Turbulent times

Francine Lemire MD CM CCFP FCFP CAE, EXECUTIVE DIRECTOR AND CHIEF EXECUTIVE OFFICER

Dear Colleagues,

It is with trepidation that I wade into some difficult waters surrounding family doctors in many parts of our country. In Quebec, the introduction of Bill 20 could mean FPs would have mandatory minimum quotas for rostered patients, hours worked, and follow-up by the same providers, and potential for clawbacks on income. In Ontario, a recent rupture in negotiations with government is likely demoralizing the medical profession, with cutbacks in income and a hold on expansion of new models of care in family practice. In British Columbia, a project is under way linking privileges to demonstration of ongoing competence. While this is a goal we can all support, there are concerns about the lack of evidence for an objective demonstration of ongoing competence, and about unintended consequences, particularly in rural and remote areas of the province.

It is not my intent to pass judgment on government approaches or the response of the medical profession to all this. One must avoid, if at all possible, contributing to divisions among the parties. Negotiated settlements must be left in the hands of our colleagues in provincial medical associations and decision makers in government. However, this does not mean the CFPC and its provincial Chapters should be silent. Much is at stake, particularly related to the provision of high-quality care for Canadians. What can be learned and what can inform our positioning?

There are approximately 40 000 FPs in Canada—59% engaged in continuing comprehensive care and 31% with areas of special interest in certain domains, most of them relevant to family practice. They are increasingly likely to work in group and interprofessional practices (only 15% practise solo) and are most often paid through a blend of remuneration methods, with fee-for-service remaining the biggest individual source.[1] We have welcomed increases in the number of family medicine residency positions and innovations in the organization of primary care and family practice (eg, family health teams).

With so much investment in renewal, why does Canada consistently rank at the bottom of Organisation for Economic Co-operation and Development countries in terms of same-day or urgent access to primary care, after-hours care, and wait times? The complexity of our patients is an important factor, some say; the reality of our situation is not well captured by the data, others argue. Perhaps. But are we the only FPs seeing complex patients? Are the data wrong for us and not for others? There has been a decline in the respect Canadians have for physicians, according to an Ipsos poll conducted for the Canadian Medical Association.[2]

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We must reflect at the individual, practice, and system levels.

Two enablers have been shown to strengthen primary care when consistently implemented: teams and electronic medical records (EMRs).[3] Well integrated, interprofessional and intraprofessional delivery of health care is good for patients and providers; and although many have experienced frustration with the implementation of EMRs, most of us would not go back to paper records; EMRs can facilitate interprofessional care and quality improvement initiatives, and help us better address patient safety.

Two other factors also correlate positively with high-quality care: clarity of purpose and alignment between decision makers and providers about priorities and goals of care (in particular, a deliberate intent to provide patient-centred care) and financing of the health care system and remuneration of providers that supports priorities of care.[3]

Another potential enabler is the Patient's Medical Home concept. Several innovative models in Canada are based on the Patient's Medical Home. Early results of the implementation of this model include increased satisfaction of patients and providers, decreased emergency department and after-hours visits, better management of chronic disease, and more sustained adherence to treatment plans.[4]

Many practitioners now play academic roles in teaching or research. It will be important to sustain engagement of community preceptors, and all teachers must invest in becoming better at what they do. Appropriate allowance and recognition are needed to sustain academic mandates and support research to affirm the maturity of our discipline.

A word about volume versus value: Complex patients might indeed require more time. However, true teamwork should facilitate addressing patient needs while still enabling providers to provide care and see a reasonable number of patients every day.

So, what should our top care-delivery priorities in family practice be? A sincere, respectful dialogue and, hopefully, consensus between decision makers and providers is a sine qua non in order to reach an agreement. Ensuring access, facilitating attachment to an FP working collaboratively with other providers, and supporting continuous quality improvement and patient engagement should be given due consideration. They would positively contribute to better health, better care, and, ultimately, lower costs.

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References

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