

Physician Heal Thyself:

An Inquiry into Physician Satisfaction and the Structure of Family Practice in B.C.

Project Lead

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**A project of the Institute for Health System
Transformation & Sustainability
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About IHSTS

The Institute for Health System Transformation & Sustainability is a not for profit organization dedicated to improving health and health system sustainability. We are BC-based and we partner with others to find practical ways to transform and sustain our health care system. We identify challenges to health and the health care system, and the efficiency (cost and quality of care) of delivering care to those who need it, and work to create useful solutions.

We do this by:

- **Thinking carefully about what problems need to be addressed.** We address health system sustainability by asking difficult questions, gathering and analyzing relevant data, and providing useful knowledge to support policy and practice change.
- **Collaborating with decision-makers.** We work closely with policy makers and partners in health care delivery to create credible evidence that they can use.
- **Producing high-quality, credible evidence.** Our consultants have research training and use appropriate methodologies. Each project has an advisory group, made up of methodologic experts and leaders from other organizations working in the context of the project, to provide a broader view to the research team.

Executive Summary

The objective of the Physician Heal Thyself project was to understand the professional and personal needs and interests of family physicians and how to meet those needs while providing high quality primary care for residents of British Columbia. We spoke with 30 family physicians individually and in small-group dialogues, to probe the nature of their practice, their areas of satisfaction and concern, and their suggestions for how to structure the future of family medicine in BC.

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. They worked in individual and group practices, integrated care teams, walk-in clinics, locum placements and hospitalist positions. 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.

Concerns 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.

The Ideal Practice 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 1500 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.

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.

The Future 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.

Overall, family doctors today are practicing 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 B.C. 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.