"Meet and greets" in family practice

Who, why, and to what end?

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Abstract

Objective To understand physician acceptance of new patients, specifically the use of "meet and greets"; and to explore FPs' rationale, beliefs, and processes regarding these appointments.

Design Exploratory qualitative interviews.

Setting Nova Scotia.

Participants A purposive sample of 12 FPs who had previously participated in the Models and Access to Primary Care Providers in Nova Scotia study.

Methods In-depth, semistructured, 1-on-1 qualitative interviews. Interview transcripts were coded using Atlas.ti and analyzed for typologies and common themes regarding accepting practices.

Main findings Four typologies of accepting practices emerged: no form of meet and greet; nonscreening meet and greet to gather a history; meet and greet to assess alignment of patient needs and provider scope; and meet and greet to screen out undesirable patients. Typology 1 was subdivided: accepting first-come, first-served and accepting with previous patient knowledge. Rationale for each varied. Family physicians employing typologies 1 and 2 emphasized the importance of equitable access to primary care. Family physicians employing typologies 3 and 4 highlighted the challenges of meeting the needs of specific populations within the context of professional and systemic constraints.

Conclusion Meet and greets before accepting new patients are purposed differently across providers. Some FPs incorporate these meetings ethically; others present challenges to the principles of equity and nondiscrimination. Policy implications exist for how providers admit new patients and what resources might support more equitable access.

Editor's key points

- The Canadian Medical Association mandates that physicians accept new patients in a fair and equitable manner, yet some individuals seeking FPs have reported practices where providers meet with them to collect a thorough history, then appear to accept or decline them based on this "meet and greet."
- Previous research indicated that about half of FPs in Nova Scotia will accept new patients either unconditionally or with conditions or exceptions, and of those physicians, nearly half require meet and greets. This qualitative study aimed to enhance understanding of the purpose, goals, and outcomes of meet and greets from the perspective of FPs in Nova Scotia.
- While meet and greets are a common practice in Nova Scotia, and likely other jurisdictions, this initial investigation suggests that the motivation behind them is complex. Economic burden and professional burnout factor into the decision to tailor one's practice. However, meet and greets might have a disproportionately negative effect on patients who require the most care, potentially further disadvantaging vulnerable populations. Additionally, cherry picking patients shunts the burden of complex and time-consuming care to physicians who are not participating in screening processes.

Points de repère du rédacteur

- L'Association médicale canadienne impose que les médecins acceptent de nouveaux patients de manière juste et équitable, et pourtant, certaines personnes en quête d'un MF ont signalé des pratiques selon lesquelles les médecins les rencontraient pour effectuer une anamnèse en profondeur, puis semblaient les accepter ou les refuser en se basant sur ces rencontres d'accueil.
- Des recherches antérieures ont indiqué qu'environ la moitié des MF en Nouvelle-Écosse accepteront de nouveaux patients, soit inconditionnellement, ou en fonction de certaines conditions ou exceptions, et parmi ces médecins, près de la moitié exigent une rencontre d'accueil. Cette étude qualitative avait pour but de mieux comprendre la raison d'être, les objectifs et les résultats de ces rencontres du point de vue de médecins de famille en Nouvelle-Écosse.
- Même si les rencontres d'accueil sont une pratique courante en Nouvelle-Écosse et probablement dans d'autres régions, cette investigation initiale porte à croire que la motivation sous-jacente est complexe. Le fardeau économique et l'épuisement professionnel sont pris en compte dans la décision de définir sa propre pratique. Par ailleurs, les rencontres d'accueil pourraient avoir des effets négatifs disproportionnés sur les patients qui ont le plus besoin de soins, et peut-être désavantager encore plus les populations vulnérables. En outre, l'acceptation sélective des patients fait porter le fardeau des cas complexes et qui demandent beaucoup de temps sur les épaules de médecins qui ne procèdent pas à des processus de sélection.

Les rencontres d'accueil en pratique familiale

Qui, pourquoi et à quelles fins ?

Victoria Smith MHA MD Emily Gard Marshall PhD

Résumé

Objectif Comprendre la façon dont les médecins acceptent de nouveaux patients, plus précisément l'utilisation de rencontres d'accueil, et explorer la justification, les croyances et les processus entourant ces rendez-vous selon les MF.

Type d'étude Des entrevues qualitatives exploratoires.

Contexte La Nouvelle-Écosse.

Participants Un échantillonnage choisi à dessein de 12 MF qui avaient participé antérieurement à l'étude sur les modèles et l'accès aux professionnels des soins primaires en Nouvelle-Écosse.

Méthodes Des entrevues qualitatives en profondeur et semi-structurées sur une base bilatérale. La transcription des entrevues était codée au moyen d'Atlas.ti, et analysée pour dégager les typologies et les thèmes communs concernant les modalités d'acceptation.

Principales constatations Nous avons cerné 4 typologies de modalités d'acceptation : aucune forme de rencontre d'accueil; une rencontre d'accueil aux fins d'une anamnèse sans intention de sélection; une rencontre d'accueil pour évaluer la concordance entre les besoins du patient et la portée de la pratique du médecin; une rencontre d'accueil pour écarter les patients indésirables. La typologie 1 a été subdivisée : l'acceptation du premier arrivé, premier servi, et l'acceptation de patients déjà connus. La justification variait pour chaque catégorie. Les médecins de famille qui employaient la typologie 1 et 2 ont insisté sur l'importance d'un accès équitable aux soins primaires. Les médecins de famille qui utilisaient les typologies 3 et 4 ont mis en évidence les défis de répondre aux besoins de populations particulières dans le contexte de contraintes professionnelles et systémiques.

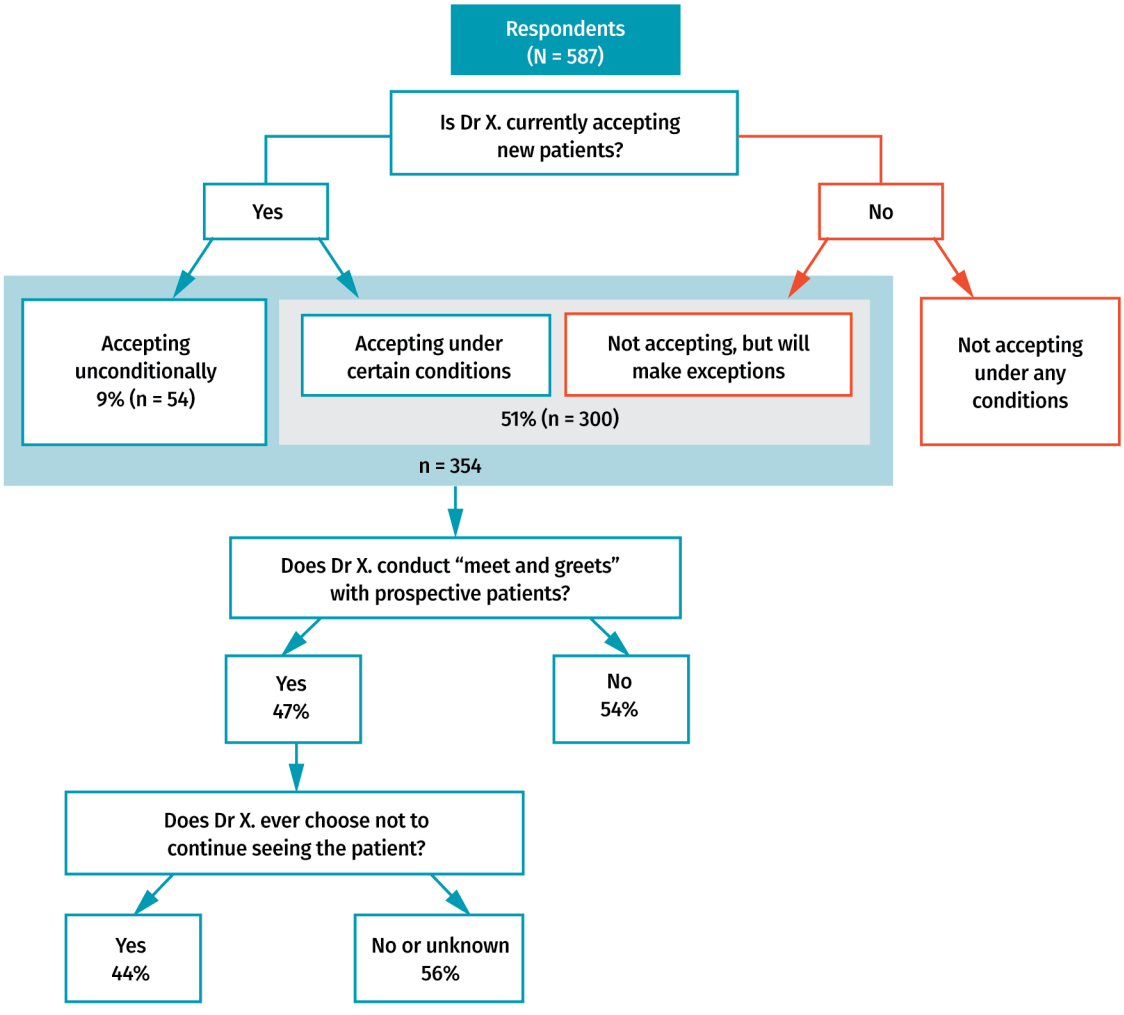
Conclusion Les rencontres d'accueil avant d'accepter de nouveaux patients ne sont pas motivées par les mêmes raisons chez tous les médecins. Certains MF procèdent à ces rencontres de manière éthique, alors que d'autres remettent en cause les principes de l'équité et de la non-discrimination. La façon dont les médecins acceptent de nouveaux patients et les ressources susceptibles de favoriser un accès plus équitable ont des implications sur le plan des politiques.

Primary care is the main point of entry into the Canadian health care system. The Canadian Medical Association mandates that physicians accept new patients in a fair and equitable manner.[1] Many provincial colleges of physicians and surgeons support this through policy statements recommending physicians accept patients on a "first-come, first-served" basis.[2-4] Despite these policies, individuals seeking FPs have reported practices where providers meet with them to collect a thorough history, then appear to accept or decline them based on the "meeting."[5] These initial meetings are often referred to as "meet and greets."

Meet and greets can be used for information exchange, to facilitate the formation of a patient-provider relationship, and to ensure the patient's needs fall within the provider's scope of practice. However, meet and greets can potentially be abused as unethical screening tools to identify preferable patients. These practices have been colloquially referred to as "cherry picking"—accepting "easy" patients into practice—or "lemon dropping"—denying more "challenging" patients.[6]

Previously published findings from the Models and Access to Primary Care Providers in Nova Scotia (MAAP-NS) study describe the prevalence of meet and greets in Nova Scotia.[7] Eighty-four percent (n = 587) of FPs in the province participated in the study. Of those, less than 10% were accepting new patients unconditionally. Several physicians stated that they accepted new patients, but only under certain conditions—such as pregnancy—while those who were not accepting new patients noted that they made exceptions. Thus, 354 FPs (about 51%) will accept new patients either unconditionally or with conditions or exceptions. Interestingly, of this cohort, nearly half (47%, n = 166) said they required a meet and greet before initiating a therapeutic relationship. Furthermore, as many as half of the providers conducting meet and greets reported at least once discontinuing seeing a potential new patient following this interview.[7] **Figure 1** illustrates these acceptance practices.[7]

Figure 1. Patient acceptance practices in Nova Scotia



Data from the Models and Access to Primary Care Providers in Nova Scotia study.[7]

While screening patients can be viewed as unethical, it is also in direct contravention of the policy statements of several provincial colleges of physicians and surgeons and the Canada Health Act.[2,4,8-10] In 2017, Statistics Canada estimated that 13.1% of Nova Scotia residents older than 12 years of age did not have access to a regular FP.[11] The low numbers of FPs accepting patients, coupled with the concurrent proportion of unattached patients, adds to the importance of understanding the decision-making practices related to patient attachment to a regular FP.

Given how little is known about meet and greets and the potential for them to be used for, or perceived as, a screening mechanism, further exploratory investigation is warranted. This study seeks to enhance understanding of the purpose, goals, and outcomes of meet and greets from the perspective of FPs.

Methods

An exploratory qualitative description study design[12] was employed to guide our focused inquiry of meet and greets in family practice. Qualitative description is the method of choice when straight descriptions of a phenomenon are desired—in this case, the phenomenon of meet and greets.[12] One author, V.S., who was a master's-prepared medical student at the time, conducted in-depth, 1-on-1 interviews with 12 FPs. Her qualitative interview experience also came from previous work as an interviewer in a national mixed-methods study funded by the Government of Canada,[13] and was further supplemented by discussion with the experienced supervising co-author (E.G.M.). A semistructured interview guide was used to uncover the nuances of meet and greets (available on request). Only FPs who had previously participated in the MAAP-NS study and had consented to being contacted for follow-up research were approached. Use of data from the MAAP-NS study facilitated a purposive sampling strategy to target potential key informants and maximize variability, as is appropriate for qualitative description design,[12] with respect to provider sex, years in practice, and use of meet and greets in practice. Saturation, a process by which the investigators agreed that no new narratives were emerging, was achieved after 10 interviews; 2 additional interviews, for a total of 12, confirmed saturation.

Interviews were audiorecorded and transcribed verbatim. The authors used qualitative data analysis software (Atlas.ti) to independently code transcripts for emerging themes. Through successive meetings, consensus was reached on the typologies and common themes.

Ethics approval was received from the Nova Scotia Health Authority.

Findings

Study participants were all practising FPs in Nova Scotia at the time of the interviews. Two-thirds (n = 8) of participants were women. Years in practice ranged from 3 to more than 35. One-third (n = 4) of participants were remunerated via alternative funding plans and the remaining were paid by fee-for-service. One participant was from a rural area. Seven participants reported using meet and greets during the MAAP-NS survey, although qualitative inquiry revealed nuance to this. Demographic characteristics of participants can be found in **Table 1**.[7]

Conversations with FPs revealed that while the phrase *meet and greet* is familiar, there is no common definition and the term applies to a variety of practices with potential new patients. While some providers use meet and greets in practice, the purpose differs. Each of our participants fell into 1 of 4 mutually exclusive typologies with respect to meet and greets, which are discussed in detail below. **Table 2** provides quotations illustrating the typologies.

Typologies

Typology 1—no meet and greet. These FPs do not use meet and greets when accepting new patients. They report deciding at the time of request whether they can accept new patients based on their current personal and professional burden. Some cited ethical considerations such as "cherry picking" and discrimination as reasons for not using meet and greets. Some interviewees discussed the ineffectiveness of meet and greets as

Table 1. Participant characteristics: *N = 12.*

CHARACTERISTIC	N
Sex	
• Male	4
• Female	8
Years in practice	
• ≤ 10	1
• 11-20	5
• 21-30	4
• >30	2
Remuneration model	
• Fee-for-service	8
• Alternative funding plan	4
Conducts meet and greets?*	
• Yes	7
• No	5
Meet and greet typology	
• Typology 1	4
• Typology 2	4
• Typology 3	2
• Typology 4	2

*According to Models and Access to Primary Care Providers in Nova Scotia study response.[7]

Table 2. Examples from each typology

TYPOLOGY	QUOTATION
$T1_A$	• "We are there to service a community; we should not be screening the practice to suit our needs" (P265) • "I don't personally hold meet and greet interviews for a couple reasons. One, because I think it may lead to the impression that I'm actually interviewing the patients to see whether I will accept them or not, and that's not the case. Once I've said I'll take them regardless of what they tell me in that interview, they're my patient as far as I'm concerned .... I think a lot of physicians have gotten into trouble practising meet and greets and I think a lot of patients have been left feeling unclear, unsure, and hurt by, kind of, outcomes from that. So, I don't practise that" (P211) • "I think it'd be pretty hard to select who you might perceive might be the best patients for you anyway based on an interview, and probably wastes a lot of time" (P444)
$T1_B$	• "Well, maybe I prescreen them, I guess .... I mean I obviously don't offer everybody I see in emerg[ency] who doesn't have a doctor to be in my practice. There's a whack of people who obviously need it .... If they have addiction issues, I honestly probably wouldn't because they usually lose their doctors because the doctor doesn't prescribe or something. So, I'll let them continue to kind of visit emerg[ency] for their chronic pain or something for which their narcotics may or may not be suitable" (P229)
T2	• "I would just book a meet and greet appointment and go through, you know, the whole history, the past medical history, medications, allergies, family history, social history, and any issues for the current visit. So, pretty informal" (P304) • "If they meet me and they don't like me, I mean that's pretty easy, they shouldn't be my patient .... And if they kind of start looking uncomfortable, I say, 'Well, you know, the relationship is important. And if you don't like me, that's okay. You know, I will always take you on, but if you don't like me, you have absolutely every right to leave. And please, don't feel bad about it'" (P360)
T3	• "I do a meet and greet. But that's basically to see if there are patients that I just can't address their needs .... I don't do psychotherapy ... I don't do a lot of chronic pain management" (P370)
T4	• "When asked to take on new patients, I don't need anybody else who's going to dominate a lot of time because my time is getting more and more limited" (P494)

a screening tool, while others did not want to be perceived as screening patients. Two subtypes exist within typology 1.

Subtype 1_A—accepting first-come, first-served: When a provider's practice is open, they accept patients on a first-come, first-served basis, with no prior knowledge of the patients. No participants had an open practice, but nearly all interviewees using typologies 1 and 2 used this approach to initially build their practices. Interviewees noted they would make exceptions to their "closed practice" for family members of current patients—a practice supported by the College of Physicians and Surgeons of Nova Scotia (CPSNS).[2]

Subtype 1_B—accepting with prior patient knowledge: Sometimes, despite having a "closed" practice, interviewees still accept new patients on an ad hoc basis depending on the medical concern or referral source. Examples include patients in need of prenatal care, patients whose FP recently retired or passed away, Francophone patients (when the provider is also Francophone), or patients referred from colleagues.

Typology 2—meet and greet to gather medical history. Typology 2 FPs use meet and greets at the outset of the patient-provider relationship, but only after accepting the patient into practice. These meetings are used to collect a history, initiate a rapport between patient and provider, and familiarize the patient with the care team and practice policies. Some providers noted that if there was an active medical issue at hand, the meet and greet would occur during the patient's first appointment. Typology 2 providers highlight similar themes regarding equity and lack of discrimination in accepting patients as those in typology 1. They emphasize that the purpose of meet and greets is entirely informative and does not affect the patient's acceptance. However, several highlighted that this initial meeting allows patients to decide if they are comfortable with the practice model and care goals, and whether they want to continue a patient-provider relationship.

Typology 3—meet and greet to assess alignment of patient needs and provider scope. These FPs describe meeting with prospective patients to discuss the scope and limitations of their practice before accepting them as patients. They assess patient needs to evaluate suitability of the potential patient-provider relationship. Some providers use this time to tell patients they do not offer certain services.

Typology 4—meet and greet to screen out undesirable patients. These FPs use meet and greets to screen out "undesirable patients." Providers meet with patients to learn their medical needs and decide whether to accept

them into practice. Undesirable patients were those perceived to be "doctor shopping," opioid seeking, having difficult personalities, or requiring complex care. Some providers highlighted their desire for professional autonomy as a reason for interviewing patients. Colleagues employing typologies 1 and 2 corroborated the challenges associated with these patients, although they emphasized that patients with complex issues are often the most in need of care and, as such, screening them out of practices is discriminatory and detrimental to their health.

Cross-cutting themes

Three cross-cutting themes exist among practitioners regardless of the typology they subscribe to: ethics of practice, compromises of practice, and freedom of practice. These themes are illustrated in **Table 3**.

Ethics of practice was discussed among interviewees using typologies 1, 2, and 3. Providers describe not only the impact on the patient who might be screened out, but also professional standards and access issues that might arise within the health care system secondary to employing screening meet and greets. Providers using typology 4 did not mention ethical principles in relation to meet and greets.

All interviewees discussed compromises of practice associated with the burdens of accepting certain patient types and remuneration models. These burdens incentivize some providers to restrict entry to their practices. Other providers compromise financial gain to ensure access for patients. Antiquated billing codes and fee-for-service remuneration were identified as motives for screening patients, as they do not appropriately compensate for the time and effort often demanded by complex patients. Providers note maintaining accessibility for current patients, striving for work-life balance, and having capacity to financially sustain their practices as challenges in serving an increasing number of complex patients. Some suggest that providing equitable, high-quality care and earning appropriate compensation are mutually exclusive.

Participants discussed empowerment, or freedom of practice, in their practice decisions, including how they accept new patients, and their practice scope and limitations. This privilege of choice is considered a unique aspect of family practice and a selling feature of the profession used to recruit new physicians. This might result in a disservice to equity and access in care, as providers feel entitled to this privilege.

Discussion

Typology 1 FPs highlight ethical issues associated with selecting patients and a desire to serve all patient populations regardless of the associated challenges. Some providers consider meet and greets futile owing to the inability to predict who will become "undesirable." We posit that typology 1_A represents the acceptance practice with the fewest ethical problems,[7] as practices are either open or closed irrespective of patient history. We speculate that typology 1_B has the potential to be used as an indirect screening method, as patient information could inform acceptance decisions. Providers themselves identified this ethical hiccup when analyzing their acceptance practices.

Typology 2 FPs use meet and greets solely for welcoming patients, familiarizing them with the practice, and collecting a history. It is possible that meet and greets may facilitate a strong patient-provider relationship and better prepare physicians for the needs of their new patients. However, regardless of intent, patients might be intimidated by this initial appointment.[10] Thus, it is important providers clarify that patients have already been accepted when inviting them for this appointment.

Typology 3 represents an ethical challenge and conflicts with the policies and guidelines of several colleges of physicians and surgeons. These stipulate that scope of practice limitations are permissible grounds for restricting patient entry to practice; however, these limitations should be communicated to patients *before* conducting any meetings with them.[1,3,4,9] Thus, meet and greets to assess the "fit" between providers and patients should not be occurring in Nova Scotia, and providers with scope of practice limitations should delineate these to all prospective patients before arranging an introductory appointment, as per CPSNS guidelines.[2] Greater transparency around their practice scope and timely provision of this information to prospective patients could prevent these physicians from being perceived as discriminatory, regardless of intent. Furthermore, the CPSNS states that when a physician's scope of practice limits their ability to meet patient needs, it is their duty to refer to another provider. Only 1 interviewee cited doing so.

It is appropriate to conclude that typology 4 FPs are acting in direct contravention of the minimum ethical and professional behaviour expected of physicians, given the explicit standards outlined by the CPSNS and the Canada Health Act. Typology 4 FPs suggest time constraints, increasingly complex patients, and preserving their own well-being as the motivators for cherry picking patients.

Most providers describe the influence of ethical considerations on accepting practices, and all identify challenges that could pressure a provider to modify these practices. We posit that most meet and greets evolved not to screen out challenging patients simply for ease of practice, but as a means for physicians to continue providing high-quality care within the context of systemic limitations and financial burdens. While there is no acceptable reason for discriminating against patients, developing an understanding of the root causes of this

Table 3. Cross-cutting themes

THEME	TYPOLOGY	QUOTATION
Ethics of practice	T1	• "We put out one ad in a local newspaper that I was accepting patients. And then I filled. And I didn't really screen people. Like, you know, anybody who wanted to come see me, could come see me. You know, I don't think it's right to cherry pick, so I didn't sort of rule anyone out" (P360)
	T2	• "Well, I mean, I think it's kind of elitist .... I don't like it personally. I think you gotta [sic] be, I mean, you can't just cherry pick your patients; you gotta [sic] take what comes through the door. I've never done that in 35 years ... if you accept a new patient and ... find out, say, after you interview them, you say 'Oh well, just because you have an opiate problem, then you can't be mine anymore.' That would be, personally, I just don't think that's proper ethical" (P444)
	T3	• "I would look to see how far in advance am I booking. And so, it's a self-stipulated rule. And so, someone that has major, major, multiple morbidities ... they have to realize that I'm only there that time, are they comfortable, and then it's a process where for me is it ethically, morally, am I gonna [sic] give them the service that I would want myself? And so that's when we decide" (P241)
Compromises of practice	T1	• "Well, those patients that I see that usually get turned down, are a lot more complicated medically. Like they might have hep[atitis] C, which a lot of family doctors aren't very well trained in. They usually have 1 or more psychiatric diagnoses along with addictions, so they take a lot longer than a regular 15-minute appointment. I'm really lucky because I'm salaried; I can book them in for a half hour or even 45 minutes if I need to. The only problem with my accessibility is my wait time. But, so for most docs that are fee-for-service, they're like losing money by taking this patient, but it's also a bit of a headache, you know; you're worrying about them drug seeking, and a lot of times they can be a bit abusive or belligerent, and so, it's not your ideal patient" (P365)
	T2	• "Community physicians are exceptionally busy. They are carrying large loads, and to, you know, to do that in a very isolated kind of setting in a fee-for-service environment I don't think, necessarily, I mean it creates these challenges in which they are kind of feeling pressed to limit the number of, you know, narcotic seekers, or the number of borderline personalities, or the numbers of, you know, whatnot. And so, I do get why they're doing that. But I think that if we try to address some of the other factors, I mean, family doctors are not going into family medicine to make money. It doesn't happen. They are very rare exceptions when somebody is, you know, abusing the system financially. I think it's just, it's the pressures of trying to cope through the day" (P265)
	T3	• "Primary care doesn't pay very well. Especially if you try to do it well ... and I think the new physicians are insisting upon doing care well .... And they're not willing to get on that treadmill of seeing 8 or 10 patients an hour. And so, the current, the current situation financially drives doctors to become more of a churning process" (P370)
	T4	• "So, I think we need to change the way it's remunerated. I stopped doing walk-in clinics because I found it completely degrading. I didn't wanna [sic] see people with 2 days of the sniffles demanding antibiotics. And I do [take] good care of my patients, but I'm very financially penalized for that. But I can sleep at night, and I know I do a good job" (P261)
Freedoms of practice	T1	• "The training for some of the more problematic patients is really limited. Like the training in family medicine residency for addictions is extremely low. And so, they don't know what to do, and so they don't want to take them on" (P365)
	T2	• "Official line is 'I'm not accepting new patients,' but I continue to take, you know, I look after someone who's moved here for prenatal care, well I'm going to take them on, or so-and-so's, you know, partner, now their physician's retiring, now I'll take them on. So, I do take on a small number of new patients, but I don't—and how do I know? I know because I have methods with my electronic medical record to know that I have about 1800 active patients, and I'm a working mother of 2, with my own interests, and I also have an obstetrical practice so I get to the point where I can only—a week or more than that to get a regular appointment with me, so I know I'm at capacity; I know I can't take more" (P304)
	T3	• "Others feel more comfortable seeing certain types and that makes sense. And as you get in practice over the years you see what you gravitate to, or you're better at than other things, OK? I really like the variety in what I do, so I keep my education and knowledge up, as well as I work in a low socioeconomic area and then I work in a university setting so, I like that variety" (P241)
	T4	• "I mean we are independent business people even though we're paid by the government. And I mean this is our job, we wanna [sic] do our job well. But we also want to have a normal life. So, I think docs, it'd be no different; a lawyer, I assume, would have a choice what clients he wants to take, an accountant has a choice what clients he wants to take. I would think that should be consistent with family doctors as well" (P494)

behaviour can inform systemic changes that can better support a climate of equity. Freedom of practice permeated discussion in a way that we posit is unique to family medicine. Non-FP specialists, for example, are not able to screen out complex or challenging patients and cannot close their practices secondary to personal or professional strains. It is worth considering this freedom of choice within a practice model—often presented as a selling feature of the profession—might contribute to a climate of inequity.

The CPSNS suggests that should "introductory meetings" be held after accepting patients into practice (ie, typology 2), it is recommended that physicians advise patients of the purpose of the appointment, not bill for this time, and follow relevant legislation around privacy and documentation.[2] It is unclear whether typology 2 physicians bill for this meeting if medical issues are not addressed. Given that interviews within typologies 3 and 4 should not be occurring, they certainly should not be billed for.

Limitations

The number of participants (N = 12) may be cited as a limitation; however, this is typical for in-depth qualitative inquiry focused on a narrow topic from a small population (Nova Scotia has approximately 1300 FPs, some of whom work in focused practice[14]). The assurance of representation is strengthened by the recruitment strategy facilitated by the principal investigator of the MAAP-NS study, whereby participating FPs had signed a consent form to be contacted for future research. Data from MAAP-NS were used to purposively sample a diverse range of FPs.

Conclusion

To our knowledge, this is the first study to explore FPs' processes and reasons for conducting meet and greets before accepting patients into their practices. We provide novel information that not all meet and greets are equivalent and that defining them solely by their colloquial term may misconstrue parameters of concern.

While meet and greets are a common practice in Nova Scotia, and likely other jurisdictions, this initial investigation suggests that the motivation behind them is complex. Economic burden and professional burnout factor into the decision to tailor one's practice. However, meet and greets might have a disproportionately negative effect on patients who require the most care, potentially further disadvantaging vulnerable populations. Additionally, cherry picking patients shunts the burden of complex and time-consuming care to physicians who are not participating in screening processes. These findings are worrisome when considered in the context of high volumes of unattached patients and few "open" family practices. A clear understanding of the factors influencing the use of these meetings can guide policy interventions to maximize accessibility and provider support. Consultation with front-line physicians regarding practical changes that could be implemented to stymie these unethical practices warrants further investigation in order to benefit both patient access and provider wellness.

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Contributors

Dr Emily Gard Marshall conceptualized and designed the study. **Dr Victoria Smith** recruited participants, conducted the interviews, transcribed most of the interviews, and co-wrote the manuscript with **Dr Emily Gard Marshall.** Both authors reviewed and analyzed the transcripts and approved the final version of the manuscript for submission.

Competing interests

None declared

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References

1. *CMA code of ethics (update 2004).* Ottawa, ON: Canadian Medical Association; 2004.
2. *Professional standard and guidelines regarding accepting new patients.* Bedford, NS: College of Physicians and Surgeons of Nova Scotia; 2016. Available from: **https://cpsns.ns.ca/wp-content/uploads/2017/10/Accepting-New-Patients.pdf**. Accessed 2019 Apr 5.
3. *Accepting new patients.* Toronto, ON: College of Physicians and Surgeons of Ontario; 2017. Available from: **https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Accepting-New-Patients**. Accessed 2019 Apr 5.
4. *Guideline: patient-physician relationships.* Saskatoon, SK: College of Physicians and Surgeons of Saskatchewan; 2016. Available from: **https://www.cps.sk.ca/iMIS/Documents/Legislation/Policies/GUIDELINE%20-%20Patient%20Physician%20Relationships.pdf**. Accessed 2019 Apr 5.
5. McCabe G. The questionable ethics of MDs screening would-be patients. *Hamilton Spectator* 2012 Aug 9. Available from: **https://www.thespec.com/opinion-story/2251685-the-questionable-ethics-of-mds-screening-would-be-patients/**. Accessed 2019 Apr 5.
6. Reese S. *Medscape ethics report 2016: money, romance, and patients.* Cincinnati, OH: Medscape; 2016. Available from: **https://www.medscape.com/features/slideshow/ethics2016-part1**. Accessed 2019 Apr 5.
7. Marshall EG, Ogah I, Lawson B, Gibson RJ, Burge F. 'Meet and greet' intake appointments in primary care: a new pattern of patient intakes? *Fam Pract* 2017;34(6):697-701.
8. *Canada Health Act. R.S.C. 1985 c C-6.* Available from: **https://laws-lois.justice.gc.ca/eng/acts/C-6/page-1.html#h-4**. Accessed 2019 Apr 5.
9. *Patient-practitioner relationships.* Vancouver, BC: College of Physicians and Surgeons of British Columbia; 2018. Available from: **https://www.cpsbc.ca/for-public/faqs/patient-physician-relationships**. Accessed 2019 Apr 5.
10. *Screening potential patients can compromise trust in the profession.* Toronto, ON: College of Physicians and Surgeons of Ontario; 2013.
11. *Has a regular healthcare provider, by age group.* Ottawa, ON: Statistics Canada; 2017. Available from: **https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1310009616&pickMembers%5B0%5D=1.4&pickMembers%5B1%5D=3.1**. Accessed 2019 Apr 5.
12. Sandelowski M. Whatever happened to qualitative description? *Res Nurs Health* 2000;23(4):334-40.
13. Versnel J, Packer T, Weeks LE, Brown J, Godwin M, Hutchinson S, et al. The everyday experience of living with and managing a neurological condition (the LINC study): study design. *BMC Neurol* 2013;13(1):30.
14. *Number of physicians by province/territory and specialty, Canada, 2018.* Ottawa, ON: Canadian Medical Association; 2018. Available from: **https://www.cma.ca/sites/default/files/pdf/Physician%20Data/01-physicians-by-specialty-province-e.pdf**. Accessed 2021 Jun 21.

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