Medical directors of long-term care facilities

Preventing another physician shortage?

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ABSTRACT

OBJECTIVE The long-term care (LTC) sector in Canada is expanding, but little attention has been given to medical human resources in this area. Our objective was to seek LTC medical directors' opinions about medical services in LTC and about strategies for recruitment and retention.

DESIGN Mailed survey.

SETTING Long-term care facilities and nursing homes.

PARTICIPANTS Seven hundred five medical directors of LTC facilities across Canada were identified from the Canadian Healthcare Association database.

MAIN OUTCOME MEASURES Responses to open- and closed-ended questions and to Likert-type scales.

RESULTS The response rate was 55%. The average age of medical directors was 54 years. Most had started work in LTC because of a vacant position, as opposed to self-perceived skills or training. Most (75.3%) reported satisfaction with their role as medical directors, but 82.7% believed that there was a significant shortage of physicians working in LTC, and 42% had seriously considered leaving their positions. Major sources of satisfaction identified were clinical, especially working with older patients and improving care. Important sources of dissatisfaction were remuneration for LTC work, on-call coverage, and excessive paperwork. Directors suggested increases to fee schedules as the main recruitment and retention strategy, and many believed that increasing exposure to LTC during residency would increase recruitment. Development of larger on-call groups for coverage and alternative methods of remuneration were not cited as important factors. Most did not believe that working in a teaching nursing home would increase their satisfaction. Directors did not think the use of nurse practitioners would alleviate concerns about shortages of physicians.

CONCLUSION Medical directors of LTC facilities are aging, and many are considering leaving their work in LTC. Without an increase in the number of physicians willing to work in LTC institutions, the current shortage of LTC physicians could increase in the near future. Medical directors' responses to questions could help guide strategies to recruit and retain physicians. Future areas of research should include the perspectives of physicians who are not medical directors and of family medicine residents.

EDITOR'S KEY POINTS

- The goal of this survey was to identify the issues related to long-term care medical directors' satisfaction with their work and to get their opinions about recruitment and retention of physicians.
- Most had started work in LTC because of a vacant position, rather than because they perceived they had the appropriate skills or training.
- Most thought that there was a serious shortage of physicians in LTC.
- Financial factors were cited as being the most important considerations for recruitment and retention.

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The proportion of senior Canadians (65 years and older) is expected to increase dramatically. By 2021, adults older than 65 will account for 19% of the population (6.7 million people). The segment of the older population growing most rapidly is seniors older than 85, which is expected to quadruple to 1.6 million by 2041. Approximately 10% of people older than 65 and more than 30% of people older than 85 reside in institutions.[1,2] The aging of the Canadian population will greatly affect the need for care provided by nursing homes and long-term care (LTC) facilities.

Several provincial governments have plans to increase the number of nursing home beds available.[3-5] The most ambitious plans are in Ontario, where 20 000 new beds are planned. There is little information about human resource (HR) needs in LTC facilities in Canada. Much primary care in Canadian LTC facilities is provided by family physicians.[6,7] With limited resources and little specialist support, care of nursing home patients can be challenging. Despite the planned increase in the number of beds available in LTC facilities, the number of physicians needed to meet the present or future demand has not been clarified.

A computerized search of the literature from 1990 to 2005, using the key words physician services; physicians/supply and distribution; physicians' practice patterns; and physicians, family/supply and distribution, which were combined with nursing homes or long-term care, did not garner any Canadian studies. Given the overall shortage of family physicians[8] and the aging population, it is crucial to understand the factors that make Canadian family physicians wish to work in this field. It is equally important to know the factors that have a negative effect and that could contribute to physicians' leaving their work in LTC.

This survey aimed to identify the issues related to LTC medical directors' satisfaction with their work and to get their opinions about recruitment and retention of LTC physicians.

METHODS

A questionnaire was developed using items and information obtained from previous surveys in the United States.[9-11] The questionnaire was pilot-tested on 50 medical directors in Ontario to clarify the wording of the questions and to provide appropriate answer categories so that closed-end questions could be used in the larger survey. Qualitative examination of the answers to open-ended questions in the pilot test provided a list of sources of satisfaction and dissatisfaction as well as suggestions for recruitment and retention. An "other" category was included to capture any important categories that might have been missed.

There are approximately 2300 nursing homes in Canada. The names of 705 medical directors of LTC facilities were identified using the Canadian Healthcare Association *Guide to Canadian Healthcare Facilities, 2001-2002*. All directors identified were mailed a questionnaire late in 2003 and they responded in 2004. A modified Dillman method was used to achieve optimal return rates.

Ethics approval was obtained from the Queen's University Research Ethics Board.

Statistical analysis was predominantly descriptive to identify factors related to physician satisfaction, recruitment, and retention. Percentages and frequencies were compared using the Student *t* test for continuous variables and using the chi-square test and odds ratio for categorical and dichotomized Likert-scale data.

RESULTS

A response rate of 55% was obtained, with 387 surveys completed and returned. **Table 1** shows demographic information about respondents. The average age of medical directors responding was 54 years. All provinces were represented; 62.9% of responses were from Ontario. Newfoundland, Prince Edward Island, and the Northwest Territories were minimally represented (<1% each). Directors had worked in LTC a mean of 18.7 years (**Table 2**; standard deviation 9.35).

The most common primary form of remuneration was fee-for-service payment (81.3%), although 28.6% reported substantial additional income from stipends, blended formulae, and other types of payment. Other features of respondents' environments are shown in **Table 3**.

Most directors (82.7%) believed that there is a serious shortage of physicians in LTC. Only 1.1% believed that there is a surplus. Although 75.3% reported important sources of satisfaction with their roles as medical

Table 1. Demographic characteristics of respondents

DEMOGRAPHIC CHARACTERISTICS	N (%)
Sex	
• Male	340 (87.8)
• Female	47 (12.2)
Age	
• ≤35	5 (1.3)
• 36-45	72 (18.7)
• 46-55	131 (33.9)
• 56-65	133 (34.5)
• 66-81	45 (11.7)

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Table 2. Practice characteristics of respondents

PRACTICE CHARACTERISTICS	MEAN (STANDARD DEVIATION)
Years in practice	26.83 (9.92)
Years in LTC practice	18.70 (9.35)
Number of nursing homes (range 1-22)	2.33 (2.35)
Number of LTC patients seen monthly* (median 80.00, range 3-1400)	125.18 (138.4)
Hours spent in LTC weekly (median 6.00, range 1-50)	8.83 (8.0)

LTC—long-term care.
*N=372.

Table 3. Respondents' environment

CHARACTERISTIC OF ENVIRONMENT	%
Community size	
• < 10 000	36.2
• 10 000-100 000	27.2
• > 100 000	36.5
Type of practice	
• Solo	39.2
• Partnership	12.6
• Group	40.0
• Family medicine network	2.6
• Other	5.5

directors, 72.5% reported important sources of dissatisfaction and 42% had seriously considered leaving LTC work in the previous 2 years. A smaller percentage (48.3%) reported satisfaction with their overall work in LTC.

The most common opportunities cited as leading them to LTC were a vacancy with no one else to do the job, the opportunity for work outside an office, the challenge of medical problems of the elderly, and enjoying work with elderly patients. The availability of a stipend, the challenge of providing end-of-life care, and personal expertise in care of the elderly were infrequently cited.

The main sources of satisfaction with LTC work are clinical factors, such as working with older patients, getting out of the office, and opportunities to improve patient care (**Table 4**). Administrative and research opportunities were infrequently ranked as positive factors.

Table 4 also shows the main sources of dissatisfaction; poor financial remuneration and excessive paperwork were most frequently cited. Ontario physicians ranked remuneration as the main source of dissatisfaction more often than other provinces, but this difference was not statistically significant. The main source of dissatisfaction with clinical work was obtaining on-call coverage and the expectations of patients and their families. Clinical factors, such as shortages of other staff and laboratory availability, were infrequently cited.

Financial factors were mentioned as the most important considerations for recruitment and retention

Table 4. Sources of satisfaction and dissatisfaction with current work as reported by medical directors

ACTIVITY	RANKED IN TOP 4 SOURCES N (%)
SOURCE OF SATISFACTION	
Working with older patients	283 (72.4)
Opportunities to improve patient care	241 (61.6)
Teamwork with other long-term care staff	234 (59.8)
Change from office practice	229 (58.6)
Challenge of medically complex patients	202 (51.7)
End-of-life care	112 (28.6)
Administrative role as medical director	63 (16.1)
Administrative support from facility	40 (10.2)
Interactions with other physicians	26 (6.6)
Research opportunities	13 (3.3)
SOURCE OF DISSATISFACTION	
Financial compensation	211 (54.0)
Excessive paperwork	189 (48.3)
Financial compensation for on-call shifts	187 (47.8)
Patient and family expectations	173 (44.2)
Getting physician coverage during absence	134 (34.3)
Interruption of office practice	125 (32.0)
Staff shortages or turnover	114 (29.2)
Availability of professional staff in facility	88 (22.5)
Lack of specialist support	89 (22.8)
Laboratory and radiology availability	51 (13.0)

(**Table 5**). Increasing the fee schedule and providing an on-call stipend were cited as most important for both recruitment and retention. Development of larger on-call groups for coverage and alternative methods of remuneration were not cited as important factors. Likewise, increased academic affiliation, such as development of a teaching nursing home, was not viewed positively. Increasing exposure to LTC in family medicine residency was more commonly cited as a positive recruitment tool.

Many respondents (46%) were uncertain whether a section for LTC in their provincial medical association would be helpful for recruitment, although 41.5% thought it would be beneficial for LTC physicians. When asked about the potential role of nurse practitioners, 42.9% did not agree that nurse practitioners would alleviate physician resource issues. There was no association between age and response regarding nurse practitioners' roles.

DISCUSSION

This is the first Canadian study to look at the perspective of LTC medical directors regarding recruitment and retention. The directors had often assumed the role

Table 5. Medical directors' recommendations for physician recruitment and retention

STRATEGIES	RANKED IN TOP 3 FOR RECRUITMENT N (%)	RANKED IN TOP 3 FOR RETENTION N (%)
Increase fee schedule	258 (66.0)	274 (70.1)
Offer on-call stipend	203 (51.9)	225 (57.5)
Increase exposure to long-term care during residency	154 (39.4)	N/A
Offer alternative funding for remuneration	138 (35.3)	148 (37.9)
Provide financial incentives from government	119 (30.4)	N/A
Increase nursing staff	N/A	114 (29.2)
Make a rotation in geriatric medicine mandatory during residency	83 (21.2)	N/A
Increase opportunities for continuing medical education	86 (22.0)	N/A
Increase links with other directors	N/A	68 (17.4)
Develop large on-call groups	61 (15.6)	33 (8.4)
Increase role of nurse practitioners	N/A	59 (15.1)
Increase availability of other professionals	49 (12.5)	58 (14.8)
Develop academic nursing homes	39 (10.0)	20 (5.1)
Offer university affiliation for physicians	25 (6.4)	23 (5.9)

because there was no one else to fill it, but reported their interest in the care of older patients to be a driving force in continuing this type of practice. Medical directors are an older group; in this survey respondents had a mean age of 54 and were predominantly male. The demographics and the sources of dissatisfaction identified by this survey indicate a need for greater attention to physician HR in LTC in Canada.

Several recent reports have examined physician HR needs in Canada, projecting substantial shortfalls for family physicians.[3,8,12] Canadian family physicians have increasingly restricted their practices to office work, with less involvement in hospital and institutional care.[8] The aging Canadian population will increase the need for physicians.[13]

Our survey found that most medical directors believe there is a serious shortfall of physicians willing to work in LTC. Almost half this group of directors had considered leaving their LTC work, and their mean age was 54. The percentage of respondents planning to reduce the scope of their practices was higher in our study than in the 2001 National Family Physicians Workforce Survey (18.4%).[6]

Although no surveys have assessed family medicine residents' plans for working in LTC,[14] many residents have little exposure to LTC during their training and might not be willing to fill the void left by departing medical directors. Our study suggests problems in the near future unless the number of physicians interested in this type of care increases. Developing specific recruitment strategies could be necessary to attract residents and physicians to work in LTC.

Increasing the fee-for-service payment schedule was often suggested; payment was the most frequent source of dissatisfaction and increased payment was the most frequently recommended recruitment and retention strategy. Obtaining on-call coverage was cited as a source of dissatisfaction, but the development of large on-call groups was not identified as an important retention strategy, perhaps reflecting directors' concerns about overly large groups or loss of autonomy. The directors in this survey did not rank teaching and research as a substantial source of satisfaction and rated them much lower as HR strategies. Although this perspective could reflect the fact that respondents were not actively involved in teaching at the time of the survey, any assumption that they would jump at the opportunity to do so should be reconsidered.

Medical directors reported satisfaction in working with older patients, and most said that increasing exposure in residency might improve recruitment. Without exposure to geriatrics during training, residents might not be drawn to this area of care. The influence of residency education on the decision to work in LTC is not well understood.[15,16] The American Geriatric Society has curriculum recommendations for residency programs and aims to make nursing homes an integral part of residency training.[17] Similarly, the College of Family Physicians of Canada has mandated that nursing home exposure be a core experience during the care of the elderly training in the third postgraduate year.

Use of nurse practitioners has been identified as a strategy to alleviate physician shortages in LTC. The medical directors here expressed uncertainty about nurse practitioners' role; only a small percentage express optimism about this strategy. What this means about their willingness to work with nurse practitioners is unclear, but it suggests health authorities would be wise to involve medical directors in clarifying and implementing this role.

American surveys reflect some of the factors associated with dissatisfaction in our Canadian study.[9,11] In recent years, liability insurance for LTC practices in some American states has become so high that some physicians have stopped providing care. Low reimbursement was cited as very or somewhat important by 48.1% of American respondents. Excessive paperwork seems to be of greater concern to American than to Canadian

LTC doctors.[11] Certification in family medicine in general has been shown to predict nursing home practice in American studies,[10,11,18] whereas fewer than half of directors in this study had Certification from the College of Family Physicians of Canada.

Limitations

There are several limitations to this study. Identifying physicians working as medical directors of a facility is difficult, given the fragmentation of the LTC sector and the lack of an organized LTC system at a regional, provincial, or national level. The database we used listing medical directors did not provide the directors for all nursing homes in Canada. Many respondents worked in smaller centres, and the experience in LTC could differ between urban and rural settings. Most respondents were male, in part reflecting respondents' ages but possibly reflecting differences in practice patterns.[8] Finally, medical directors' perspectives differ from those of other physicians working in LTC, especially given their expanded roles. For these reasons, the results might not be generalizable to all LTC physicians.

This survey is a first attempt to discern the perspectives of physicians in LTC. Many questions related to practice choice and experience could not be asked in this survey. Efforts are under way to gain more qualitative perspectives, such as the "ABCs of LTC" project in Ontario. There is a need to examine perspectives of LTC physicians other than medical directors, and a survey of this group is currently under way. To understand the possible severity of future physician shortages, a study of residents' perspectives and plans about LTC work could provide information about the number of young doctors planning to provide care in nursing homes.

Conclusion

Medical directors responding to this survey reported great satisfaction with their role. The average age of directors was 54, however, and many directors had considered discontinuing LTC work. Directors' most common suggestion for recruitment and retention was increased financial compensation. Developing academic roles was not frequently cited as a retention strategy, although increasing educational exposure in residency was identified for recruitment. The survey highlights concerns about physician HR in this expanding health sector.

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Contributors

Dr Frank *was involved in the literature search, study design, and data analysis, and helped prepare the manuscript and make the revisions.* **Ms Seguin** *contributed to the study design, data analysis, and manuscript preparation.* **Ms Haber** *and* **Dr Stewart** *contributed to the study design and manuscript preparation.* **Dr Godwin** *contributed to the study design and data analysis.*

Competing interests

None declared

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