



Sheldon Gordon

**F**amily physicians have traditionally offered their patients a full-range of medical services. Today, the average family physician/general practitioner (FP/GP) acknowledges the increased diversity and range of services that can be provided when he or she combines skills and interests in a group practice or family practice network, and this is confirmed in the latest data from the National Physician Survey (NPS).

Under pressure to provide comprehensive, around-the-clock care to a growing number of patients with chronic diseases, often requiring complex care, many FP/GPs see working closely with colleagues as a way to provide high-quality care while maintaining their own work-life balance.

“I think it [the trend] is accelerating somewhat, and it’s a good strategy,” says Dr. Ruth Wilson, president of The College of Family Physicians of Canada (CFPC). “Family doctors get a lot of joy out of their relationship with individual patients. We know that there’s a lot of value in continuity of care and getting to know our patients over time. But the opposite tug for us is that we can’t be available 24/7, 365 [days of the year]. So we need to find ways to provide that continuity and relationship without always being personally available. The best way to do that is group practice, with other physicians sharing the calls, the load and the coverage.”

Dr. Cal Gutkin, CEO and executive director of the CFPC, says the trend over the last decade has

**SOUVENT,** les médecins de famille répondent aux besoins de leur clientèle de plus en plus nombreuse en conjuguant leurs efforts au sein d'une pratique de groupe ou de réseaux de médecine familiale. Le SNM 2007 constate que cette tendance, amorcée depuis une dizaine d'années, se maintient. On assiste à une augmentation à la fois du nombre de pratiques spécialisées et de cliniques de services intégrés offrant un plus vaste éventail de soins dispensés par des médecins de famille œuvrant dans le contexte d'une entente de collaboration. Par exemple, 11 % des médecins de famille et omnipraticiens signalent qu'au moins 10 % de leurs

patients appartiennent à une minorité ethnique. «Il reste beaucoup de besoins non satisfaits dans diverses populations de patients», affirme le Dr Cal Gutkin, chef de la direction et directeur général du Collège des médecins de famille du Canada. «On demande aux médecins de famille de répondre à ces besoins et pour le faire, ils doivent consacrer davantage de temps et d'énergie à certains groupes de patients.» Un phénomène relativement nouveau, les hospitalistes qui gèrent les soins aux patients hospitalisés dans les hôpitaux communautaires, répond à un besoin, mais peut poser des défis au maintien de la continuité des soins entre le médecin de famille et l'hôpital.

been very clear. "Each time physicians are surveyed, the result is that higher percentages are working in some kind of a group or networked strategy. Even family physicians who prefer solo practice are trying to network with colleagues who are in the community, or the nearest community possible, to share some of the practice responsibilities."

He adds, "There is evidence outside of the NPS ... that group practice is the way to go in terms of being able to provide a more comprehensive basket of services to patients and to also protect the physician's health and well-being and professional satisfaction."

The NPS data reveal clear differences between the services provided by individual FP/GPs and those offered by their group practices. Only in non-urgent health care and acute health care does the proportion of individual FP/GPs offering these services approach that of group practices offering them.

In other categories, the divergence is substantial. Only 52% of FP/GPs provide gynecology care, whereas 63% of group practices do so. Only 48% of individual FP/GPs make house calls, compared with 59% of group practices.

"Perhaps we have a perception that the old-fashioned family doctor is extinct," says Wilson. "But when you see that almost half of family doctors are personally making house calls, that's probably a surprise to the public. And the fact that within their group practice there's an even higher percentage that makes that available is even better. Those are good-news numbers that are surprising even to me."

Inpatient hospital care is offered by 43% of individual FP/GPs, but by 55% of group practices. For palliative care, the proportions are 55% and 66%, respectively. Nutritional counseling is available from 42% of FP/GPs, but from 57% of group practices.

Whereas 37% of group practices offer hospitalist care, only

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23% of individual FP/GPs do so (although the proportion rises to 36% among family doctors under age 35). In clinical services, such as alternative medicine, cosmetic surgery and anesthesiology, the proportion of individual FP/GPs who offer these services is less than 5%; the proportion of group practices doing so is 3 or 4 times as great.

Another revealing finding of the survey is the increasing tendency of FP/GPs to have practices focused on particular types of patients. For some 11% of FP/GPs, ethnic minorities account for one tenth or more of their patient load. That proportion rises to 22% among FP/GPs serving an inner-city patient population. Some 11% of respondents reported that a tenth or more of their patients live in poverty (25% in inner-city areas). Smaller but significant proportions of FP/GPs serve Aboriginal Peoples, recent immigrants, homeless people and transient or seasonal populations.

"There are a significant number of unmet needs for different populations of patients," says Gutkin. "Family physicians are being called upon to try to meet these needs, and to do so requires them to focus more of their time and energy on particular populations of patients."

Wilson says she is "surprised and pleased" to see some of the

## The practice of medicine

patient groups on which family doctors are concentrating. “For example, there are small groups of family doctors in major urban centres who are focusing exclusively on the homeless.” On the other hand, the ethnic focus “might reflect the introduction of international medical graduates just recently into the Canadian health care system in a more concentrated way. Patients may be attracted to a doctor who speaks their language or comes from their background.”

For smaller but still significant percentages of FP/GPs, more than 10% of their patients have chronic mental illness, cancer,

HIV/AIDS, addictions or permanent physical disabilities.

Physician resource planning must recognize this trend toward family doctors working with specific groups or illnesses, says Gutkin.

“Well over 75% of our graduates and practitioners should be providing comprehensive continuing care. But we will need 25% developing some special skills in a whole list of other areas where patients have unmet needs.”

*Sheldon Gordon is a Toronto-based freelance writer.*

Clinical service	Proportion of FPs/GPs who offer this, %	Proportion of FPs/GPs who said that either they or others within their practice offer this, %
Non-urgent health care	87	89
Acute health care	85	88
Emergency medicine	39	53
Alternative/complementary medicine	7	21
Anesthesia	5	22
Community medicine/public health services/health promotion	31	45
Cosmetic medicine	4	17
Dermatology	40	51
Gynecology	52	63
Liaison to home care	53	63
Hospitalist care	23	37
Housecalls	48	59
Infectious disease care	53	59
In-patient hospital care	43	55
Intrapartum care	11	32
Legal/medico-legal consultations	14	25
Mental health care	70	76
Nutritional counseling	42	57
Occupational/industrial medicine	17	31
Pain management	62	69
Palliative care	55	66
Psychotherapy/counseling	62	71
Rehabilitation medicine	16	29
Sports medicine	27	38
Substance abuse care	27	39
Surgery	12	31
Surgical assisting	19	33
Travel/tropical medicine	28	39
Well child care	59	68

Source: National Physician Survey 2007