Continuity of care in family medicine

From clinical clerkship to practice

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Every Quebecer wants his or her own family doctor, yet family medicine residents completing their training are shunning doctors' offices. Is the way in which continuity of care is taught in family medicine units contributing to residents' lack of interest in this area of practice? A newly Certified family physician weighs in.

Family medicine units and lack of interest in continuity of care

Fresh out of clinical clerkship, family medicine residents are thrown into a world that is completely new to them. From one day to the next, they are suddenly meeting patients with multiple pathologies, yet the basis of the periodic medical examination is still unknown to them. This situation generates anxiety and feelings of incompetence. As a result, new residents find very little satisfaction in it.

During a resident's first consultation with a patient, the patient's medical history has to be reviewed; it is often voluminous and has been added to by several residents. A large proportion of patients attending family medicine units have multiple pathologies, a long list of medications, and a complex psychosocial background. Some patients need to be followed at home. In university hospitals, it is not unusual for patients to be followed by different specialists, and this complicates file review. Some patients let out an audible sigh when they see that their doctor has changed yet again. For a beginner, this is quite a challenge!

In the office, new residents must learn to manage their time. They must review each patient's family history—possibly the 10th review since the patient started coming to the clinic. They believe that they must know everything about the patient because their supervisors will bombard them with questions. Latest workup? Latest mammogram? What about a bone density test? What about testing for blood in the stool?

Generally speaking, at the start of residency, residents must review each case with a supervisor before the patient is allowed to leave. If the supervisor is busy, the patient has to wait, and appointments run late. If the patient has numerous and complex complaints that need to be addressed, the supervision period stretches out. Patients are unhappy at having to wait, residents do not believe they are doing a good job because they are always rushed, the teaching is far from optimal and is indeed limited, and the days are never ending. When a patient leaves the office, the resident believes that he has barely grasped the patient's problems. Of course he renewed some medications, but were they absolutely necessary?

When the clinic is finished, notes have to be written up, forms completed, laboratory results managed, and the day's calls returned. Residents often have to fax test requisitions or prescription renewals themselves. On top of that are the more "classical" tasks such as on-call duty, other rotations, classes, presentations, academic projects, and then on-call duty all over again. Before long, the residents' schedules are extremely heavy. Unfortunately, some family medicine units add office hours or classes in the evening, without easing the pressure elsewhere in the schedule. So it is no great surprise that continuity of care is often perceived from the outset as a burdensome task, offering little stimulation or appreciation.

Conflict exacerbated by government rules

The promotion of family medicine often focuses on diversity of practice: emergency, hospitalization, care of children, care of the elderly, women's health, mental health, and so on. Young doctors seeking an adrenaline rush will certainly head toward a practice in emergency medicine or the birthing room before investing in an office practice—often with a view to getting out of debt quickly. Moreover, specific medical activities* push residents completing their training toward hospital practice, as continuity of care is not recognized as a specific medical activity in several regions. When that is the case, the doctor is required to follow a minimum number of vulnerable patients. Moreover, regional physician resource plans give preference to doctors wanting to work in hospital settings. Once again in 2010, candidates in Montreal who wanted primarily to perform continuity of care were unable to obtain positions. The government wants all Quebecers to have a family doctor. And yet, by imposing all these constraints on general practitioners, it is moving in the wrong direction.

*Specific medical activities were created under *An Act Respecting Health Services and Social Services*.[1] They require physicians with 15 years of experience or less to provide care in certain priority areas (such as emergency medicine, hospitalizations, and obstetrics).

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What is the solution?

Working in an office provides considerable latitude in terms of scheduling, makes it easier to balance work and family, and makes doctors feel valued. To spark interest in continuity of care, we must first limit the irritants associated with continuity of care during training.

First, residents must acquire a minimum level of skill before taking on continuity of care. Whether through classes, workshops, or observation, they deserve to learn the rudiments of continuity of care. How do you plan a meeting? How do you manage chronic diseases? What information must be entered in the file? How do you limit the time spent writing up notes? Residents need tools to facilitate learning (summary sheets in files, practice guides, etc). Effective clerical support must be available for managing appointments, photocopies, faxes, laboratory test requisitions, and other tasks. Computer access to laboratory results, imaging, and reference sites is essential in offices, as, increasingly, is access to computerized files and prescription forms. A multidisciplinary team must be integrated with the family medicine unit: nurses who handle joint follow-up with patients, psychologists or social workers, pharmacists, nutritionists, and consulting specialists. Family medicine units must be appealing to residents, just as community medical clinics are.

Balanced distribution of cases

Ideally, more complex cases should be distributed evenly among all residents. There should be time for reviewing files with a supervisor's help. New patients should be assigned so as to allow residents to really take charge of the patient. Some time slots should be left free, so that patients with acute conditions can be seen and so that there is time for administrative tasks. Appointments should be planned so as to add at least 15 minutes for residents who need to consult with a supervisor before the patient leaves. Finally, evening office hours should be avoided or associated with a half-day off at some other time during the week.

Ideal supervision in family medicine units

There should be 1 supervisor for every 2 medical residents to avoid making patients wait for supervisors. After completing 12 months of residency, senior residents should be able to release their patients without requiring approval from their supervisors. This practice boosts residents' confidence and helps them to manage their time more effectively. They should also play an active role in supervising clinical clerks.

The government must move toward its goals

Universities are not the only ones to blame for this lack of interest in continuity of care. The Quebec government must also make considerable changes to its management practises. The ministry of health and social services should either recognize continuity of care as a specific medical activity or abolish specific medical activities altogether; adjust general practitioners' salaries upward; provide financial support for new doctors wishing to start office practices; and enhance the incentives associated with continuity of care. Finally, family medicine units must be funded in such a way that they offer a stimulating and attractive practice environment for physicians in training. Although some changes have been made, we still have a lot of work to do.

There is general agreement in the health care community that the shortage of family physicians with offices is a critical problem that results in unnecessary costs, overcrowded emergency rooms and hospitalization units, and inadequate follow-up of sick patients. A preferred route for improving the health care system as a whole would be better primary follow-up of patients. It is time to make whatever changes are necessary to facilitate resident training in continuity of care and to make this practice attractive to them.

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None declared

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The opinions expressed in commentaries are those of the authors. Publication does not imply endorsement by the College of Family Physicians of Canada.

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