Physicians' Forums ACFP
Regional Visits - June 2008

Visits to regional centres have been both informative and energizing. There are many issues to be addressed and timing is critical in dealing with this mandate. Salient points tend to be similar from one community to the other with some unique considerations related to the demographics and geography of the catchment area.

Section A contains a summary of the discussion at each forum. Section B presents submissions written by family physicians who weren't available to participate in the forum but wanted to share their issues with the College and others.

A. Regional Centres: Summary of Forum Discussions

Aspen – East: Bonnyville

Bonnyville was identified as the central site in the eastern half of the Aspen Health Authority. Participant physicians were all local. Areas of importance identified by this group:

- **Supply of physicians** – estimated that 75% of physicians in NE Alberta are from South Africa. This supply is being seriously curtailed. What is the alternative?
- **Workload and work life balance** (or lack thereof) – stress, burnout, paperwork
- **Political and administrative upheaval** is not making a positive contribution to care or to professional climate. Disruption results in no stability within the system and within the region. The participant physicians' plea was for 'no more administrative changes'. Ironically, the Government announced the formation of the Superboard the next day!
- **Limited autonomy in fiscal management of PCN.** Framework is somewhat inflexible (unable to take charge of cash flow and accumulate surpluses to apply to future program initiatives.)

The challenge of strengthening Family Medicine and making Alberta the destination for family physicians – the preferred place to practice led to discussion of:

- PCNs offer potential to contribute exponentially to work life and professional comfort of the family physician. Maximize the role of the interprofessional team and establish trust among professionals. Need more nurses, not more pay/person e.g. PCN has developed valuable protocols for Chronic Disease Management.... not enough personnel to carry them out.
- Positive support for the Cancer Board. Cancer care is continually improving for patients in the Bonnyville area.
- Home care is an area of concern. System under review.
- Status for family physicians is important to attract the youth. For quality of professional life, "remuneration should be for what we do, not for the number of patients we see." Need to review the remuneration schedule e.g. Chronic Disease Management compensation warrants serious reconsideration (compared

to the remuneration for short visits for patients with minor or self-limiting illnesses.)
- Keep family doctors in family medicine. With attrition, the numbers are dwindling and for the important work of the family physician (such as spending extra time with chronic patients in time of need), the time is just not available. Opportunities abound for overworked FPs to opt out and go to boutique medicine or areas of special interest. These areas are not necessarily aligned with the need to provide comprehensive care to the community.
- There was a concern about the "greying" of Family Doctors in the community; there are few younger FPs in the community.

Important role for the ACFP? Where should the priorities lie?
- First and foremost must be advocacy with the government. 'No one else can do that.'
- College focus on accreditation is clearly the education area that is most valuable at this time.

How to communicate?
- Other than e-mail communication, sessions such as CME and local events like this one are valuable. One suggestion: include spouses. It was agreed that the ideal would be to have local or regional events in the area. Could host a supporting function for spouses and later gather together for dinner, etc.
- Participant feedback forms were completed and found to be positive.

Capital Health: Edmonton

ACFP was invited to speak at the Edmonton Medical Staff meeting at the Misericordia Hospital. There were about 50 physicians attending the meeting; approximately half were family physicians. ACFP issues blended well with the issues of other speakers. Major point of concern for Capital Health FPs was referral frustrations. General attitude toward PCNs is strongly positive with fleeting reference to challenges of dealing with mounting overhead costs. As usual, there was evidence of vital frustrations around paperwork and low numbers of FPs. Darryl LaBuick, AMA President, also spoke at the meeting. It was affirming to present alignment of our two organizations on key issues and messages.

Northern Lights – West: High Level

High Level, Fort Vermilion and the surrounding communities are a long way from the centre of the province and a long way from Fort McMurray, their regional centre. The physicians in that northern area were most appreciative of the opportunity to share the challenges they face and to present feedback that could influence advocacy efforts for FPs. Dr. Linda Smith and I were awed by the dedication and commitment of the local physicians and relieved to know that they have locums (albeit commuting from South Africa!) that offer some positive impact on the difficulties of striving for work life balance in these communities. The major issues were around physician shortages, lack of staff resources, and the challenges of a transient and diverse patient population.

Palliser: Medicine Hat

Medicine Hat is nestled in the far southeast corner of the province and central to the Palliser Health Region. Eight physicians attended to offer the local picture of family

medicine in the area. Several participating physicians have held additional positions of responsibility and influence over time further contributing to the interesting mix of perspectives on the issues. Physicians in this region feel that between elections they are 'forgotten' and abandoned in favour of the big city docs. These are the physicians who need the additional support that their College can offer. Stated **local concerns** included:

- Lack of specialist support
- High overhead
- High incidence of unattached patients ... complex chronic conditions being managed in 'walk in' clinics
- Lack of support for comprehensive care
- Patient load and offloading of complex patients...especially OB/GYN
- Weak administration
- Fee inequity

Northern Lights – East: Fort McMurray

Fort McMurray, located 435 km northeast of Edmonton, has been experiencing unprecedented population growth due to the oil sands development. The 2006 census noted a population of 64,441 with a sustained annual average growth rate of 8.5% between 1999 and 2006. Forecasts estimate that Fort McMurray will reach a population of 100,000 by 2012. The impact of this continued growth is felt on all sectors of this regional centre, including its health system.
Participants at the forum shared some of the **issues in their community** including:

- Physician shortage of about 10 – 20 FP's for population of 90,000
- Population is transient over years, younger, many social problems, substance abuse
- Patients have high expectations for instant care (example is that offices protect emergency slots for Health Link to fill with < 24 hr urgent problems; however, most patients simply go to ER so they don't have to wait to be called by FP with an urgent appointment!)
- *Transient* FP population – an 'older' FP participant said he has been practising in community for about 10 years - the shelf life is around 3 years for a community FP
- They see Fort McMurray as 'urban remote' rather than 'rural remote'
- Seven FP's have left in the last 3 years (not surprisingly they see the issue of *retention* as being more critical than *recruitment*)
- Significant issues related to overhead, supercharged local economy – staff recruited with difficulty (paying support staff minimum of $20/hr to start) and lack of space available with high overhead ($30/sq foot rent)
- Note that the space issue may be being addressed by Region Health Unit which will rent out space to PCN
- Identified support for new physicians arriving in the community as an issue (good collegiality but not great mentoring around logistics: billings, referral pathways, etc.)
- Obtaining local CME was an issue with this group – especially if you are a 'non-self directed' learner who enjoys e-CME.
- Doctors are BUSY here – the theme was more due to the need to see high volumes to pay overhead rather than the 'need' in the community (different concept than other communities. All docs have closed practices and seem to try

ALBERTA COLLEGE of FAMILY PHYSICIANS

to limit number of patients in panel to avoid burn out….BUT see over 50 patients a day, don't take lunch, etc.)
- There were sentiments that fee for service is not serving FP's well
- Politics around hospital and ER – seems that community docs generally don't do hospital rounds
- Little or no teaching of med students – issue of space and cost of teaching identified as reasons
- There was a feeling that PCN has been very positive – bringing services to patients, assisting with local issues, that "Family Doctors here are more united and supportive of each other" since PCN formed
- There was clearly some tension with the local specialist population – example: all new babies cared for by the three local paediatricians who see most of the healthy kids as primary health providers

Only one of the three participants had **feedback on the ACFP**:
- She felt that the Chapter was invisible – hard time to know what we did beyond the ASA which she could never attend due to family commitments.
- Said that a friend challenged her on why belong to CFPC – she had a hard time defending her membership
- Seemed to be okay with ACFP priorities but there was more emphasis around CME in this group

Overall feedback on representation by physician organizations:
- PCN was seen as the group best representing them

Organization	☺	☹	indifferent	Not sure what they do
CFPC	2			2
CPSA		2		
AMA	2			
SRM				2
ACFP	1	1		
SGP				2

Suggestions for improvement:
A specific CME program in Fort McMurray for FP's:
- Practical
- Mainpro C
- Saturdays
- Skills-based
- Based on local issues
- With credits

Red Deer
Local issues
- Physicians seem quite happy with things as reported by attendees
- The PCN is encouraging members to provide 'full service' family practice (all members of the PCN must have hospital and nursing home privileges) and compensation is linked to these activities
- While there is seen to be a shortage of Family Doctors, it doesn't seem nearly as acute as other areas
- Perhaps the biggest issue is the 'greying' of Family Medicine and the bubble of near retirement FP's

- The issue of 'generational work life balance' was cited as an upcoming issue of the future – 'it will take 3 recent grads to handle the workload of one of the retiring physicians', was a point made
- One of the attendees was a previous rural physician from a small town outside Red Deer who commented that he was burned out practising in rural Alberta due to heavy workload issues. He commented that "the years that my kids were growing up is a blur to me", recounting long days and heavy clinic responsibilities. His implication was that this kind of practice is not healthy or sustainable.
- There was general discussion about the challenge of rural practitioners.

ACFP Role

- Indifference to lack of awareness of who we are
- One of the attendees let his membership lapse because he didn't feel that there was much value in membership
- when asked what major issue ACFP should be involved with – advocacy, although there was some indifference about even this
- the 'unit' of identification was clearly their local PCN – they felt engaged by it, energized and proud of the work it did (although the group was heavily represented by PCN leadership.)

Suggestions

The messages that came out were strong sentiments that we continue to value 'full practice' family medicine and the concern about the next 5 to 10 years as local 'workhorse' physicians retire.

Calgary

Participants

- 14 members including two from rural areas

Local Issues

- Discussion of crushing overhead was the major local issue
- One participant called Calgary a "Model of despair" for family physicians
- Family Physicians want to feel supported – but do not at this point
- Problem of med students leaving with high debt load was another issue discussed
- There was a sense that the whole system needed to be re-tooled with the following comments around this theme:
  - The funders will listen to cost avoidance, keeping care close to home, sustainability
  - Regional clinics where infrastructure is paid for.
  - Community health centres – why is there no traction for this? Involve patients in clinic design. Provide options for care.
  - Set up a model of payment where 'high quality Family Medicine is rewarded".
  - Family Medicine is like 'mothers milk' and should be seen this way.
  - Fee for service is "inadequate and probably always will be".
  - Respect = income, family docs won't get any without substantial increases.

Medical School/Family Medicine Residency and Family Medicine

- Many comments on this topic.
- Community medical practice 'not on the radar screen' for new FP grads

- 2004/5 FM grads mostly stayed in AB (75%) with most in metro areas (65%) but the majority landed in 'specialty areas' such as hospitalists, hospital clinics etc.
- Med School must pay for teaching by community family physicians. At the same time, we must increase the size of the academic department of FM.
- Suggestion for a first year med school FP mentorship
- FP's need to 'take back the education'
- We need to be able to tell med students the 'good news' and have specific and positive answers to questions like 'how much do you make?'
- Dean has established a working group to address the problem of low numbers going into FM with a target of 40 – 50% matching to FM. HOWEVER the sentiment was "it means that things have to be better once you get out".
- Note that one PCN is providing financial incentives to teach.
- There were some concerns that the current training for FM grads was inadequate and should go to 3 year program. Some feeling that quality of FM exam and training inadequate.

ACFP Role

- My 'sense' is that there was a feeling that we should continue with advocacy.
- Some comments:
    - "Family Physicians want to feel supported"
    - "We need to make noise about FM – target medical community, average citizen, politicians";
    - The College is being too Pollyanna
    - Favourable comments on collaboration
    - Favourable comments on support for research:
        - with the proviso that it is credible, looking for sources of external funding,
        - It would be seen as credible since done by the College.
        - Heath care services research should be a priority.
        - Is there time for FPs to do this?
        - Should be looking at regions and PCN's for funding
- Themes of open dialogue and advocacy were discussed.

Representation

Organization	☺	☹	Indifferent	Not sure what they do
CPSA		8 1/2	3	
AMA	5	4	2	
ACFP	0	4	7	
SGP	2	6	1	3
CFPC	0	5	5	

There were comments that people didn't know what the CFPC did plus lack of responsiveness. Positive feelings about the Members' Forum in connecting with family physicians & general practitioners.

Suggestions

Asked two groups to identify specific strategies to 'make AB the best place to practise comprehensive family medicine'. These were the results:

GROUP 1

1. Good PR. Keep talking about the value of Family Medicine and role of the FP. Need to do the 'full Monty with the media'.
2. More $ into the pockets of family doctors – especially early in their careers.
3. Reduce student debt. Why are we charging such high tuitions?

4. Develop funding support for students who commit to family medicine (similar to return-to-service agreements that Armed Forces has in place.)
5. "Shoot the hounds" – AHC audits of family doctors, downloading of business costs, EMR set up and maintenance costs.
6. Give support for non medical costs like archiving of records.
7. Simplify the FFS schedule and offer different payment mechanisms.
8. Develop support for robust 3rd party billing

GROUP 2

1. Articulate
   - security (however there must exist financial models which $ in pockets)
   - support
   - flexibility
   - collaborative and relationship-based care
   - other intangibles that drive 'better part of business'.
2. Highlight our professional roles – lifelong learning and CME
3. The importance of collaborative care. Working with others to manage complex problems.
4. Our accountability is to the community…not politicians.
5. There needs to be an assurance of quality of practice and standards of care

B. Individual Submissions

Submission #1

Hi Rick, Congratulations on taking such a proactive stance toward your term as ACFP president. I'm sorry but I will be unable to make the meeting tonight in Calgary. It feels like we are at an important crossroads with respect to family medicine. If resources are not directed at the core concerns of primary care physicians I wonder if we will be the last generation of family physicians. Those of us in academic practices are not faced with the same overhead issues as community physicians. However, we earn significantly less than the average FP and this has impeded our ability to attract future academic leaders for family medicine. Those of us with academic positions who teach (about ½ of our GFTs) are working at and above capacity to train the FP of today. The addition of IMGs have added a huge work load as the amount of training that even the best of these physicians require is substantial. (I am in favor of training IMGs but feel that the amount of work required has been grossly underestimated.) Of course we face the same expectations as other university profs with respect to research. Given our teaching load it is almost impossible to carve out time for significant research that reflects the needs of family medicine rather than those of the general research community. Further, there are not many research dollars available to family medicine researchers further limiting our ability to be effective in this arena. I certainly agree with the issues you summarized in the letter arising from your previous meetings with physicians. However, I would like to ensure that the voice of the small percentage of the membership that are academic physicians is also heard. I hope the meeting goes well tonight.

Submission #2

Family Medicine in Alberta is not healthy. In some geographical areas, rural and urban, it is already critically ill. I was already frustrated with practicing family medicine in Alberta for the following reasons:

1. Remuneration is grossly inadequate for Calgary's commercial lease market (the most expensive in all of N. Am, except for New York. We are being gouged in Calgary). AHW and the government have been unwilling to accept this and to act in a timely manner. Family medicine in Calgary & the province is rapidly dying.
1. UofC medical students are aware of this and consequently, few choose Family Medicine. Family Medicine residents are not setting up practice.
2. Number 1 above also speaks to the CHR's priorities which have also been devastating to primary care.
3. PCN's have been the one light. However, their ability to address the increasing demands in primary care - given the growing chronic disease and aging population - is limited. Also limited is the ability to provide direct support to maintain my business.
4. Human resources. Recruitment and retention of staff in my private practice has been a growing problem for years now.
5. The CHR and AHW, the 'system', has been working against me. I train up staff only to have them leave for CHR positions. The system has also dumped the work load on primary care without consideration to how my practice is going to manage given my even less resources. Amazingly this continues from the system and other specialists.
6. I have on numerous occasions over the past 13 years presented innovative and creative solutions to the AMA, CHR, Capital Health, and AHW only to be met with disregard for any number of reasons. I have engaged in numerous projects with all of these groups and on 3 occasions, when I accepted more patients and complex patients, they pulled the funding and staff leaving me holding the extra responsibility of the patient care needs.
7. The quality of patient care and safety in the system are being compromised and threatened. This is unacceptable and threatens not only my patients but my practice and professional and personal life.

Moving forward:

1. Family physicians in practice need to be remunerated not only to just barely sustain their practice but to provide appropriate income.
2. The AMA and AHW need to address the income disparity among physician groups, namely to appropriately fund generalists. It is clear from their actions that generalist medicine is held in poor regard for our skills, knowledge, training and importance in providing sustainable health care the improved the health of the population. We are not valued.
3. There not enough physicians and nurses to provide the care directly.
4. Thus we need others who can assist us so that our skill sets can be directed at the more complex patients that the allied health professionals are not trained to provide. The inter-professional team work must be properly resources and supported. Expecting family physicians to pick up the tab for AHW has been what was expected and is simply grossly erroneous. AHW must pick up the tab and do it quickly. Worrying about exactly how to do it is wrong. We need to just start and then build on mistakes and knowledge from around the world. But

we already have some good strategies, and persons such as myself already have the skill set to work in teams. Let's build on these family physician champions and support them.

5. AHW and the regions need to start listening and acting timely on the advice of physicians and nurses working in primary care. We are dedicated, skilled, caring people who are not just making suggestions for ourselves, but for the patients we see every day. AHW must see us as allies and not money grabbing people.
6. Communication about patient care, procedures, medication, history, etc must be more timely and comprehensive. Having care teams with proper clerks and administrative support can improve this. Their work would free up MD and RN time to do the clinical work. Currently, much of our time is wasted on tasks that others could do.
7. Family physicians must change their practices to allow team support. This is a major shift from the solo practice silo. At one time this worked because family physicians were integrated into the system by way of their hospital practice. However, having all family physicians in urban practice return to seeing their own patients in hospital is not practical from a time and remuneration perspective in the current urban setting.
8. Family physicians need timely access (i.e. same day access) to treatment/rehabilitation beds. The older and more complex patients require access not just to ED and Acute care, and many times this actually worsens their health and outcomes. Acute care is not designed to manage chronic disease so we need to build into the system the community supports that these patients and older patients need.
9. Bottom-line: the regions and AHW need to make the mental and funding shift that will properly support primary care in the community. When this is done Patient Care in Alberta will be healthier and more sustainable. And then Family Medicine in Alberta will also be healthy.

Final note: now that I am again a patient in the system I can comment from that perspective. My family physician is great; however, her ability to assist me in finding timely and adequate care is grossly restricted. I am poorly satisfied with the system as a patient. When will AHW step to the plate and provide primary care and the system the proper funding and support?