RESPECT from specialists

Concerns of family physicians

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ABSTRACT

OBJECTIVE To explore potential solutions to the challenge of gaining more respect for FPs from other specialists.

DESIGN An original Web-based qualitative survey, from May 27, 2004, to January 5, 2005, involving 5 rounds.

SETTING Province of Alberta.

PARTICIPANTS A sample of 28 Alberta FPs of differing experience, locations, and types of practices.

METHODS Purposeful maximum variation sampling was used to identify a heterogeneous sample of FPs. The Delphi technique was used with an anonymous, iterative, Web-based survey to develop consensus among participating FPs. The first 2 rounds of the survey were designed to generate rich, thick descriptions of the rewards and challenges FPs experienced; the last 3 rounds were designed to refine this information and identify potential solutions and support that key organizations could provide. This information was collapsed into themes using thematic content analysis and reviewed by a working group; with input from the working group we decided to focus our analysis on the challenge of gaining respect from specialists.

MAIN FINDINGS Each round yielded an 86% to 96% response rate, from which 11 key challenges were identified including "respect from specialists." Suggestions of potential solutions to gaining more respect included the need to create and develop relationships between FPs and other specialists and to support each other's roles; to raise the profile of family medicine in universities and teaching hospitals; to change negative attitudes by promoting the expertise and role of family medicine to others; to demonstrate and maintain a comprehensive skill set; and to address intraprofessional inequities and provide appropriate incentives. Participants suggested roles that organizations could play; for example, universities and medical schools could avoid making negative comments about family practice, reward FPs involved in teaching, and decentralize medical education to provide more experience in community settings and environments that model interactions between specialists and FPs. Organizations could recognize and promote the role that FPs play in the health care system, seek their input into decisions involving primary care, and move toward equitable and fair remuneration.

CONCLUSION Perceived lack of respect toward FPs from some of their specialist colleagues might be reflective of issues that go beyond family physician–specialist interaction. Solutions will likely require the involvement of academic centres and other organizations.

EDITOR'S KEY POINTS

- Lack of respect from other specialists is a key challenge for family physicians and might stem from a lack of understanding and recognition of family physicians' important role in the health care system.
- Five potential solutions were identified that address this important issue. Some solutions can be implemented at an individual level, but others require the involvement of governing bodies, associations, and academic institutions.
- Family physicians should promote the expertise and role of family medicine to others, maintain and demonstrate an excellent skill set, and work to develop good relationships with other specialists. Intraprofessional inequities need to be addressed with the provision of appropriate incentives. Academic institutions should aim to enhance the profile of family medicine in universities.
- Failure to address this important issue might result in a continued shortage of family physicians in Canada.

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RESPECT de la part des spécialistes

Une préoccupation des médecins de famille

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RÉSUMÉ

OBJECTIF Explorer des stratégies pour obtenir plus de respect des spécialistes à l'égard des médecins de famille (MF).

TYPE D'ÉTUDE Enquête qualitative originale sur Internet comportant 5 étapes, effectuée entre le 27 mai 2004 et le 5 janvier 2005.

CONTEXTE Province d'Alberta.

PARTICIPANTS Un échantillon de 25 MF albertains avec des expériences et des lieux et types de pratique variés.

MÉTHODES Un échantillonnage raisonné à variation maximale a été utilisé pour identifier un échantillon hétérogène de MF. On s'est servi de la technique Delphi avec une enquête itérative anonyme sur Internet pour obtenir un consensus au sein des MF participants. Les deux premières étapes de l'enquête étaient destinées à générer une description riche et fournie des défis et sources de satisfaction rencontrés par les MF; les trois dernières étapes cherchaient à raffiner l'information et à identifier des solutions et aides potentielles de la part d'organisations clés. Une fois réduite en thèmes par analyse de contenu thématique, l'information a été révisée par un groupe de travail; à partir des données du groupe de travail, nous avons décidé de concentrer notre analyse sur le défi d'obtenir plus de respect de la part des spécialistes.

PRINCIPALES OBSERVATIONS Un taux de réponse de 86-96% a été obtenu à chacune des étapes, permettant d'identifier 11 défis clés incluant « le respect de la part des spécialistes » . Les solutions suggérées pour obtenir plus de respect incluaient la nécessité de créer et d'améliorer les relations MF-spécialistes, et d'appuyer mutuellement les rôles de chacun; de mieux présenter le profil du médecin de famille dans les universités et les hôpitaux d'enseignement; de changer les attitudes négatives en vantant l'expertise et le rôle du MF auprès des autres professionnels; de maintenir un ensemble important d'habiletés, de corriger certaines inégalités et de fournir les incitatifs appropriés. Les participants ont suggéré des rôles que pourraient jouer les organismes; par exemple, les universités et facultés de médecine pourraient éviter de faire des commentaires défavorables sur la médecine familiale, récompenser les MF qui participent à l'enseignement et décentraliser la formation médicale pour permettre davantage d'expérience dans des milieux communautaires et des environnements qui privilégient les interactions MF-spécialistes. Les organismes pourraient promouvoir le rôle des MF dans le système de santé, tenir compte de leur opinion dans les décisions concernant les soins primaires, et faire un pas vers une rémunération juste et équitable.

CONCLUSIONS Le manque de respect que ressentent les MF de la part de certains de leurs collègues spécialistes pourrait relever de questions qui dépassent les simples interactions entre MF et spécialistes. Les solutions exigeront probablement l'intervention des centres universitaires et d'autres organismes.

POINTS DE REPÈRE DU RÉDACTEUR

- Le manque de respect de la part d'autres spécialistes est un important problème pour les médecins de famille et pourrait être issu d'un manque de compréhension et de reconnaissance de leur rôle important dans le système de santé.
- On a cerné 5 solutions possibles pour remédier à ce problème. Certaines peuvent être appliquées à l'échelle individuelle, mais d'autres demandent la participation des organismes gouvernementaux, des associations et des institutions d'enseignement.
- Les MF devraient faire valoir l'expertise et le rôle de la médecine familiale, conserver et démontrer un excellent ensemble de compétentes, et travailler à développer de bonnes relations avec les autres spécialistes. Il faut s'attaquer aux iniquités intra-professionnelles en utilisant les incitations appropriées. Les établissements d'enseignement devraient viser à améliorer le profil de la médecine familiale à l'université.
- Si l'on ne règle pas cette importante question, la pénurie de médecins de famille pourrait se poursuivre au Canada.

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Respect is a long-standing concern in most workplaces, and medical workplaces are no exception.[1] In the last decade, relationships and respect among medical disciplines seem to have deteriorated. Researchers have examined the habit of "badmouthing" or "bashing" varying disciplines, particularly from medical students' perspectives.[2-5] Although surgical disciplines have been frequent recipients of disparaging comments,[3] family medicine has undeniably been the focus of substantial negativism from specialist colleagues.[2-6] Such negativism, although not the sole cause, has contributed to a declining enrolment in family medicine.[2,3]

Disrespectful behaviour, such as badmouthing, might be a symptom of a problematic relationship between FPs and other specialists. According to the 2004 National Physician Survey,[7] 23.1% of Canadian FPs were very satisfied with their relationships with specialist physicians, whereas 1.1% were very dissatisfied. Canadian FPs were more satisfied with their relationships with their patients (53% were very satisfied; 0.3%, very dissatisfied) than with their specialist colleagues.[7] As FPs' relationships with consultant specialists appear to affect their referral decisions,[8] poor intracollegial relationships could affect patient care.

Concerns about physicians' working relationships have been expressed in other arenas. The College of Physicians and Surgeons of Alberta published a letter[9] from an Alberta FP who described frustration with consultants' behaviour in the referral process. The Alberta Registrar indicated that the College "hear[s] frustration like this all too frequently, and the majority of these letters and calls come from family doctors."[9]

There is a lack of research on whether or not FPs feel they are respected by other specialists. Our Web-based Delphi survey,[10] which identified 11 key challenges in family practice in Alberta, found that "respect from specialists" was a priority for FPs. A second objective of the survey was to explore participants' suggestions of ways to deal with these key challenges. This paper describes ideas obtained from the Delphi survey about how to meet the challenge of gaining respect from specialists and the roles specific organizations should play in this process.

METHODS

Purposeful maximum variation sampling[11] was used to identify a heterogeneous sample of FPs across Alberta who were actively practising, had access to computers, and were willing to participate in a 3- to 5-round Delphi survey. Participants were purposefully selected so that the sample reflected urban and rural areas, male and female physicians, academic and non-academic settings, varying numbers of years in practice and volumes of practice, diverse scopes of practice, and different payment modalities.

Recruitment occurred in 2 ways: First, potential participants were identified by the research team and through word of mouth. Researchers then reviewed the sample and identified FPs that were not yet represented, including representation from each of the 9 health regions in Alberta. Second, information about the study was e-mailed to members of the Alberta College of Family Physicians and study information was posted on the College's website. The study received ethics approval from the Health Research Ethics Board at the University of Alberta in Edmonton. A detailed description of the methods of the Delphi survey's development and execution has been published elsewhere.[10] In brief, the Delphi technique was used with an anonymous, iterative, Web-based survey to develop consensus among the panel of participating FPs.[12,13] The initial rounds were designed to be generative, whereas subsequent rounds were designed to clarify, refine, and facilitate the emergence of consensus.[12] A total of 28 FPs agreed to participate and provided signed consent. Five rounds of Delphi surveys were conducted from May 27, 2004, to January 5, 2005. Detailed descriptions of the rounds are published elsewhere.[10]

Participants developed consensus on 11 challenges in family practice. During the final rounds, participants commented on how the challenges could be met and included suggestions about how specific organizations could help physicians meet these challenges. A large amount of information was generated and collapsed into themes using thematic content analysis.[14] This information was then reviewed by a working group that consisted of male and female academic FPs, a rural FP, a nonphysician representative from the Alberta College of Family Physicians, and academic colleagues experienced in both family medicine research and the Delphi method. With input from the working group we decided to focus our analysis on the challenge of gaining respect from specialists.

FINDINGS

Purposeful sampling obtained a heterogeneous sample of 28 FPs (11 women and 17 men), representing 7 of the 9 Alberta health regions. Length of time in practice ranged from 2 to 34 years and the physicians represented a variety of practice settings.

Each round of the Delphi survey yielded an 86% to 96% response rate, and consensus was developed on 11 key challenges that affect Alberta FPs. Thick descriptions were obtained in particular on the challenge of respect from specialists and included potential solutions.

Family physicians described a perceived lack of respect, leading to further problems, in family physician–specialist relationships, as articulated by this participant:

> Loss of regular day to day contact with specialists as peers, increasing subspecialisation and an assumption that [family medicine] is the fallback option and will "pick up the pieces/extra ward responsibilities/overnight call coverage/completion of WCB forms, etc" when the specialist decides not to. Comments to med students and residents along the lines of "just a family doctor," "you are smart; you can do better," "look at the mess the FP made of this case," "how did they miss this Dx" are, unfortunately, not uncommon.

Another participant observed the following:

> Respect from specialist colleagues is there, but obviously not from all specialists. I fully recognize that I limit my referrals to specialists who treat both the patients and my referral/level of knowledge/skill/expertise with respect; technically competent specialists who berate my referrals become the contact of last resort, typically only on call, from emergency.

Potential solutions

When participants were asked what could be done to meet this challenge, 5 distinct themes were identified.

1. Create and develop relationships between FPs and specialists and support each other's roles. Participants described how they have become isolated from specialist colleagues and perceive that specialists no longer recognize or understand the role of the FP.

> In the past, before regionalization, family doctors and specialists had more opportunities to meet and work together. The days when family doctors met each morning with specialists and subspecialists in the coffee room are gone, and this kind of interaction has not been replaced. Our relationships have suffered.

> Our role in health care needs to be recognized by our specialist colleagues.

Participants described the need to develop relationships with specialist colleagues to better support and understand each other and each other's roles:

> I think it would be hard for a specialist to disparage medical colleagues they actually know well in a social context.

> We need to have more "full meal" family physicians working in hospital alongside our specialty colleagues to promote and maintain understanding about family medicine and to promote collegiality.

> The issue is more of a relationship issue than a one way lack of respect. There is also a lack of respect from family physicians towards specialists. Both are needed to provide the excellent care that we provide in Canada. A partnership between these two groups to manage the care provision better and to support one another needs to be developed. This requires all of us to look beyond our little micro world of the office and the individual patient and see ourselves as part of a bigger system.

> Collegiality begins with understanding the challenges that we each face, appreciating the good effort we DO make, and overlooking the omissions/"errors"/"failures" that we encounter. How I wouldn't love to hear "your family doc has done a great job in keeping things going" from a patient when they return from a distant specialist appointment. Supporting each other in our roles is a major priority in preserving the medical community.

2. Enhance the profile of family medicine in universities and teaching hospitals. The participants described how universities and teaching hospitals might contribute to the development of negative attitudes. This quotation is typical of their responses:

> There is a distinct need for medical schools and universities to stop denigrating family practice. This attitude breeds a feeling amongst many students that family practice is kind of the "default" career that one might undertake if all else fails. It is not until one gets some experience practising family medicine that one appreciates its complexity.

Thoughts on how universities and medical schools could deal with the problem included the following: avoiding negative comments about family practice and viewing family practice as a default career choice; involving more FPs as positive role models in teaching; exposing students to family practice; rewarding FPs involved in teaching; decentralizing medical education so more experience could be obtained in community settings; and exposing learners to environments that model interactions between specialists and FPs. Specifically, participants made the following comments:

> Increased exposure to family medicine and ambulatory care at all levels of training—theoretical, student intern, and residency levels. Increased input into curriculum development by family physicians.

> I believe this challenge [respect from specialists] is best addressed by providing positive role models of family physicians at all levels of medical education—however it seems to be a continual uphill battle to incorporate family physicians into the specialist

> dominated university environment—especially since we have been essentially excluded from the hospitals.
>
> Encouraging exposure of all medical students to a family practice experience (mandatory); and rewarding family physicians who continue to be involved in medical education.
>
> Look at decentralizing medical education so that more is done in smaller centres and community based practices and less is done at the universities and university hospitals.
>
> In addition a huge step forward would be paired teaching, ie, FP AND specialty expert modeling the interaction between the two disciplines and value of each.

Participants described the importance of exposing all medical learners to family medicine so that they develop an understanding of the FP's role. One participant reflected:

> Family medicine was supposed to be recognized as a specialty when the College of Family Physicians [of Canada] was created. Ironically, this led to the abolishment of the 1 year internship. Previously, this 1 year internship allowed many new physicians to try out "family medicine," and many physicians discovered how challenging it was and returned to school to pursue a specialty. Many of my specialist colleagues who treat me with respect come from this background—ie, have worked as a generalist before and therefore recognize how challenging it can be.

3. Change negative attitudes by promoting the expertise and role of family medicine to others. Lack of respect for family medicine was described as a pervasive issue. Participants reported that they had experienced negative attitudes toward family medicine on the part of specialists, allied professionals, instructors, medical schools, patients, and even other FPs. They suggested that there was a need to promote family medicine to these other groups. Participants noted the following:

> We are also undervalued by patients and allied health professionals.
>
> Just like we teach our children, respect starts at home. FPs need to respect themselves as vital "specialists" within the system and centres of learning need to promote this attitude, as well as "reorienting" those whose attitudes are hostile.
>
> [We need to start] promoting the image of a skilled and community based physician, opportunities for FPs, and early recruiting pre-university.
>
> Family medicine must be clearly identified as a "specialty." This has to be communicated widely—for instance insurance forms ask for "area of specialty."
>
> [We must] provide evidence for change to the system and justification for primary care à la Barbara Starfield.

4. Demonstrate and maintain an excellent comprehensive skill set. Participants described how good skills earn respect. Unfortunately, poor work done by some might reflect on the group as a whole; hence, FPs need to take responsibility for maintaining and practising to the highest possible standards:

> [Family medicine] has become a specialty in its own right and is now a detailed, complex, multitasking field, where skills need to be kept up.
>
> Unfortunately there are a few family doctors who ended up where they are by default. I think it sometimes shows in their work. They may not have the same enthusiasm and commitment as those family doctors who made the positive choice. Maybe they tarnish our reputation as a group.
>
> I don't think they (specialists) really undervalue us if we do our work well. But if we dump our complex patients on them with sketchy referral letters and inadequate preliminary work-up we lose their respect.

5. Address intraprofessional inequities and provide appropriate incentives. Inequities were described as contributing to a perception of not being valued or respected:

> Primary care can be much better than it is in Canada. Comparative studies such as those of Starfield and [the] WHO underline that. The level of respect can be determined by the level of underfunding. Policy makers will grease the squeaky wheels of lack of access to beds, [and of] hips and knees, but we get lots of lip service but no respect in the form of infrastructure funding.
>
> Specialists will always undervalue our role if it benefits their relative value under the global funding system—[we] need to address funding issues.
>
> Often, and maybe because patients do not pay us a fee, I feel we are not fully respected, but expected to do things (like phoning in prescriptions, completing forms, phone calls) for free. Patients seem to take more advantage of FPs than they would ever expect from a specialist.

Participants also described how appropriate incentives could break down barriers that prevent FPs from being involved in teaching, administration, and other activities. Inadequate compensation can affect the quality of work and result in both a lowered respect for the profession and a lowered desire for potential learners to become FPs. Comments were as follows:

> Incentives for family physicians to stay involved in hospital/academic/teaching practices need to be considered more strongly.

> I believe that part of the reason residency programs have a hard time filling family practice spots is because family practice is seen as poorly paid and poorly respected (both true!) relative to other specialties. I think this aspect also affects our ability to take the time for paperwork so we don't have to do it after hours; it affects our ability to take the time for extra training; and it affects our ability to take the time we should with our patients.

> With decisions involving primary care, input should be obtained from family physicians participating in administrative exercises and committee meetings. These contributions should be appropriately recognized and compensated [by] regional health authorities or Alberta Health.

DISCUSSION

This study identified the perceived lack of respect for FPs by specialist colleagues as a key challenge for family medicine and suggested that these relationships are in trouble. The lack of venues where FPs can meet and develop relationships with specialists might contribute to isolation and subsequently the lack of understanding of each other's role in the system. The need to develop relationships between FPs and specialists is supported by a qualitative study of Dutch general practitioners, who identified the development of personal relationships as being their primary motive to initiate and sustain new models of collaboration with specialists.[15]

Family physicians described a negative attitude toward the discipline of family medicine, including a lack of recognition of their expertise. Suggestions to improve this perception included promoting the discipline as a specialty. This suggestion, however, might not make family medicine a more desired discipline. Since the American Board of Medical Specialists designated family medicine as a specialty 50 years ago, the proportion of FPs in the United States has actually decreased.[4,16] The problem might not result from a lack of recognition of family medicine as a specialty, but rather a lack of understanding and recognition of the importance of FPs to the health care system. Studies have demonstrated the positive effects that primary care providers, including FPs, have on population health.[17,18] For example, lower mortality was associated with increased primary care compared with specialist care.[18]

There might be a hierarchical status structure of physicians in Canada, which could cause asymmetry between how specialists and FPs are valued and perceived. In a qualitative study, specialists in the Netherlands confirmed that they neither felt they had anything to learn from GPs nor considered GPs to be their equals.[19] A number of these specialists also believed GPs and their patients regarded specialists as having a higher status.[19] It could be worthwhile to further explore physician status and societal values, and address inequities.

Universities and medical schools can play a strong role in dealing with FP shortages and the declining popularity of family practice among medical students. The proportion of medical students choosing family medicine fell from 40% in the early 1990s to less than 28% by 2001 as more students decided to pursue specialty careers.[20] Studies from the United States show that badmouthing or bashing among disciplines in medicine has a lasting effect on students.[3,4] The profession, through its governing bodies, associations, and teaching institutions, would do well to address and end this negative, disrespectful behaviour.

Our study suggests that positive and realistic FP role models are needed. Learning environments are also important. Students need to develop skills to perform well in the environment in which they will practise. Family physicians describe the importance of exposing learners to a milieu in which FPs and other specialists interact. Family physicians need to review and study the influence that various learning environments have on students.

Conclusion

This is the first Canadian study to identify and examine the issue of respect between FPs and their specialist colleagues. It identified meaningful and important information that will resonate with many medical practitioners, both specialists and FPs. More research is required to further elucidate these concerns and verify the findings.

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Contributors

All authors contributed to the conception and design of the study, which was conceived by **Dr Manca**. All authors contributed to the development of questionnaires and the analysis and interpretation of the data. **Dr Manca** organized the meeting of the investigators. **Dr Manca** wrote the article with assistance from **Dr Varnhagen** and **Dr Brett-MacLean,** and **Dr Allan** and **Ms Szafran** critically revised the article. **Dr Allan** performed the literature review. All authors reviewed and approved the manuscript for publication.

Competing interests

None declared

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