

## Who has time for family medicine?

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Recently a number of articles in the medical literature have discussed the many dissatisfactions of primary care physicians, including family physicians.

Bodenheimer<sup>1</sup> has clearly documented the growing pressures on primary care physicians in the United States. Patients are dissatisfied as they experience longer wait times and perceive the quality of care they receive to be inadequate. Physicians are dissatisfied because they feel they are paid for volume, not quality; they earn half the income of specialists and the gap is widening; and they find that the workload is becoming impossible to sustain. The situation is similar in Canadian primary care.

### Time pressures

The first published evidence examining family physician workload appeared in 2003. Yarnall et al<sup>2</sup> used published and estimated times per service to determine the physician time required to provide all of the services recommended by the US Preventive Services Task Force, at the recommended frequency, to a patient panel of 2500 with an age and sex distribution similar to that of the US population. They found that to fully satisfy the US Preventive Services Task Force recommendations, a physician would have to spend 1773 hours per year, or 7.4 hours per working day, providing preventive services.

Recently, using similar methods, Østbye et al<sup>3</sup> applied guideline recommendations for 10 common chronic diseases to a panel of 2500 primary care patients (with an age and sex distribution and chronic disease prevalence similar to those of the general population) and estimated the minimum physician time required to deliver high-quality care for these conditions. The result was compared with time available for patient care for the average primary care physician. They found that 823 hours per year, or 3.5 hours a day, were required to provide care for the 10 most common chronic diseases, provided the diseases were stable and in good control. They recalculated this estimate based on increased time requirements for uncontrolled disease. The estimated time required increased by a factor of 3. Applying this factor to all 10 diseases, time demands increased to 2484 hours per year or 10.6 hours a day. The authors concluded that meeting current practice guidelines for only 10 chronic illnesses requires more time than primary care physicians have available for patient care overall.

When we combine the results of these 2 studies, the average American family physician will spend between

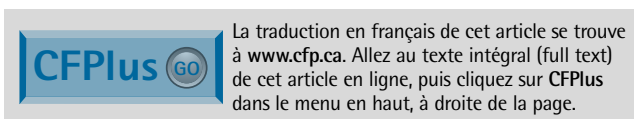
10.9 and 18 hours per day delivering preventive and chronic illness care. Such estimates fail to account for time spent in the delivery of acute care for common conditions, such as upper respiratory tract infections and urinary tract infections, that make up much of a typical day. They also fail to account for time spent outside the examination room answering telephone calls, filling out forms, making referrals, and so on, which takes up a substantial part of the day.<sup>4,5</sup>

The situation begs some obvious questions. How did expectations for family physicians outstrip the number of hours in the day? Since even the most conscientious family physician is not working 24 hours a day,<sup>6</sup> how do family physicians cope with such expectations and demands on their time? Finally, how can expectations of family physicians be made more realistic without compromising the quality of patient care?

### Guideline explosion

Several factors have contributed to the time crunch for family physicians, but I believe one factor in particular has had an enormous effect—the explosion of clinical practice guidelines (CPGs) over the past decade. Clinical practice guidelines emerged in the 1970s in most of the industrialized world, beginning with the Canadian Task Force on the Periodic Health Examination in Canada and the US Preventive Services Task Force in the United States. The task forces had an admirable purpose and necessary goals: to evaluate the scientific evidence behind preventive care and to make evidence-based recommendations for practice. These task forces established clear evidence hierarchies and a clear process for the evaluation and the dissemination of clinical evidence. Their recommendations continue to guide primary preventive care today.

Since that time there has been an explosion of CPGs aimed at family physicians. There are more than 2000 guidelines available from the website of the National Guidelines Clearinghouse ([www.guideline.gov](http://www.guideline.gov)) in the United States (although not all of them are relevant to family physicians). At last count there were 124 CPGs posted on the website (<http://gacguidelines.ca>) of the Ontario-based Guidelines Advisory Committee (GAC), an organization dedicated to the evaluation and dissemination of guidelines relevant to family physicians;



the GAC's mission is "to promote better health for the people of Ontario by encouraging physicians and other practitioners to use evidence-based clinical practice guidelines and clinical practices based on best available evidence. In particular, to increase awareness and use of best available evidence, [they] identify, evaluate, endorse and summarize guidelines for use in Ontario."

While the GAC evaluates and rates CPGs according to criteria for quality, there are many problems with CPGs, including many of those that the GAC has favourably evaluated. First, there is strong evidence that guidelines are not developed according to stringent criteria. Shaneyfelt has demonstrated that "Guidelines published in the peer-reviewed medical literature during the past decade do not adhere well to established methodological standards. While all areas of guideline development need improvement, greatest improvement is needed in the identification, evaluation, and synthesis of the scientific evidence."<sup>7</sup> Second, guidelines follow the clinical research paradigm and are often developed with only one condition or disease in mind. Patients seen by family physicians usually present with several chronic and interacting conditions, making the application of guideline recommendations more difficult.<sup>8</sup> Third, guidelines often do not take into account patient preferences for care, something that family physicians are explicitly trained to do. Fourth, even

high-quality guidelines fall short in the way they are disseminated to family physicians. Guidelines are usually passively distributed by mail and in paper form. Although there are increasing exceptions, they also tend to be long, detailed, and do not provide specific clinically useful summaries for busy doctors.<sup>9</sup>

### Improving guidelines

Is there a way to improve CPGs and to reduce the enormous time pressures that burgeoning guidelines place on family physicians? I believe that the answer is yes, but several changes in current practice and in the way that guidelines are developed and disseminated are necessary.

Guidelines need to be "done" differently. Guideline panels typically consist of large numbers of specialist content experts with 2 or 3 family physicians included. Having sat on a guideline panel in the past,<sup>10</sup> I can reflect that much of the discussion over 2 days was about research evidence to support the recommendations. While this discussion is critically important, very little time was spent on the equally important issue of dissemination (or knowledge translation). This is a world turned upside down. I propose that guideline panels of the future have much greater representation from family physicians working in different settings, with a small number of content experts to advise them

on content. In that way, perhaps, greater attention will be paid to how family physicians can use the guidelines in their practices.

Greater emphasis needs to be placed on applying guidelines to the type of patients seen in family practice settings—the elderly and those with multiple chronic conditions. Furthermore, greater attention needs to be placed on the evidence for the effectiveness of interventions in guidelines. Family physicians are swamped with maneuvers supported only by expert opinion.

This has been said and written many times before, but more attention needs to be paid to the effective dissemination and implementation of good guidelines. Stronger input from family physicians is crucial if dissemination is to be successful.

As family physicians move toward working in family health teams or groups that incorporate and integrate other health care professionals, greater attention needs to be paid to the role of other providers in the delivery of acute, chronic, and preventive care. Clearly, if family physicians are to continue to provide high-quality care and incorporate guideline recommendations into their practices, they will need to share this work with other professionals. Many preventive care maneuvers can be performed, for example, by nurse practitioners integrated into family health teams. Similarly, nurse practitioners can effectively provide care for some chronic conditions, allowing family physicians to focus on acute care or on patients with chronic illnesses that are unstable.

Family physicians are under increasing time pressures to provide both preventive and chronic illness care. The growth in CPGs for both preventive and chronic care and the expectation that they will be closely followed by family physicians has contributed substantially to the time pressures. Improvements in the quality and in the dissemination of guidelines and the integration of other health care providers, such as nurse practitioners, into family health teams could help ease time pressures on family physicians and improve the quality of their work lives.



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### Competing interests

None declared

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