The family physician teacher:

An essential contribution to service to the population

Position Statement to the Commission de la santé et des services sociaux

Special consultations on Bill 20: *An Act to enact the Act to promote access to family medicine and specialized medicine services and to amend various legislative provisions relating to assisted procreation*

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Department of Family Medicine

Département de Médecine de famille et médecine d'urgence

Département de médecine de famille et de médecine d'urgence

Département de Médecine familiale et de médecine d'urgence

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This position statement expresses the consensus on Bill 20 of the directors of the family medicine and emergency medicine departments of the four Québec universities with faculties of medicine.

It was respectfully submitted to the National Assembly by Dr. Jean Pelletier, representative of *the Table des directeurs de départements de médecine familiale et de médecine d'urgence du Québec*, Director of the Department of Family Medicine and Emergency Medicine of the Université de Montréal, on behalf of his colleagues the directors of the family medicine departments of the three other faculties, who have approved its contents.

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INTRODUCTION

We thank the *Commission de la santé et des services sociaux* for offering this occasion to express the point of view of the four university family medicine departments mentioned above regarding Bill 20. This position statement complements the position statement already submitted by the deans of Québec's four faculties of medicine on February 25, 2015.

Physician-teachers play a vital and essential role in the accessibility to care offered by doctors to Québecers. Our main role, as directors of family medicine and emergency medicine departments of the four Québec universities with faculties of medicine (DMFMU), is to train the next generation of family doctors and emergency doctors, in sufficient numbers to meet the needs of the population. Some 3,300 family physician-teachers contribute in varying degrees to medical training in Québec. About 800 are in one of the 48 Family Medicine Units (FMUs) distributed throughout the territory. In 2014, more than 300 new family physicians trained in the FMUs finished their training. About 1000 residents in family medicine are currently registered in our programs and will enter into service to the population over the next 3 years. Beyond their teaching mission, these clinical training facilities offer comprehensive care to more than half a million people. Physician-teachers and the residents are serving the population.

Social responsibility and the comprehensive approach to patients that we care for are at the heart of the values of our profession. We recognize the gravity of the problems of accessibility experienced in Québec for far too long, and we subscribe fully to the objectives of Bill 20. However, we disagree profoundly with the bill itself, as well as the approaches recommended by the minister in attaining these objectives. We are convinced that Bill 20, in its present form, risks great damage to the contribution of physicians to the training of the next generation. It will have results completely contrary to the objectives it pursues.

In this position statement, we will demonstrate the importance of the contribution of family physician-teachers to the training of new physicians and hence to the accessibility to medical care. We will explain why Bill 20 directly threatens this contribution. We will propose some pragmatic solutions from our field of expertise that could help to resolve the accessibility issue in the fastest and most efficient manner, all while maintaining or improving the quality of care. We wish to reaffirm our willingness and our commitment to working in partnership with all of the key players to accomplish this.

WHO ARE WE? THE ROLE OF FAMILY PHYSICIAN-TEACHERS

Family physicians play a vital role in all aspects of medical training, whether in the faculty of medicine itself or in the clinics where medicine is practiced. Some bring occasional help of a few hours here and there, while others make much larger contributions, for example as supervisors of clinical internships, course teachers or heads of training programs.

All family physician-teachers, in addition to their teaching activities, continue to care for patients. They practice and teach medicine at the office, the hospital, in emergency rooms, in birthing rooms, in homes and/or in palliative care units, responding both to the needs of the population and the need for teachers. Most are part of community-based medical teams, mostly Family Medicine Groups (FMGs), and work in teams with colleagues who are nurses, social workers,

psychologists, nutritionists and pharmacists.

Family Medicine Units: Intensive teaching in clinics

The 48 Family Medicine Units (FMUs) are clinical facilities for "intensive" learning for future doctors and other health professionals. About 800 family physicians work in them. These FMUs are spread throughout Québec and are representative of the urban, suburban and regional realities of our society. They prepare future family physicians for different types of practice across Québec, and contribute substantially to populating the regions with competent family physicians who dedicate themselves to serving the population.

The family physicians in FMUs supervise mainly residents in family medicine, medical students (external), and nurse-practitioners in training. The FMUs also host doctors with foreign diplomas for evaluation periods or immersion that can eventually lead to their practicing as family physicians in Québec. They equally provide a locale for Québec doctors who have been requested by the Collège des médecins du Québec to refresh their knowledge in order to continue serving the public well.

Teaching family medicine, more complex than it seems!

A good doctor must know how to approach the patient in a manner that helps to elicit relevant information, develop good diagnostic hypotheses, prescribe the right tests without abusing them, ensure good relations with other members of the health care team, recommend good treatment and ensure that the patient has properly understood, all while taking into account the patient's fears and expectations. To become a family physician, competent and capable of responding to the needs of patients, is a demanding and complex process.

Students and residents learn by practice, but supervising physicians must closely monitor this. These teachers supervise several types of interns who are not all at the same stage of their training, and who do not learn at the same pace. Therefore it is important to adapt the manner of supervision to each student, if students are to be given every possible to chance to be fully competent by the end of their training. Teachers must therefore be as efficient as possible, and there is no question of improvising or giving free rein. Proven teaching strategies must be put to use, which means that both teacher and student must be proactive.

Family physician-teachers are ultimately responsible for the quality of care given to patients seen by these students. They must decide therefore at what point they must redo part of a patient consultation after talking to the student. This is about the quality of health care given to the public, so there is no question of skimping in this regard.

Since the family medicine residence program only lasts two years, and the knowledge and skills to be acquired are many and complex, the work of family physician teachers demands a great deal of time and dedication.

Family physicians, key players for faculties of medicine

Family physicians perform from 20 to 60% of the teaching tasks for students in the 1st, 2nd and 3rd years of medicine in Québec's faculties of medicine. They contribute to the training of all medical students, whether the students later choose careers in family medicine or another specialty. Some family physicians also fill important positions in the universities: dean, vice dean, program director, director of teacher training, etc. The invaluable and essential contribution of family physicians to faculties of medicine is well-recognized.

This contribution by family physicians also contributes to the teaching in health sciences of a generalist approach to the patient. This approach is a solid foundation for any future physician. It takes into account the entire person, the entirety of their health, preferences and choices. It integrates prevention and must be accomplished in collaboration with other health professionals.

The doctorate program in medicine is continually evolving. Knowledge progresses, needs change, and technology develops. Physicians must design courses and review teaching methods, give courses, lead small group work, evaluate students, etc. This considerable task cannot be taken lightly since it deals with the quality of the training and the quality of care that will result.

Family physician-teachers develop and maintain diverse expertise, as clinician, teacher and sometimes as academic manager. This double or triple expertise demands specific training, experience and time. The quality of medicine in Québec is rooted in this recognized expertise of those who take care of teaching.

Without the pedagogical contribution of family physicians, the faculties could not offer their training programs.

Skills and high standards to maintain

Medical training is regulated by very high standards determined by independent organizations, in Québec (Collège des médecins du Québec), in Canada (College of Family Physicians of Canada, Royal College of Physicians and Surgeons of Canada, The Association of Faculties of Medicine of Canada) and in North America (Liaison Committee on Medical Education). These organizations are responsible for authorizing our faculties of medicine to teach medicine. If we do not meet their standards, there is a risk of losing the right to train students or residents.

HOW BILL 20 JEOPARDIZES THE CONTRIBUTION OF FAMILY PHYSICIANS TO TEACHING

This Bill proposes resolving the problem of accessibility by requiring that "every general practitioner … to the extent provided for by government regulation, provide medical care to a minimum caseload of patients."[1] The regulation to which Bill 20 refers is not yet known, but

[1] Explanatory notes, p. 2

proposals that have been circulating suggest that the requirement will be high, as will the risk of a financial penalty in the event of non-compliance. Our colleagues are faced with the prospect of having to achieve unachievable targets in a short time.

There will be strong pressure on family practitioners to increase time spent with patients, thereby relegating their other tasks to the back burner. Activities that risk being detrimental to accepting and seeing patients, such as teaching-related activities, will be of much less interest and risk being progressively abandoned.

Equivalencies and weighting: A cumbersome exercise, necessarily imperfect and clearly risky

To compensate, the Ministry is considering introducing a system of equivalencies, in which a certain number of hours of teaching would be equal to a certain number of patients accepted, with considerations for patients accepted by residents, etc. In all likelihood, this system of equivalencies would be cumbersome and complicated to manage, and it would not take different situations into account.

Teaching is complex, as we have seen, and consists of numerous associated and interrelated tasks, which are often neither visible, nor identified, nor equally divided among physicians, and varies considerably from day to day, week to week and year to year. The physician-teacher is constantly adjusting to the needs of patients, residents, students and faculty. How could equivalency systems take all of these situations into consideration, as well as the considerable variability in the workload over time? A system such as this is much more likely to do harm than good.

Recruiting and maintaining the number of physicians needed to maintain medical teaching activities is already a challenge. Bill 20 could prevent us from training the next generation of doctors. It would have the opposite effect of that intended.

March 2015: Negative interim report for our teams

Bill 20 already has a number of impacts that have us fearing the worst.

Even if our colleagues are behaving professionally, we can unfortunately sense that they are becoming demotivated, cynical, discouraged and disengaged. In recent weeks, too many of them have begun to tell us, albeit with the greatest of respect, about projects that would call into question their involvement in teaching. Some are considering leaving an FMU so they can see more patients in a setting where there are no interns. Others are considering accepting one of the growing number of positions available at private clinics not affiliated with RAMQ, which offer private radiology services on site and whose clientele consists primarily of people in good health. Still others, who had been planning to retire in 3 to 5 years, are talking about early retirement and transferring their patients—but to whom?

All of this will result in reduced services for the public, which runs counter to the needs of Québecers and the Bill's objectives. The full consequences might not be evident until the medium term, when we feel the impacts of today's decisions and when those responsible for making these decisions are no longer there to answer for them. There is a real risk of seeing family physicians disengage from training new doctors, to devote their time to the tasks of developing and tending to their caseload to the detriment of teaching and research. The training of a skilled and motivated new generation of doctors could be compromised if family physicians are pushed to disengage from teaching.

IMPROVING ACCESSIBILITY: POSSIBLE SOLUTIONS

Here is what the teaching network has to offer as concrete solutions to the problem of access to family physicians. We are also including proposed deadlines and indicators that would make it possible to evaluate progress over time.

1. Increase the number of patients seen in the FMUs, through "timely access to care" in all FMUs. This way of organizing schedules would give patients an appointment when they need one. The method, which has proven to be successful, has been introduced in recent years in some provinces and in many locations in Québec. To be successful, however, it calls for certain conditions, including teamwork, stable staffing, strong support from the CISSS and the frequent presence of physicians in the clinic. Some FMUs are already doing this and several others are in the process of converting, even if it presents specific challenges for the FMUs, in the opinion of Ministry professionals who provide training to teams considering this change. Indicators: number of FMUs and proportion of physicians practicing with timely access to care. Deadline: April 1, 2017

2. Ensure that all FMUs also become FMGs, provided that the management of the FMGs and FMUs (FMG-U) takes specific situations into account, notably in the case of some FMUs in the regions or at the initial stage. More than half of our training sites are currently FMGs, and the vast majority of the others are involved in the FMG accreditation process, or are part of a multi-site FMG. Indicators: number and proportion of FMUs that are FMGs. Deadline: April 1, 2017

3. Ensure that all graduates of our family medicine programs are trained in timely access and in FMGs, and are able to get involved quickly and effectively in taking on more patients. This represents about 1,000 graduates three years from now. Indicator: proportion of graduates who have practiced timely access to care and mastered its principles. Deadline: June 30, 2017

4. Continue to train sufficient numbers of family physicians: With the aim of better meeting the public's health needs and at the behest of the MSSS, the number of admissions to Québec's medical faculties more than doubled between 2004 and 2014. In recent years, the proportion of students who opt for family medicine has grown and is approaching a target of 55%. This increase imposes a significant workload on the FMU teams, but as long as the MSSS supports them, the FMU teachers and the entire teaching network will proudly assume their responsibility for training new doctors.

5. Like all of Québec's family physicians, physician-teachers will increase the number of patients they take on, notably through timely access to care, by reconciling their clinical responsibilities with their academic duties.

To be able to act on the above-mentioned elements, there are certain essential conditions that come under the jurisdiction of other partners, including the MSSS:

1. Ongoing, formal collaboration among the players that have a role to play in the matter of accessibility: the MSSS, the federations, the institutions (CIUSSS and CISSS), patient organizations, universities and clinical training sites.

2. Protection of the teaching mission in the governance and procedures of the new CISSS/CIUSSSs must be done quickly.

3. Recognition of the complexity of teaching and the essential role of family physicians in teaching and research.

4. Recognition that clinical settings, in particular the FMUs, have variable configurations and require adapted resources that vary according to the setting in order to meet training needs.

5. Adequate support for interprofessional practice in teaching environments, both for exposing future physicians to collaborative models and in helping define best practices in interdisciplinary primary care in the Québec context. We must seek to ensure that the right person takes the required action at the best time for the patient. The writing of collective prescriptions must also be facilitated and optimized.

6. Recognition of shared responsibility for managing teaching teams. This would create a dynamic where objectives are assigned to teams and where they would be supported in the change instead of supervised individually. Several briefs submitted to the Commission as part of this consultation have made the same recommendation.

7. Adequate support for practice in a hospital setting: Family physicians regularly spend up to 30 or 40% of their time during patient appointments managing information, which includes: looking up test results, looking for summaries of hospital stays and nonexistent consultation reports, etc. Physicians practicing in hospitals are entirely dependent on the MSSS and the institutions when it comes to electronic medical records, telephone access, Internet access, IT support, and clerical and professional support.

8. Conditions that enable patients to make appointments more easily and report for their appointments, including: effective communications tools, websites, needs and satisfaction surveys, affordable and adequate numbers of parking spots.

9. The necessity of positioning primary care front and centre in the system and providing it with the means to do its work, both among primary care players and among players in primary, secondary and tertiary care. Simplifying and facilitating requests for consultation. Encouraging and facilitating the exchange of information among players in the network. Providing access to secondary ambulatory services on a timely basis.

CONCLUSION

The lack of accessibility to primary services in family medicine is a real problem for which there are numerous potential solutions. Our family medicine teaching network is essential to resolving this problem: on one hand, it contributes to accessibility by training new physicians and implementing new practices, and on the other, it provides fundamental and crucial clinical services to the population.

While we fully support the objectives of Bill 20, we strongly disagree with the Bill itself and with the approaches taken by the Ministry to achieve these objectives. We believe the proposed approaches put undeniable achievements into jeopardy in the medium term. Bill 20 would have the opposite effect to that intended.

We are now seeing the warning signs of disengagement by Québec's family physicians with respect to training the next generation. For the sake of possible short-term gains in accessibility, Bill 20 will compromise the future of the universal healthcare system to which Québecers are entitled.

We reiterate our commitment to continue and step up the actions required within our realm of responsibility to resolve the problem of accessibility while improving quality of care, as quickly as possible.

We thank you for your attention and for your interest in the views described in this statement, as well as the proposed solutions, in a spirit of collaboration.