

G. R. MUSGROVE M. D., C.C.F.P.
1200 Woodmont Cr.
LaSalle Ont. N9J 3H9
Ph. 519-734-0785

Family Practice – Alive but not Well

Family physicians services have been in short supply in our area for some time now. Fewer medical graduates are entering Family Practice. The training to receive certification in Family Practice is not much shorter than it is in many higher-earning and perhaps less-demanding specialties. Family doctors can expect to earn about 60% of what the average specialist earns – and this percentage has been falling for years with no apparent end to the disparity in sight.

Government's misplaced zeal in eviscerating medical school programs and reducing the number of medical graduates has come back to haunt it. In addition, the cost of tuition has skyrocketed to a point where most graduating physicians now carry a staggering student debt load well into their careers. Many cannot afford the lower income that family docs generate while attempting to start a career, raise a family and pay off large student loans (often in the \$100,000 range).

Another beacon to new graduates has been the emergence of walk-in clinics. This method of practice has many more financial rewards and many fewer headaches than has traditional family practice. Many long-time family docs are also raising the white flag and retreating to walk-in practice, again reducing family physicians services. This trend is likely to increase as long as the pressures on family practice remain.

Newer medical school graduates generally do not have the same workaholic tendencies that many of their predecessors had. They want to spend more time with their families or in other non-professional pursuits – as well they should. These activities are a necessary part of coping with the substantial stresses of the job. However, it does diminish the time available for patient care.

A large percentage of new graduates are now women – up to 50% or more of current graduating classes. Most of them have childbearing and family-related demands that impact more heavily on their availability as physicians than it does on male doctors, rightly or wrongly. There are many advantages to society in having more female physicians. One of the *disadvantages* is that they generally do not perform as much patient care over the course of their careers as do their male counterparts – reportedly 70% as much. With many more female doctors now graduating family physician availability will be proportionately reduced.

Governmental underfunding has choked off access to new technology and treatments and specialty programs to a point where family doctors are forced to become apologists for an almost third-world level of care in many underserved areas such as ours. The unfair burden of bearing the bad news, as the gatekeepers of the system, weighs heavily on the shoulders of our already overwhelmed family physicians. An inordinate amount of family doctors' time and emotional energy is frittered away attempting to explain to angry patients why needed services, tests, drugs and treatment is either not available or so severely rationed that it might as well not be. This, coupled with the

stresses in watching, helplessly, as patients deteriorate needlessly while being denied care, does not enhance family medicine as a career choice to many new graduates.

New graduates have been trained to treat patients with state-of-the-art services. Here, family doctors are not even allowed to order such routine but severely rationed services such as MRI scans. Even if these are ordered by specialists, there is a scandalously long wait for them. This demoralizing milieu has even less appeal to new grads when backdropped against the superior U. S. services so close at hand and where Canadian-trained family physicians are highly respected and widely sought.

The burden of performing the administrative work in family practice is one of the heaviest in all branches of medicine. Payment for these services ranges from poor to nil. Too much of family doctors' time is spent performing mindless paperwork heaped on them, often without consultation, by a myriad of government and private agencies. Forms required by the Workman's Compensation Board, Social Service Agencies, Ministry of Transport forms (e.g.; for fitness to drive and for handicapped parking privileges), passport documentation, disability forms for employers and insurance companies, forms to document insurability, forms to apply for Nursing Homes, forms to request consultations to medical consultants and for tests, forms to document disabilities for various government and private pensions all contribute to an ever-lengthening list that grinds our family docs down. We are forced to waste time and effort filling out forms – often fruitlessly – even to document the need for basic prescriptions for patients. New drugs and treatments are purposefully withheld from patients by creating such onerous paper-devouring hurdles that docs and their patients often are forced to give up and use inferior products. We are drowning in forms! I wonder how many more patients could be treated by family docs if so much of their time was not consumed by such often needless paperwork. Most of us did not seek careers in a field where shuffling paper has become the mainstay of our work, and it certainly tarnishes the luster of this type of practice for new medical graduates. (to be continued)

((Last week we touched on some of the factors that have led to decreased availability of family practice services. This week we will continue the theme and expand upon it.)) Family practice entails high costs of overhead (40-50% of gross billings) coupled with miserly remuneration. This forces most family docs to concentrate on the better rewarded aspects of their practices; namely, seeing high volumes of patients in their offices. Increasing numbers are no longer able to bear the burden of carrying the system on their backs. They have cut down the volume and scope of their practices or have retired early when they could. Others have chosen to work in non-OHIP-controlled pursuits such as administration, industry, or clinics catering to American patients (who find our discounted fees a real bargain).

The lack of funding for many of the traditionally more professionally stimulating aspects of family practice is another disincentive in our field. Attending patients at home, in hospital, or in nursing homes, assisting at surgery, performing deliveries etc. has become so underpaid that such services are becoming extinct. As an example, hospital visits net family doctors the princely sum of about \$5 per visit after taxes and overhead – barely covering auto costs getting to and from the hospital site for many. House calls used to be a common service – rewarding to both patients and doctors. These services have been essentially choked out of existence by underfunding. (House calls gross about \$40 per visit – compare to skilled trade rates (\$75 per visit and up). The

marginalization of fees for its services make family practice a less desirable option for new medical graduates diminishes the incentive for current family doctors to provide many of their traditional services and shortchanges their patients.

By working harder than the provincial average in attempts to service large patient loads in our underserved area, a significant number of our local hard-working honest family physicians have been subjected to Medical Review Committee investigations lately. This witchhunt allows Ministry of Health agents to audit doctors in a non-judicial kangaroo court-like process that penalizes them for providing more complex and higher volumes of services and brands them as thieves. Demands are made that voluminous records of patient encounters be kept – at the risk of having fines and recapture of income visited upon them if they do not comply. Repayment of what OHIP considers inadequately documented services is extrapolated to all such services for several years retroactively, with interest, and payable by confiscation of current income at OHIP's discretion. Any appeal is at the physicians' expense and generally entails expenses starting at \$12,000 with a virtual nil chance of success. This whole insidious process has had a chilling effect on family practice in our area. It has led to many family doctors working less, and often being unable or unwilling to deal with multiple complaints by patients at one visit. It pressures them to spend more time documenting what they do (shuffling paper) than in actually providing care to patients.

Is there an immediate solution to the lack of family doctors' services? Probably not. Many of the factors cited above would take years to rectify. Assessing and licensing additional foreign medical graduates might help somewhat in the short term but is fraught with many difficulties. Will Primary Care Reform, even if forced upon patients and doctors, relieve the shortage? As proposed, it does not address many of the issues above, certainly does not provide more manpower and would probably further *reduce* the services available in areas such as ours by encouraging physicians to limit their roster size through financial disincentives.

In the meantime what can people do who do not have a family doctor? Contact the Essex County Medical Society for the names of physicians taking on new patients. If none are available, keep checking in because they do appear from time to time. Walk-in clinics and urgent care centers provide interval care and some of their physicians will take on regular patients – although they often do not publicize it. As a last resort, emergency departments provide many family practice services by default. Some local residents seek care in other outlying towns where some family doctors still see new patients. Some people travel to the U. S. for services unavailable here. None of these options is particularly attractive to someone seeking a family doctor.

The cure for our system's shortcomings will only come when government either funds medicare properly or admits the obvious – that it cannot – and allows a parallel private system that every other country – even the most socialist – has, to provide what it cannot. Until our politicians develop the courage to overcome the loud Luddite resistance of the vocal minority that rejects meaningful change, we are destined to see family practice (and our entire health care system) become much sicker before it gets well.