# Legislating away the future of family practice

## *Dangerous transition from continuity of care to continuous access*

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There is a trend spreading across the country that threatens to redefine the practice of medicine in general, and family practice in particular. For various political reasons, professional medical colleges in several provinces have made changes to the definitions of *professional responsibility*—changes that threaten to redefine one of the fundamental tenets of family medicine: continuity of care. With these subtle changes doctors become responsible for something much different: continuous access to health care for patients. Family physicians have been responding with variable success. I believe it is because family physicians are having a hard time differentiating the subtleties of the small but critical differences.

Continuity of care is a fundamental principle of family practice and it forms the bedrock of the physician-patient relationship. *Continuity of care* refers to both the ongoing professional relationship between a physician and a patient over time and the concept of ongoing guidance of patient care as the patient transits through various health care services. Both are important to maximizing the efficiencies of health and disease management. Although purportedly trying to address perceived weaknesses in the application of the second definition, the proposed changes morph the altruistic ideals at the base of both facets into something continuity was never intended to be: continuous responsibility for a patient.

### Changing tide

Colleges in the provinces of British Columbia,[1] Manitoba,[2] and Alberta[3] have made a transition from previous professional codes of conduct requiring physicians to notify patients of local availability of after-hours medical care to a more sinister interpretation that "Each physician must ensure that medical care is continuously available to the patient in his or her medical practice."[2]

Most physicians agree that access to health care is indeed a critical issue, but most of us do not pretend that each of our patients has continuous access to us as individuals. I do not believe it is the responsibility of an individual physician, nor indeed a group of physicians, to ensure that every patient that has ever walked through the door will never want for health access for the rest of his or her life. I am not sure how that fits anyone's definition of *professionalism*, but I do not know of any other profession that would consider such a responsibility.

Although British Columbia and Manitoba policies specified that this policy applies to all physicians regardless of location, specialty, or type of practice, Alberta has limited its policy to "A physician whose practice includes established physician-patient relationships."[3] The reality is that, with all of these policies, most of this onus will fall on family physicians and a very few other specialists with similar ongoing relationships. Although some patients who recently received care from a non–family physician specialist might seek his or her help for a directly related problem, most patients prefer to talk to their family physicians, even about advice or treatments they have received from other specialists.

### Locus of responsibility

The practice of medicine has always had to adapt service to the demands of society and health systems, but professional behaviour has been guarded by traditionally sound principles. Changes should be carefully thought out, and their full effect carefully considered. I believe the current changes threaten to undermine both the traditional and the practical definition of *primary care medicine.* They blur the distinction between individual professional responsibility to continuity in the physician-patient relationship and the responsibility of a health care system to provide a full range of after-hours care to patients.

In my view, there is no medical condition at 2:00 AM that warrants being called a primary care problem. If a patient is sufficiently concerned about a problem at 2:00 AM to seek medical help, it is an emergent problem. The ultimate diagnosis or disposition of that problem is irrelevant. Shifts in patterns of those who seek out-of-hours help and the reasons for their behaviour are a genuine concern for the health system, but such behaviour shifts cannot be resolved by simply relabeling them as continuity of care. The rapid growth of urgent-care centres and emergency-like centres on both sides of the border in North America reflects the rising importance of *convenience care* to consumers[4] and speaks to the complexity of the problem.

The danger of these changes to the physician-patient relationship is that it places responsibility entirely on

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one side—the physician side. As a physician it is my responsibility to provide medical advice to patients and to recommend tests or medications that help the patient make good health and treatment choices. A patient also accepts responsibility: the responsibility to seek help appropriately, to undertake testing as agreed upon, to follow agreed-upon treatment regimens, etc, and to follow up as needed. For this service, they (or their insurer) agree to pay me for my expertise and time. I do not own patients, and they do not own me. We agree to cooperate for the betterment of their health. In fact, I think if you asked, most patients would not see round-the-clock availability as part of the expectation they have of their family physicians.

Providing adequate access to health care services for patients is a vast, multifaceted problem, not just a physician problem. It requires commitment from many partners within the health care system. Various system resources need to be available including staffed emergency services, functional data management systems (for access to testing results, medication histories, etc), and reporting mechanisms that support both physicians and patients. We see from the crowding in emergency departments across the country that such services are not meeting demand. Data systems are just beginning to become effective enough to be useful.

## Unintended consequences

It is understandable that family practice would be targeted to resolve some of the access issues and other problems in the system. The value of family practice and continuity of care has been demonstrated repeatedly in the literature.[5,6] It is well demonstrated that patients who make the effort to receive care in a longitudinal fashion from a physician who knows them well will receive more efficient care, will cost the system less money, and will be happier with the care they receive. Of course I can care for my patient Mrs Jones more efficiently at 2:00 AM than a physician who does not know her, and if I only had Mrs Jones to care for, I would be more than happy to do it. The problem, of course, is that I have 1500 Mrs Joneses and only 1 of me. I also have pesky needs for things like sleep, food, and time with my family.

Most of these policies recommend that physicians form groups to cover after-hours care and also require that they make arrangements with local emergency services, etc, in a more formal way than before. These requirements are not practical and can quickly become unmanageable. Forced into such arrangements, physicians of course will aim for self-preservation by developing large groups for coverage. Improved data access and reporting could assist with continuity in such groups, but the advantages to the patient are quickly lost when a single physician is covering, say, 15000 patients (10 average-sized doctor practices). While this might initially be seen to reduce the load on emergency services, it dramatically increases the load on family doctors. In many areas the anticipated reduction in demand on emergency departments and related services might actually be the opposite. Unless family physicians and the networks they develop are able to build more infrastructure, things such as off-hours laboratory and diagnostic imaging services in many centres might only be available through emergency departments and hospitals. This paradoxically results in increased pressure in the emergency department as community family physicians try to access the same limited resources for their community patients as emergency physicians need for emergency patients.

I believe many long-term financial and practical implications have not been adequately considered. There will be considerable time, cost, and legal responsibilities that will accompany such policies. Payment mechanisms in many provinces do not currently cover the mandated after-hours activities. Legal ramifications have been inadequately considered. Professional colleges have the ability to sanction or suspend physicians who do not meet these new obligations,[7] but what about patients? Would they be able to sue if they perceived that their physicians had not met their expectations for access?

A more fundamental consideration is the harm to a primary care environment that has successfully been building across North America and elsewhere for the past 2 decades. Primary care has made great strides toward improving not only access but also integration of care for many Canadians. We already share many of the ideals that have motivated these policies. In addition, many provinces have developed support structures and networks around community family physicians to enhance and integrate longitudinal patient care in a variety of practice settings. We need to be careful that these structures are not jeopardized by these policy changes.

Adoption of these policies essentially spells the end of solo practice as a viable practice model. A single physician cannot meet these requirements without help. The policies are especially punishing to small rural practices. These physicians already work beyond any typical workplace safety standards to try to meet the needs of their communities. By strictly applying the criteria espoused in all versions of this policy, a small-town physician, if unable to find locum coverage, would be unable to leave town ... ever! Rural locums are difficult to find, and there are currently no exemptions in the college policies for such situations. Who would ever set up practice in a small town knowing they might never be able to leave? The same could apply to single regional specialists.

I believe that in the long run these policies will backfire. Only recently has graduate placement into primary care residency positions begun to approach the

sustained need for family doctors. The increased workload, expanded administrative load, and after-hours time demands established by these changes will discourage new graduates from entering the field and could sink a resource that is already stretched beyond capacity. Physicians will be tempted to avoid family practice or, worse yet, family physicians will abandon continuity of care in favour of convenient care to avoid the quagmire of requirements tied to providing continuous patient access. Over time a progressive shortage of family doctors will cause the weight of these responsibilities to spiral out of control, and we will be left worse off than when we started.

## Physicians take action

Concerned physicians have already started to raise the cry and effect meaningful change. Action by physician groups in Manitoba successfully convinced the College of Physicians and Surgeons of Manitoba (CPSM) to delay implementation of its Statement 190 and form a multilateral working group to address the concerns. The CPSM ultimately accepted the group's recommendation to rescind the policy.[8] The CPSM will continue to work with physicians to craft more appropriate solutions to address the dual problems of after-hours access and continuity of care.

In Alberta, the Representative Forum of the Alberta Medical Association has passed motions in each of the last 3 semiannual meetings urging the College of Physicians and Surgeons of Alberta to undertake a similar dialogue and policy change, but thus far the college has refused.

## Working together

As family physicians, we need to speak up and help regulatory bodies see the destructive end of these policies. We need to work with policy makers to develop solutions that recognize the critical difference between a balanced professional responsibility to continuity of care and the much broader system responsibility of access to care. Every Canadian deserves timely access to health care, but not by legislating family doctors into a life of perpetual servitude.

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**Competing interests**
None declared

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