

## Being community-responsive physicians

### *Doing the right thing*

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#### ABSTRACT

**OBJECTIVE** To explore how primary care physicians respond to a community's needs and challenges.

**DESIGN** Qualitative study using focus groups.

**SETTING** Fee-for-service practices or community health centres in downtown Toronto, Ont.

**PARTICIPANTS** Purposive sample of 21 community family physicians (10 women and 11 men).

**METHOD** Participants were invited to join focus groups of four to six physicians. Themes were derived from qualitative analysis of the data using grounded theory.

**MAIN FINDINGS** Three major themes were identified by these community-responsive physicians: they carry out specific roles (collaborator, health educator, advocate, resource, and tailor of care); they face several challenges, including lack of funding and a dysfunctional health care system; and they share common beliefs about practising medicine. Whether current health care structures support physicians to actually carry out these roles in practice, however, is unclear.

**CONCLUSION** This study increased understanding of how primary care physicians respond to community needs and what they experience in the process.

#### RÉSUMÉ

**OBJECTIF** Examiner de quelle façon les médecins de première ligne répondent aux besoins et aux défis de leur communauté.

**TYPE D'ÉTUDE** Étude qualitative à l'aide de groupes de discussion.

**CONTEXTE** Cabinets de pratique rémunérée à l'acte et centres de santé communautaire du centre-ville de Toronto, Ont.

**PARTICIPANTS** Échantillon raisonné de 21 médecins de famille engagés dans leur collectivité (10 femmes et 11 hommes).

**MÉTHODES** Les médecins ont participé à des groupes de discussion de quatre à six médecins. Les thèmes ont été extraits par analyse quantitative des données à l'aide de méthodes éprouvées.

**PRINCIPALES OBSERVATIONS** Ces médecins engagés ont cerné trois thèmes principaux: ils ont des rôles spécifiques à jouer (collaborateur, éducateur, et promoteur de la santé, personne-ressource et dispensateur de soins adaptés); ils font face à plusieurs défis, incluant l'absence de rémunération et un système de santé dysfonctionnel; et ils partagent les mêmes idées sur la pratique médicale. En pratique, toutefois, on ignore si les structures actuelles du système aident le médecin à jouer de tels rôles.

**CONCLUSION** Cette étude a permis de mieux comprendre comment le médecin de première ligne répond aux besoins de sa collectivité et comment il vit cette expérience.

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Cet article a fait l'objet d'une évaluation externe.

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**M**edical schools face increasing pressure to become more socially responsive rather than being driven from within.<sup>1</sup> Medical disciplines are looking for ways to teach both individual and collective problems of health and disease so that medicine's role in the larger scheme of human affairs is better defined.<sup>2</sup> Communities are expressing a desire and need for physicians to be more than "biomedical clinicians."<sup>3</sup>

The Educating Future Physicians of Ontario project provided an opportunity for patient and community stakeholders to identify ideal physician roles. These roles (medical expert, communicator, collaborator, health advocate, learner, manager, scholar, and "physician as person") influenced medical curricula in Ontario's five medical schools.<sup>4</sup> Other Canadian medical schools have been changing their curricula also to address the needs of the communities they serve by teaching similar ideal roles.<sup>5</sup> As a desire emerges to have physicians be more than just biomedical clinicians, some observers are questioning whether our current health care system supports these other roles in practice. In fact, a study conducted in 1998 found that 62% of Canadian physicians surveyed report having had workloads that they considered too heavy.<sup>6</sup>

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Yet many physicians do practise in a way that reflects the ideal roles that the community or larger society expects. This study attempted to find some of these physicians to gain a firmer understanding of what they do and to understand their experiences of community-responsive practice through their stories. The findings of this study could help teach trainees how to respond to the needs of their communities.

## METHODS

### Design

Qualitative methods<sup>7</sup> were chosen to uncover the nature of these physicians' experiences. Focus groups capitalized on dynamic communication between participants and were an efficient way to examine the range of opinions and experiences participants had.<sup>8</sup>

### Setting

The study was conducted at the University Health Network, Toronto General Hospital in Ontario.

### Sample

Purposeful sampling was used to recruit a group of general or family physicians who were deemed "community responsive." Lists of physicians perceived as aware of community health issues and as responsive to community needs were generated by speaking to key informants representing various communities in Toronto and opinion leaders within the Department of Family and Community Medicine at the University of Toronto. This recruitment strategy attempted to gather a diversity of participants within the sample while ensuring that they were similarly responsive to their communities. Participants were invited to join the study by phone or fax. Participants were included if they were general or family physicians and had practised primary care at least 2 days weekly for the past 5 years. Physicians affiliated with the clinical practices of primary investigators were excluded from the study.

The four focus groups consisted of four to six participants each; ideal focus group size was between four and eight. Number of focus groups needed was determined by the point of saturation: when no new or relevant data emerges and information gathered is confirmed in subsequent groups.<sup>9</sup>

Before each focus group, written consent was obtained from each subject. Participation was completely voluntary, and participants' compliance or lack thereof would not compromise them in any way. Explanations of audiotaping stressed anonymity and confidentiality. An experienced facilitator used a semistructured interview guide to provide a consistent framework for each interview. Field notes were made to capture nonverbal information and information about the interview process. Audiotapes were transcribed and analyzed before the next session. The interview guide was modified between sessions to refocus on areas requiring further exploration. Participants received an honorarium.

Each investigator independently analyzed transcribed data from the focus groups. Analysis was inductive. Open coding and analysis of transcripts was ongoing and occurred after each focus group. The computer software program NVivo<sup>10</sup> was used to support nonnumerical unstructured data indexing. Once preliminary themes were identified, investigators consulted with each other. Preliminary themes were tested on subsequent groups, and the facilitator sought exceptions and contradictory findings. Focus groups were conducted until saturation was reached; this occurred after four sessions. Overall dominant themes were then identified.

The University Health Network Research Ethics Board granted approval for the study in July 2001.

## FINDINGS

A total of 21 primary care physicians participated in the study. The sample included 10 women and 11 men, all practising in either fee-for-service medical practices or community health centres in urban Toronto.

Three major themes emerged from this study (Table 1). The first relates to the various roles that

**Table 1. Themes participants identified as relevant to practising medicine that is responsive to the community**

1. Family physicians carry out specific roles (collaborator, health educator, advocate, resource, and tailor of care) in being community responsive
2. Physicians face several challenges in being community responsive, primarily inadequate funding and poor integration within the health care system
3. Community-responsive physicians share common beliefs about practising medicine in a socially responsible manner

focus groups identified as responding to community needs: collaborator, health educator, advocate, resource, and tailor of care. The second relates to challenges in carrying out these roles; the third recognizes beliefs shared by community-responsive family physicians practising medicine in a socially responsible manner.

### Physicians' roles

**Collaborator.** Physicians collaborated with other health care providers as colleagues to provide care for their patients: “[I]f I have a patient [who] I suspect has early Alzheimer’s disease, ... I will involve the Alzheimer Society. ... I’ll make sure that the Community Care Access Centre is involved at an early stage to give me all the help I can [get].”

Physicians who practised within community health centres were able to collaborate with appropriate health care providers working within their centres. “I think [the homeless] need a social worker or a community worker more than they need a physician. So we’ve responded by hiring those people.”

Participants recognized a need for family physicians to work within a network of other health care providers to decrease the sense of isolation. “I think the family physician should not be isolated—should not be a lonely voice, but should be inserted in a team with social workers, occupational therapists, nutritionists, and so on.”

**Health educator.** Participants discussed acting as health educators in the community. They viewed the role as focused on educational seminars providing information on the prevention and management of disease: “I’ve done some speaking on diabetes to a local group.” As health educators for

other health professionals and community agencies, they often provided in-service training. “I’ve done ... a lot of educational things around HIV ... with some of the AIDS service organizations ... to help train people who are providing care for people who are [receiving palliative care].”

**Advocate.** The role of advocate focused on supporting patients’ access to health and social services within the community (eg, housing, income support, mental health services): “I find I do a lot of advocacy letters. I often find just having an MD, CCFP behind your name carries more weight.” These physicians recognized that advocacy could be offered at various levels to both individuals and communities.

One physician commented: “I think being an advocate is important. You can be an advocate on a one-to-one basis, or you can be an advocate on a community basis.” Participants thought primary care physicians had a particular role in advocacy because, as one physician said, “We know the context of the patient’s particular problem, so we can advocate well.”

**Resource.** Physicians’ roles as resources to the community came to light when physicians discussed the work they did on committees and boards: “We would do a fair amount of work with the hospitals or the district health council.” Participants also recognized that a physician on a committee provides (as one doctor described) a “particular role or voice as a family physician,” lending expertise or experience that can be helpful at a community level. At times, the resource role developed into a leadership responsibility: “I was the founder of ... an institution dealing with domestic violence.” This role of resource not only helped increase public awareness of health care needs among particular patient populations but also helped agencies develop programs designed to meet the needs of specific communities.

**Tailor of care.** This role emerged when patients encountered barriers to accessing health care services. To make their services more accessible, physicians would individualize care for the circumstances, “I go and visit shelters, because [most of]

those people... are psychiatric patients. They won’t go to any physician.” Another physician explained, “We used to do clinics in what we used to call sweatshops or factories all over Toronto where... working immigrants couldn’t afford to take time off to go see a family doctor.”

Within their practices, physicians could tailor their medical practice to issues concerning various communities:

[S]peaking of public health, one of my patients is a public health nurse, and she told me that they’re seeing an incredible increase in syphilis. And so ... young women who would come in with their vaginal discharge—we hadn’t routinely been doing the bloodwork for syphilis, because we hadn’t seen it. And now she says it’s really increased, especially among young Caribbean women.

## Barriers to community response

Physicians face several obstacles to being community responsive related to government funding issues and poor integration within the health care system. Physicians reported many challenges as they tried to respond to the needs of the community. They cited lack of funding support for both physicians’ services and community agencies as blocking their efforts to get involved in the community, which often generated negative feelings. Physicians reported that they do not get paid for the time it takes to be community responsive:

Certainly, everything I’ve ever done has been volunteer; I’ve never been remunerated for anything, so I had to eliminate that barrier of saying, “Well, I should get paid for what I’m doing.” ... You have to eliminate your own barriers because sometimes there’s no funding for stuff.

Another physician stated, “It takes a lot of time, because you don’t get paid for this stuff. You’re sort of doing it after hours, and weekends.”

Participants commented that funding restrictions and funding cuts to community resources affected their opportunities to collaborate with

other health care providers, effectively limiting patients' access to community services:

I feel like I'm working so hard to support this community, and then the government doesn't give you any more resources when it's clear that you need them and you know when they cut home care to the people that are so dependent. ... I just see [the system] falling apart in front of my eyes.

Physicians saw the lack of overall integration of health care services among family physicians, specialists, hospitals, community resources, and allied health professionals as limiting their ability to respond to the community's needs. "The lack of communication with the physicians and nurse or visiting nurses between physicians ... and schools is actually a horrible situation. ... This system seems all disconnected."

This "disconnected" health care system often left physicians feeling frustrated: "I do find that very frustrating; . . . you're just superficially dealing with the medical problems that are coming in, but not really getting to the underlying problems."

Physicians reported feeling powerless:

I think, as physicians for individual patients, it's very difficult to be the front person for a system that is crumbling, and ... we're quite powerless even within the system to impact, let alone as acting as advocates for our population who aren't in the systems at all.

Physicians often remarked about feeling burned out: "So if you want to go and do community stuff, honestly, it's all out of the goodness of my dear heart. ... I think it's abuse on doctors. It's exhausting trying to be ideally what you think you should be." Despite all the challenges they faced, these physicians strove for professional excellence by being community responsive.

## Shared beliefs

Community-responsive physicians shared a common belief that medicine should be practised in a socially responsible manner. They reported feeling

an obligation "to do the right thing" and to "make a difference in people's lives." One physician nicely summarized: "We have to be involved in the social determinants of health, health in the bigger picture as opposed to just what we do in our office with an acute medical problem that we diagnose and treat."

Hence, physicians practised medicine to enhance the holistic health of the individuals and communities they worked with through their understanding of social determinants of health.

## DISCUSSION

This study aimed to gain a firmer understanding of what community-responsive physicians do and what they experience in being community responsive. Five roles emerged from the experiences of participants. Two roles identified both in this study and in the literature (including the Educating Future Physicians of Ontario project) are those of collaborator and advocate. These roles seem to surface frequently.

Collaborative practice has been defined as interdisciplinary health care teams working together to provide integrated health care services that meet the needs of a practice population effectively applying the knowledge and skills of providers.<sup>11</sup> The College of Family Physicians of Canada (CFPC), by recommending family practice health networks be established throughout Canada, supports collaborative practice.<sup>12</sup> The Commission on the Future of Health Care in Canada clearly emphasizes that networks of qualified interdisciplinary health care providers are essential to ensure both continuity and coordination of care.<sup>13</sup> Although there is consensus about the need for interdisciplinary or collaborative training at both undergraduate and postgraduate levels, many questions must be addressed: who benefits from collaborative care, what should be taught, when should training be introduced, and how should this training be given?<sup>14</sup> More educational research is needed if we are to teach physician trainees to fill the collaborator role.

One way physicians in this study responded to the needs of the community was by advocating for patients. The CFPC recognizes that family physicians are uniquely positioned to advocate for their patients because trusting relationships with them are built over time.<sup>5</sup> Successful individual and community advocacy work requires critical skills and attitudes including persistence, patience, and assertiveness; skills in negotiation, prioritization, and conflict management; and recognition of the need for collaboration with other health and social service providers.<sup>15</sup> Current medical education emphasizes pedagogy related to doctor-patient relationships and hence advocacy opportunities at this level. There has been movement toward educating trainees on the role of physicians in the community as community advocates,<sup>16-18</sup> but there is certainly room for improvement and innovation in teaching community advocacy.

Although changes are being made to teach these two ideal roles to trainees, we must question whether the current health care system acknowledges the time required by physicians to advocate on behalf of patients or to collaborate with other community health care professionals. Why teach something that cannot be practised? In this study physicians told us government cutbacks have interfered with their responsiveness to their communities. This finding meets the second objective of this study: to understand the experiences of physicians in being community responsive. Physicians' descriptions of feeling powerless, frustrated, and burned out reflect the health care system's failure to support community-responsive physicians in the work they do. Health care professionals in one study described the Canadian health care system as "chaotic."<sup>19</sup> This chaos has isolated physicians and in fact has prompted some community-responsive physicians to gravitate to community health centres. Here, they felt more supported and could work more collaboratively in their efforts to practise community-responsive medicine.

Despite all the challenges they faced, these community-responsive physicians have continued to practise medicine in a way that they consider socially responsible. They have overcome obstacles

#### EDITOR'S KEY POINTS

- Although family physicians (FPs) are theoretically trained to be responsive to their communities' needs, there is little information on how this is done and what barriers prevent being responsive.
- This study revealed that FPs are responsive to their communities in five ways: by collaborating with other caregivers, by helping to educate the public, by advocating for individual patients, by acting as a resource or consultant for community services, and by tailoring their care to their patients' circumstances.
- Challenges to providing this service include lack of funding for their time (the work was mostly voluntary), reduced funding for social services, and lack of integration of social and health services.
- Community-responsive FPs shared a value system of "doing the right thing" or trying "to make a difference in peoples' lives."

#### POINTS DE REPÈRE DU RÉDACTEUR

- Même si le médecin de famille (MF) est théoriquement formé pour répondre aux besoins de sa collectivité, on ignore à peu près tout de la façon dont il s'acquitte de cette fonction et sur des obstacles qu'il rencontre.
- Cette étude révèle que le MF répond aux besoins de sa communauté de cinq façons: en collaborant avec les autres dispensateurs de soins, en participant à l'éducation du public, en agissant comme défenseur de patients individuels et comme personne ressource ou consultant dans les services communautaires, et en adaptant les soins aux conditions particulières des patients.
- Parmi les obstacles rencontrés, mentionnons l'absence de rémunération pour le temps consacré (il s'agissait surtout de bénévolat), une rémunération inférieure pour les services sociaux et un manque d'intégration des services sociaux et médicaux.
- Les médecins engagés dans leur collectivité partageaient les mêmes valeurs: «faire ce qu'il faut» ou tenter «d'intervenir dans la vie des personnes».

and have implemented a way of practice that is community responsive because of a feeling of moral obligation. This shared obligation helped them to identify and co-manage health issues related to the determinants of health for the communities they served. Some of these physicians have chosen to work with marginalized or underserved populations. Others work with particular ethnic-cultural groups in suburban Toronto. By understanding what influences these physicians to practise medicine in a socially responsible manner, perhaps we can learn what is teachable and what is innate. There is evidence that formal training in medical school and residency influences how physicians later interact with the communities in which they work.<sup>20</sup> Thus, providing a continuum of learning

from undergraduate to postgraduate through to continuing medical education could encourage development of community-responsive physicians.

## CONCLUSION

This study describes how primary care physicians actually respond to the needs of their communities and the challenges they face. Being community responsive is fraught with challenges. It is time for schools and the health care system to support physicians serving in the roles society expects, thereby preventing burnout and rewarding responsiveness. ❁

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### Contributors

**Dr Oandasan, Dr Malik, Mr Waters, and Ms Lambert-Lanning made equal contributions to developing, implementing, and reporting this study.**

### Competing interests

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