they had experienced in group practice situations, but most satisfied that interest through their private practice. The episodic nature of visits was also a concern, concentrated towards the end of semesters when students were most stressed. Finally, lack of sufficient mental health support for clinic patients was an issue, but that is a common problem for most types of family practice.

Some family doctors had been solo practitioners. Of those we talked with, all had taken over from an older physician and inherited their long-term patient relationships. These practices tended to be composed of mostly elderly patients. One doctor who had practiced alone for close to two decades enjoyed the autonomy of running his own practice, but also missed the support found in a group practice. All mentioned the difficulty in getting time off, requiring a

locum for relief, and the doctors we talked with who currently were in solo practice were hoping to merge into a group.

Some of the physicians we interviewed were currently working as locums, but many had had brief locum periods following their residencies or when close to retirement during which they travelled and experienced family medicine in different contexts. These locum periods were useful in providing further exposure to diverse models of family practice, helping young doctors to decide where to work and with what population if and when they established their own practice. However, the current locums we spoke with also missed developing long-term relationships with their patients.

After working in a well-established group practice, one woman had returned to locums for family reasons. Her “Aha!” moment came while on vacation overseas with her husband, when she realized she was catching up on charts throughout her holiday rather than vacationing. She had a child shortly after, and resigned from her general practice in favor of part-time locum work so she could control her hours and workload and eliminate onerous administrative work, as well as the burden of overhead and the stress of running a business.

Family physicians may also work as Hospitalists, and were positive about that arrangement. They enjoyed the adrenaline rush of hospital medicine, and integration with diverse colleagues from medical and allied health professions. One hospitalist noted “*We work together as a team towards the patient improving.*” Another found palliative care particularly rewarding. Hospitalists enjoy a regular and predictable salary and the lack of administrative work, but also mentioned missing the long-term patient relationships they experienced when in general practice.

Two physicians we spoke with have an unusual house call practice specializing in frail elderly care, which receives an envelope of funding support in addition to their own remuneration. The practice is collaborative, with nurses and other health care providers, and has six to seven family physicians. Due to their funding model, they don’t have to limit patient visits to the ten minutes typical of general practice, and where appropriate it is the allied health professionals instead of the doctors who visit patients. The program apparently is popular among patients, and cost-effective by reducing hospital stays. There is a three-month waiting list to get into their practice.

Significant challenges in practice

There were a number of challenges mentioned frequently in our conversations with physicians that transcended any specific mode of practice. One challenge that family doctors in private practice find particularly vexing is the amount of administrative work, the many forms and paperwork that take away from doctoring. One noted “*A lot more of my effort is going into administration than patient care; just let me take care of them without struggling to take care with how to get paid.*” Yet, they receive almost no training in the business end of practice, and many didn’t feel they had the skills needed to run their business, and certainly not the time. Most complained that the fee-for-service compendium is particularly complex, and some mentioned high turnover rates of medical office assistants as an issue.

Financial pressures also were noted by most as a serious challenge in private practice. High overheads encourage doctors to overbook too many patients into too-short appointments. They need to fill up their days to the point that appointments frequently back up, and patients often experience one- to three-week waits before they can even be fitted into an office visit. Some doctors only take new patients with easy care, non-complex profiles, and many mentioned needing more time with patients than the short visits encouraged by fee-for-service payments. Another consequence of financial pressure is that physicians don't take enough time away from what is already a very stressful job.

Another significant issue cited by doctors was the lack of support services from allied health professionals, particularly mental health. Their patients experience great difficulty in accessing mental health services, so they return repeatedly to their family doctors who are not adequately trained and do not have the time needed to accommodate their needs. Family physicians see first-hand the lack of community-based resources and services, and spoke about lack of action to provide adequate mental health resources. Their patients with mental health issues often end up in emergency rather than a community-based service more appropriate to their needs.

Similarly, the physicians we spoke with are experiencing a growing elderly population. These patients need more complex care, which requires a support system of allied health professionals, in-home services and housing at various levels of care in addition to medical assistance. We heard that our BC care system is far in arrears in provisioning quality elder care, a serious challenge in their practice as family physicians.

We also heard concerns about poor electronic access to patient records. The physicians we spoke with find themselves challenged by lack of information about their patients past histories, laboratory tests, specialist visits, etc.

Finally, some of the physicians, and especially the younger ones, felt challenged by a health care system they perceive as too "medical" and not focused enough on social determinants of health.

Ideal practice

We asked the physicians we spoke with to describe their ideal practice, and the results were remarkably consistent. Almost all preferred either an integrated care team or a large group practice, ideally about eight to ten doctors supported by nurses and/or nurse practitioners and a receptionist, with administrative assistants for a group practice and a wide array of allied health professionals for integrated teams (see section on Integrated Care Teams [below](#)).

Our physician respondents were willing to staff their practices evenings and weekends, so long as the workload was shared equitably and the number of hours outside the 9-5 workweek were not excessive. Most were enthusiastic about flexible hours, realizing that extended hours are important today for the quality of long-term patient care.

They suggested that the ideal general practice would have 1,500 patients, although focused practices might have fewer depending on complexity of care, age, gender, and special needs

such as disability, addiction, poverty, pain, diabetes and other factors. Compensation would be salary-based, include holiday pay, extended medical and pension contributions, and scaled to accommodate physicians who might choose reduced workloads (for more detail on remuneration, see Compensation section [below](#)). Practices would schedule weekly team meetings to organize care and share expertise.

The ideal practice would provide sufficient durations for office visits so that family doctors would not feel rushed with patients, and could build trust, listen to patients and hear their stories. Currently, most of the participants schedule 10-minute office visits, which they do not consider sufficient for quality interactions between patients and their doctors. Ideally, office visits would be scheduled with four patients per hour, or perhaps three per hour in practices with a high proportion of complex patients, some of whom would only need a short 10-minute visit and others who might require 20 to 30 minutes, depending on the complexity of health issues.

Patients would have their own family doctor but be attached to a group practice or clinic, so that physicians could manage population care for their particular patient profile. Each patient would have a designated alternate if their primary doctor was away, and physicians and other health professionals would have electronic access to each patient's complete medical records.

The participants in our study recognized that one size does not fit all, and proposed that each clinic be given latitude to develop its own culture and logistics depending on the unique profile of its patients. Some family doctors within each clinic might develop specialized skills within the larger clinic setting, such as geriatrics, palliative care or marginalized patients, while others might prefer a broad range of patient profiles.

A critical component of the ideal practice would include nurses, nurse practitioners and/or physician assistants to take phone calls, conduct intake appointments, follow up physician visits, and provide pre- and post-care treatments where appropriate. Nurse practitioners would be the most useful in assisting with chronic disease patients. Mental health support workers would also be a key component of the ideal practice.

Ideally, the role of family doctors might expand slightly to manage a wider range of care, setting a somewhat higher bar for specialist referrals, and returning patients to the family physician's care at an earlier stage following specialists' treatments. Also, the physicians we spoke with suggested that specialists should come regularly to their offices rather than patients going on someone's wait list, so that patients' health care could be geographically concentrated, take place at an office with which patients were familiar, and create more of a care team culture between the family physician and the specialist.

Regarding administration, the ideal practice would receive funding for a manager to administer the business. Minimizing after-visit work was a high priority for our respondents, keeping physician's time focused on health issues rather than paperwork.

The ideal practice also would implement patient education programs and the inclusion of non-medicinal support groups for particular health issues, creating a small-town level of relationships even in bigger cities.

Finally, family doctors asked for a cap on the number of walk-in clinics in British Columbia, to direct family doctors towards meeting the needs of patients through long-term practices rather than walk-in clinics. This was an interesting observation, indicating that physicians today are thinking about mechanisms to improve continuity of care and are willing to accept government initiatives that encourage and incentivize family physicians in that direction.

Attracting more GPs into practice in which they have long-term patient relationships

We found it interesting that all physicians – from residents to early career family doctors through more senior physicians – indicated similar preferences for their ideal practice, although the younger cohorts expressed somewhat higher interest in integrated teams while the older physicians tended to prefer group practices weighted more heavily towards doctors and nurses.

However, there was one inconsistency in what we were hearing that led us to probe how to attract young family doctors into long-term practices.

Some young family doctors felt compelled to earn as much money as possible quickly, in order to pay off their student loans. At the same time, we heard that they didn't want to work with the intensity, long hours, short appointments and family-destructive career culture that too often characterized their predecessors. The solution for those motivated by debt relief seemed to be working in walk-in clinics and as locums or hospitalists, maximizing income and minimizing responsibility, although they also bemoaned the poor patient care that resulted from that strategy.

What we heard from mid-level to senior physicians was that we have enough family doctors in British Columbia but we are not deploying them effectively. Too many general practitioners are doing walk-ins instead of full service family practice, and there is no structure or mentoring culture to steer residents towards continuing care practices. Further, young doctors aren't as keen as their predecessors to run an office, hire staff and deal with leases, preferring situations where someone else runs the business.

Everyone we spoke with mentioned the poor quality of care that results from high volume and short visit medicine. One useful solution would be to address student debt that pushes young family doctors towards walk-in clinics, locums or hospitalist appointments, which increases their income but sacrifices quality patient care. Some respondents suggested tuition for medical school be reduced or even eliminated in return for a commitment to practice for a certain number of years in a continuity of care situation. Younger physicians expressed a willingness to receive lower salaries if they could begin practising with less or no debt.

Another way to attract residents into long-term practice situations is to provide a more attractive health care culture in which they could work. Young doctors seem willing to work hard but not in the model of overly long days and weekends that characterized family practice in the

previous generation. Senior physicians can sound nostalgic about the old days but they also recognize the high frequency of divorce, estrangement from family, alcohol and drug abuse and stress-related health issues that accompanied an earlier generation's medical practice.

Any ideas to attract younger family doctors into continuity-of-care practices need to accommodate a more positive work/life balance. Young physicians today are looking for flexibility in hours so they can engage in family life, and a career that recognizes gender equity both at work and home.

Our respondents suggested incentives for family physicians to provide continuity of care, which might include higher salaries in those practices compared to walk-in/locum arrangements, or perhaps only allowing older family doctors nearing the end of their careers to work in walk-ins. Financial stability in group practices and integrated teams would be another powerful incentive, providing guaranteed incomes through salary as well as paid benefits. Income security came up often as a reasonable tradeoff for income level.

Establishing a work environment that reduces the business tasks in their practices and allows them to focus more on delivering health care also would attract newly-graduated family physicians. Perhaps it would be useful to provide seed funding to work in integrated teams, and a more formal mentoring system and physician support groups early in practice would help maintain newly-graduated residents in long-term practice.

The cultures of medical school and residency were perceived as devaluing family practice. The teaching and cultural elements of medical school and residency might be addressed to improve the perceived value of generalists in medicine.

Integrated Care Teams

Many of the physicians we spoke with had experience with integrated care teams that included family physicians and allied health professionals either in rural practices, inner city clinics for marginalized populations, specialized geriatric home care, diabetes clinics, rehabilitation teams or one of the few experiments with a general practice structured as an integrated team. Their experiences were almost invariably positive in terms of working environment and patient care. Although our respondents were quite favourably disposed towards integrated models, they also pointed out that the funding, structural and logistic components of these teams have lagged behind enthusiasm for the concept.

We heard strongly the need for integrated patient-centred care teams that could deal effectively with patients with complex profiles, but integrated models would also benefit patients who are generally healthy. Our participants encouraged multiple formats, with teams designed to focus on marginalized, geriatric, diabetes, rural, rehabilitation, chronic pain or general populations, among others. They stressed that diversity of models was important, allowing teams enough independence in structure and hiring to best serve each team's constituency.

The most favourable element of integrated teams was seen as high quality patient care. Medicine isn't about health narrowly defined; social determinants are often involved, and physicians are not always best placed to deal with these other factors. Still, generalist family physicians are key to integrated health care teams as they are well suited to deliver whole-person health care.

Our respondents saw considerable advantages to working in the same office as allied health professionals, both for patients as well as for the benefits of broad collegial interactions in providing a supportive consultative and social environment. One physician told us "*The more aspects of a person you can reach within your walls the better.*" The most significant collaborative need beyond nursing was seen as mental health clinicians, but other commonly-mentioned allied professionals and services included physiotherapists, nutritionists, social workers, home geriatric care, pharmacists, optometrists and an in-clinic laboratory for frequently-performed tests.

Preventative care was mentioned often as an important element of integrated teams, although it may take decades to see the impact. Education around exercise, alcohol and substance abuse, and smoking would be particularly useful, as well as more specialized groups focused on specific health issues such as diabetes. Useful incentives for patients to improve their own health might be developed: "prescribing" recreation centre passes and nutritionally-focused cooking and meal programs were a couple of examples.

Integrated team practice also was seen as providing an excellent window into public health. Physicians see what's ailing or troubling individual patients and accumulate a view of systemic public health concerns. Thus, teams could serve as an early warning system as new concerns emerge.

We discussed team leadership and functioning with our respondents, who generally agreed that physicians are not always the best suited to lead integrated care teams. They have little training/experience in leadership or group dynamics, while other health care professionals may be better equipped with skill sets to lead/facilitate. Also, physicians have a large burden of primary care, so having someone else organizing care delivery might be better for patient quality of care and physician satisfaction.

Most of our family doctors were not concerned with who would be in charge, and were comfortable with the team gatekeeper being a nurse or nurse practitioner. Nurses may be the best first contact, as in emergency rooms, and could order some laboratory tests before patients see their doctor. A good administrative manager was seen as essential, preferably with some clinical expertise, and collaborative meetings should be regular aspects of team dynamics.

The enthusiasm for integrated teams among our participant physicians was palpable, but tempered by practical concerns about credentialing, licensing, privacy, liability, practice structure, clinic design and especially funding.

Funding models need to change dramatically so that costs are fully covered, but the physicians we spoke with believed that integrated teams would reduce health care costs substantially and

let family doctors focus on medical issues. Allied professionals would focus on aspects of health care that don't require a physician and are better delivered by a non-physician.

Our respondents believed that funding should provide for the full services of integrated teams, with the capacity to refer patients within the group and allocate resources as patient needs evolved. Teams could implement revenue-generating services now provided at specialized sites, such as basic laboratory work, ultrasounds, x-rays, stress tests and others. Physician compensation could be structured in many ways, but they suggested that a hybrid combination of salary, capitation/rostering and complexity of care adjustments would be best. Physicians would like to see a better connect between longer patient visits and compensation, which recognizes the time needed for complex patients through a differential fee structure.

One physician described the substantive nature of financial change required well: *"Blow up walls between government-supplied budgets."* Integrated teams would require adjustments in how allied health professionals are paid so that patients could receive coverage. Even so, integrated teams won't solve the current low level of government funding for allied fields such as physiotherapy, psychological counselling or pharmaceuticals, unless increased funding in those envelopes emerges along with team structures.

The family physicians we spoke with noted that integrated teams require significant structural changes beyond funding, including ownership, mandates, governance, evaluation, licensing and liability. For these concerns they provided questions rather than solutions: Will integrated teams be operated as businesses similar to group practices, and if so how will ownership be divided? Will team mandates be decided by individuals who decide to associate, or handed down by government through licensing? How will the performance of teams, and team members, be evaluated? Who will take responsibility for errors, where will liability be housed, and how will malpractice insurance work?

These were seen as solvable issues, and on balance there was considerable enthusiasm for experimenting with integrated teams. They were optimistic that integrating family physicians with allied health professionals would enhance patient health outcomes as well as physician satisfaction.

Organizations

We asked our participants to comment specifically on administrative and organization-based concerns that detract from their ability to practice medicine. We were particularly interested in whether the Ministry of Health, Doctors of BC and Divisions of Family Practice contribute positively, are neutral or impede the way they practice medicine. While this was a minor component of our interviews and focus groups, their comments did provide some useful insights into how family physicians interact with these three organizations.

They had relatively few comments about the Ministry of Health. One said the Ministry *"was not on my radar,"* while another mentioned that he *"had no contact, but they do pay the bills."* These were typical of the physician's lack of direct engagement with the Ministry.

One doctor suggested that government was too conservative in implementing health care reform. Another was concerned that she didn't have control over the funds that were necessary for her integrated team to function. In contrast, two of the physicians we talked with pointed to the Ministry of Health as being helpful in setting up their frail elderly home care practice and supporting a workable funding model with team funding, yielding better patient care.

As described previously, the most consistent and vocal comments about the role of government in family practice was a deep concern about the administrative burdens placed on family doctors. Too many forms and complex billings characteristic of fee-for-service were universally decried, and all indicated that the level of paperwork required in their practices seriously detracted from the quality of patient care they were able to provide.

The Doctors of BC (formerly BCMA) was seen as helpful in providing some specific services, but problematic in representing the interests of family physicians. On the plus side, our respondents appreciated discounts on insurance, RSP packages and assistance in small business functions. Some found the Doctors of BC useful in advocating for complex care funding increases.

Overall, their perception of the Doctors of BC was neutral or negative. Some felt the organization has yet to address the disparity in pay between groups of physicians, creating envy and dividing the medical profession and yielding hostility that interferes with patient care. Others felt it was too specialist-driven, and slanted towards fee-for-service, rewarding traditional physicians rather than new models of practice that interest younger doctors. Doctors of BC was seen as supporting older doctors who have different attitudes than the young, and who prefer free enterprise business models and practice structures not considered desirable or even viable by younger physicians.

Our respondents saw the Divisions of Family Practice (DFP) in a positive light. They particularly appreciated the collaborative opportunities to connect with colleagues arranged by the Divisions. Many referred to interesting programs, constructive experiences focused on community care and provision of medical education that was not pharmaceutical-based. One said it was *"like joining a family,"* while another pointed out that the DFP *"has brought life into our community."* A few noted that, while it was still too early to tell about the DFP's political utility, they felt the collective voice of family doctors was being heard more and more by government, and that the DFP was becoming a better advocate for their interests than the Doctors of BC.

A few disagreed. One felt that the DFP duplicates what Doctors of BC and the College of Physicians and Surgeons do, and another believed it shouldn't have a political function.

Another was neutral, pointing out that he doesn't interact much with his Division because he has a young family and wants to be home in the evenings, when most of their events occur.

Compensation

The family physicians we talked with had experienced a wide range of remuneration, having worked under a number of systems during their careers. We discussed advantages and

disadvantages of various models, but a salary-based blended system was preferred. Fee-for-service was considered lucrative but not widely supported due to reduced quality of patient care and excessive paperwork under that system.

A blended system that mixed salary, capitation/rostering, gradations of pay based on complexity of care and addition of vacation pay, medical coverage and pension compensation would provide the income, security and flexibility most desired. The physicians suggested there was no reason to mandate only one type of blended option, but rather provide a range of options for different types of practice.

Flexibility in workload and pay was suggested, but with an important caveat. Incentives would be justified for those who work harder, which should be built into any remuneration system, including a blended salary approach. Providing a base salary that could rise or fall depending on workload, responsibilities and performance would be desirable. Young physicians trying to pay off loans should have options to work extra if they desire, while those who wish to work less for family or other reasons should be able to scale their workload and salaries down.

But a significant factor in assigning workloads is the diminished quality of care that results from overscheduling appointments. A cap on the maximum number of daily and weekly patients would be an important component of any blended model, to avoid the overscheduling characteristic of fee-for-service. All agreed that compensation should reflect complexity of care, and the complexity and diversity of each family practice should be evaluated and compensation designed accordingly. Seeing a smaller number of complex patients, each for longer office visits, should be financially equivalent to more patients who each only requires a short appointment.

Pensions and other benefits should be factored into a more complete compensation package. Physicians seemed willing to trade off immediate salary compensation for longer-term financial security. Income might be lower, but quality of patient care, flexibility in workload and economic security make up for that, and physicians could always do extra things if they desired additional income, up to a defined maximum. A blended model seemed particularly attractive for those interested in integrated teams, as teams would function more effectively under a blended, salary-based system.

Many agreed that different practitioners should receive variable salaries based on their amount of training, responsibility, liability (i.e., surgeons are in a higher-risk branch of medicine), stress and inconvenience (night calls, weekend work, emergencies, lack of predictable hours). There also was support for bonuses based on extra skills and training.

The principle advantage of fee-for-service was also seen as its principle disadvantage. For those who desire higher incomes, fee-for-service is the most lucrative system if doctors see many patients for short visits. Doctors are compensated for how hard they work, get paid for what they do and get to choose their workload.

However, that also can be its main disadvantage: cycling many patients through the office in short visits during which they present only a single health issue, and packing in many appointments per day, result in reduced quality of patient care. Yet, high overheads as well as

debt for younger physicians trap physicians into overworking and providing lower-quality patient care.

Another major disadvantage of fee-for-service was seen as the excessive paperwork required. Billing codes were perceived as unduly complicated, and many reported paperwork spilling over into late evenings and weekends, time for which they aren't compensated and which they prefer to spend with their families, or at least directly doctoring. Some mentioned tension with practice partners if they billed too little, a further incentive to keep office visits short.

We found most of the comments from physicians to be reflective and thoughtful, but their concern about paperwork and administrative burdens was when their thoughtfulness became more pointed. Clearly this is one of, if not the most, vexing issue we heard during our project.

Fee-for-service also was reported as being frustrating for patients who don't understand how payments are done and why they are being rushed through an office visit. Also, that system doesn't allow time for patient education or for consultations on multiple health issues, and in those ways is costly in the long-term.

Other concerns about fee-for-service were similar to those expressed when we discussed blended models. Remuneration often is not well matched with the intensity and complexity of patient care, and lack of benefits such as vacation payments, medical coverage and pensions were concerning.

Some discussion about inequities among specialists, allied health professionals and family doctors arose during our conversations. Midwives, for example, were reported as earning three times more than family physicians for the same level of care, and some family doctors resent the considerably higher compensation provided to some specialties. Generally our respondents felt they were sufficiently compensated, but resentments arose when they compared their remuneration with that of specialists.

One suggestion was to place a maximum cap on compensation, which could be different for categories of physicians depending on training, responsibility and stress, but with the salary spread between physicians being narrower than the current scale. With a cap we could afford more physicians, each working a reasonable amount, rather than the shortages we have today with many family doctors and specialists overworked. A few suggested that all doctors should be paid less and work more reasonable hours. If so, we would have more doctors, and more satisfied ones, as well as improved patient care.

We also heard considerable support to reduce medical school tuition, balanced by paying entry-level physicians less. Younger doctors were willing to trade lower pay for less debt. Would family physicians in general settle for lower salaries? Perhaps, if the tradeoff was the opportunity to be part of a team, providing higher quality patient care for their patients, lower administrative burdens, better benefits and improved work-life balance.

Many young doctors are choosing to lower their administrative work and improve work-life balance by working in walk-clinics and as locums, but in doing so they sacrifice the quality of patient care they had hoped to achieve in family practice.

Moving Forward

Our final exercise during the interviews and group discussions was to ask the participants to propose one first step that would improve family physician satisfaction while maintaining or improving quality of patient care. The answers we heard generally had been covered during the earlier part of our interview/group sessions, but are listed below to provide a snapshot of what this group of family doctors suggest moving forward with first.

Integrated team based care was frequently mentioned, based on team rather than individual funding. Prevention should be a key component, and also addressing non-medical issues that impact health. Support funding should be provided for clinic and management expenses, and diverse teams allowed to evolve; a model for the Downtown Eastside's marginalized populations would not necessarily be the same as that for a pain or diabetes specialty, or for a diverse general practice. Family doctors, specialists, allied health professionals, home care, laboratory tests and mental health clinicians would all be available through the same integrated team.

Remuneration structured through blended models was another common theme. Doctors suggested testing diverse models based on salaried income that could go up or down depending on complexity of care, number of patients, age and gender, call/weekend/evening hours and other factors.

Taken together, those two ideas could be summarized as creating a blended compensation system and new organizational structures that allow for integrated care with allied professionals and improved work/life balance. Overall, such a system would be healthier for doctors and patients alike.

Another frequent first step mentioned was to hand off paperwork to a funded position. It doesn't make sense to pay doctors high fees to do paperwork. Physicians can sign off on forms when necessary, or if they must fill a form they could charge per question. As one doctor put it, he wanted to *"get paid for being a doctor."*

A number of our participants chose creating a province-wide system of electronic medical records. They didn't talk at length about this option, considering it an obvious step, but the lack of such a system was clearly problematic, and implementation seen as sorely needed.

A few suggested attracting more doctors to family practice: *"If trainees could see the beautiful depth and wonder of family practice it would encourage them to keep doing it."*

One suggestion was training medical students more extensively into a culture of continuity of care and long-term relationships with patients by connecting with mentors during medical school, residency and for five years post-residency. Passion for the patient as a whole person needs to be revived. Creating more opportunities for focused general practice, such as

geriatrics, obstetrics, palliative care and others, might be a good way to mix the benefits of being generalists with those of specialists.

Patient education was brought up by a few of the participants. One mentioned the [Choosing Wisely Canada](#) movement that encourages patients to take responsibility to shift towards appropriate care.

Educating patients about what's not covered by MSP, such as sick notes and annual checkups, also came up.

Younger physician participants suggested addressing social justice issues. One indicated that the best thing we could do to improve health care would be to have a guaranteed minimum income.

A few other ideas included:

- Eliminate Health Authorities
- Reduce Pharmacare denial of coverage for certain medications
- Provide higher compensation for physicians with continuity-of-care practices, reduce compensation for walk-ins

Conclusions

Our conversations with family physicians were content-rich and contemplative. The focal group participants were enthusiastic about the opportunity to dialogue together and reflect about how they practice medicine. Those interviewed one-on-one expressed appreciation for the opportunity to talk more deeply about issues often overlooked in the day-do-day tumult of medical practice.

Perhaps a side benefit of the Physician Heal Thyself project was to recognize the appetite for thoughtful discourse among physicians, and the benefits of using structured dialogue to generate ideas about how health care might evolve in the future. This approach might be useful to stimulate more extensive in-depth conversations, and hopefully could extend to the rural physicians we were not able to encompass in the current project.

It was clear from the participants that British Columbia's system of family practice is fraying at the edges, and even the centre is beginning to erode. The current mainstream model of family practice, driven by fee-for-service, short patient office visits, increasing reliance on walk-in clinics, high administrative burdens on doctors and a culture of physician overwork is not sustainable. This traditional form of family practice may have served us well in the past, but we need to evolve new models to meet current and future needs of doctors and patients.

What might the future of family practice look like? A strong picture emerged from our respondents, of integrated health care teams or large group practices that are funded and supported through new organizational and funding models. The goal would be to increase the proportion of patients served by long-term physician care while improving working conditions and job satisfaction for doctors.

The ideal practice would maintain a roster of about 1,500 patients per physician, but be adjusted downward for practices with high numbers of complex care patients. Physicians would maintain an average norm of 15 - 20 minute slots for office visits, with each patient having their own doctor and an alternate. A position would be funded for an administrator to manage the business end of practices and the paperwork, freeing physicians to practice medicine rather than fill out paperwork.

Electronic medical records accessible to health professionals across BC should replace the current piecemeal system, with appropriate privacy restrictions. A nurse or nurse practitioner would be associated with each group, and integrated teams would add other allied health professionals appropriate for their clientele. Social determinants of health would be recognized as significant components of health, and addressed more energetically by expanding the range of what is conceptually included in health care.

Compensation would change from fee-for-service to a blended model of salary, benefits, and pensions that could be adjusted based on workload. System-wide salary discrepancies would be addressed and family doctor and specialist compensation capped, at levels that vary appropriately to reflect level of training, responsibility and complexity of patient care. Overall earnings might be lower than today, which would be an acceptable tradeoff if balanced with benefits, pensions and reduced medical school tuition.

Another suggestion for significant structural change in the practice of family medicine emerged from our discussions, which was a recommendation to reduce the frequency and prominence of walk-in clinics. They serve today as a safety valve for those patients who don't have their own family doctors, but were seen as delivering inferior medicine. For physicians, they may be desirable to generate higher incomes with reduced responsibilities and greater flexibility, but the reduced quality of patient care is problematic. The ideas that emerged from the Physician Heal Thyself project, if implemented, would reduce the need for walk-in clinics for patients by improving working conditions for family doctors in continuity of care practices.

How might we move to overcome the increasing disadvantages of current family practice models towards new paradigms that better serve both doctors and patients? A combination of incentives for physicians, government leadership through funding and encouragement of organizational change and shifts in medical education and culture over a ten-year period would be feasible devices for change.

While all of our respondents would like to see increased health care budgets, desirable changes could be accomplished within the boundaries of current funding, through an overhaul of compensation models, deeply reduced administrative burdens on doctors, shifting of some physician roles to less costly allied health professionals, efficiencies from concentrating health care in comprehensive clinics and improvements in patient health that would diminish overall health care spending.

Perhaps the clearest message we heard beneath the specific concerns and ideas our respondent physicians expressed was this: The idea of practising medicine like we used to is simply a non-starter, especially since younger physicians have little interest in that path.

Change is more than overdue, and it's time for bold decisions to move family medicine in a progressive direction that will improve physician satisfaction with their work while improving quality of care for patients.