

The Five Types of Urban Family Doctors

DETAILS ON THE STYLE AND SCOPE OF PRACTICE OF PROVIDENCE HEALTH CARE'S DEPARTMENT OF FAMILY MEDICINE MEMBERS

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OBJECTIVES

There are approximately 1000 family doctors working in Vancouver (as per the CPSBC); however, few details are known about their practice styles. This study provides a reasonable estimation of how urban family doctors in Vancouver describe and organize their work.

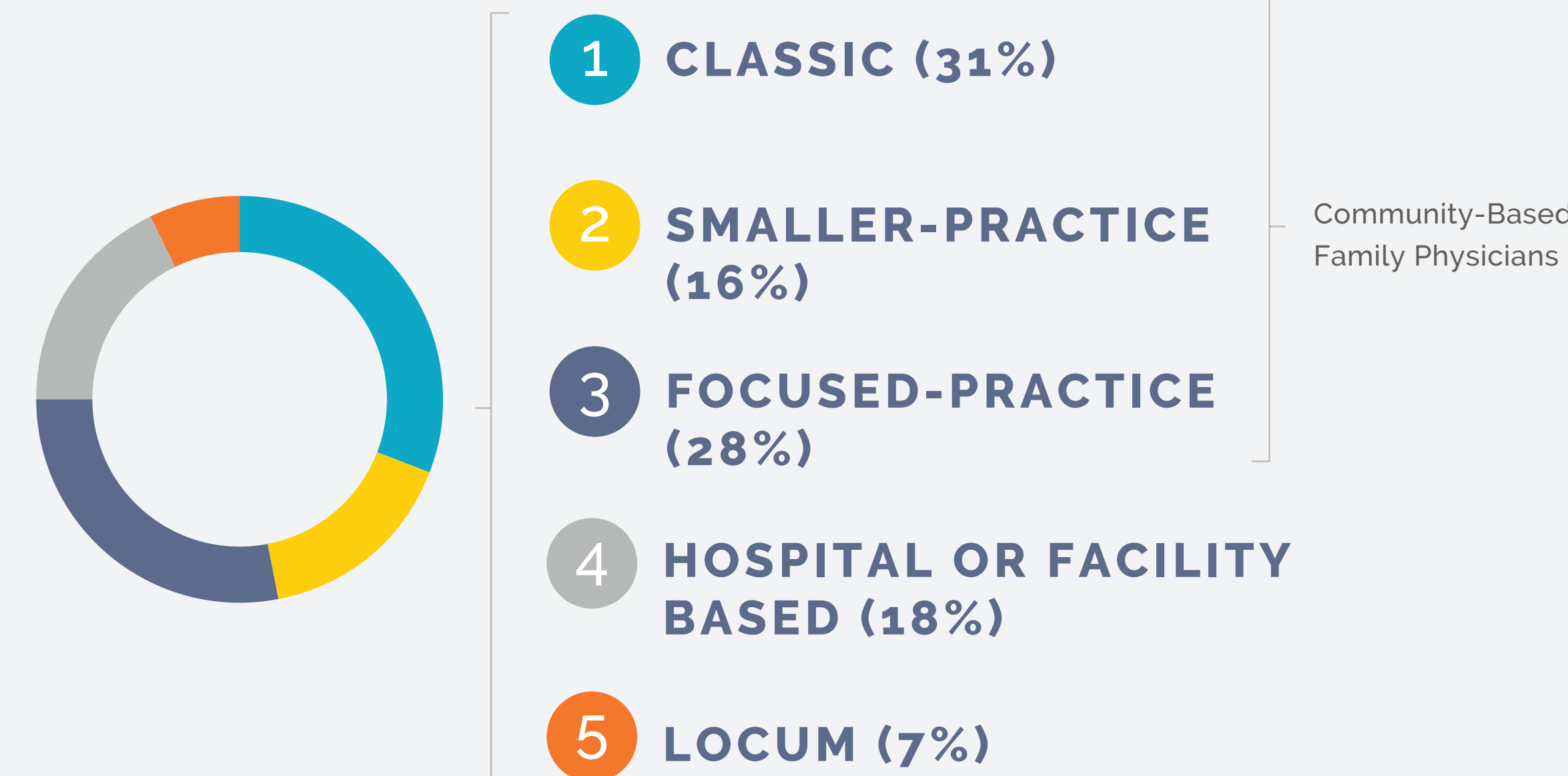
METHODS

This cross sectional study is a part of the **Models and Access Atlas for Primary Care at Providence Health Care (MAAP-PHC)** project.

In spring 2016 members of Providence Health Care's Department of Family Medicine members (PHC-DFM) responded to an online survey, which asked about scope and characteristics of their practice. The survey response rate was 86% with 254/295 members completing it. This study was approved by Providence Health Care Research Ethics Board and modeled on a similar study done in Nova Scotia (MAAP-NS).¹

1. Models and Access Atlas of Primary Care in Nova Scotia (MAAP-NS), Department of Family Medicine, Dalhousie University

RESULTS



1 CLASSIC (31%)

Where >1000 patients in the community call this person their family doctor.

- Most Classic GPs are **male** (59%)
- Classic GPs are the **least** interested in **alternate payment methods**
- Most Classic GPs practice at a **single location**—almost exclusively at "typical FP" clinics (95%)
- 1984**—The median year of med school graduation is 1984—the **oldest** of all 5 types of urban family doctors

2 SMALLER-PRACTICE (16%)

Where 500-1000 patients call this person their family doctor.

- 55% of Smaller-Practice GPs are **female** & 45% are **male**
- Similar to Classic GPs, most Smaller-Practice GPs practice at "typical FP" clinics (78%)
- Smaller-Practice GPs have the **highest rate** of **home visits/house calls**
- Smaller-Practice GPs self-reported a high interest in **retiring** in 5 years

3 FOCUSED-PRACTICE (28%)

Where <500 patients call this person their family doctor.

- Most Focused-Practice GPs are **female** (58%)
- Focused-Practice GPs are the **most** interested in **alternate payment methods**
- Focused-Practice GPs practice at **several different locations** with the highest rate of work at **community health clinics** (28%) and **specialty clinics** (39%)
- 2000**—The median year of med school graduation is 2000—the **youngest** of the Community-Based Family Physicians

4 HOSPITAL OR FACILITY BASED (18%)

This family doctor only provides care in facilities, s/he does not provide community-based, continuous primary care.

- Most Hospital or Facility-Based Family Physicians are **female** (58%)
- Together with Focused-Practice GPs, Hospital or Facility-Based Family Physicians self-reported the **lowest interest in retiring** (14%)
- Hospital or Facility-Based Family Physicians self-reported the highest **Providence Health Care hospital work** (88%)

5 LOCUM (7%)

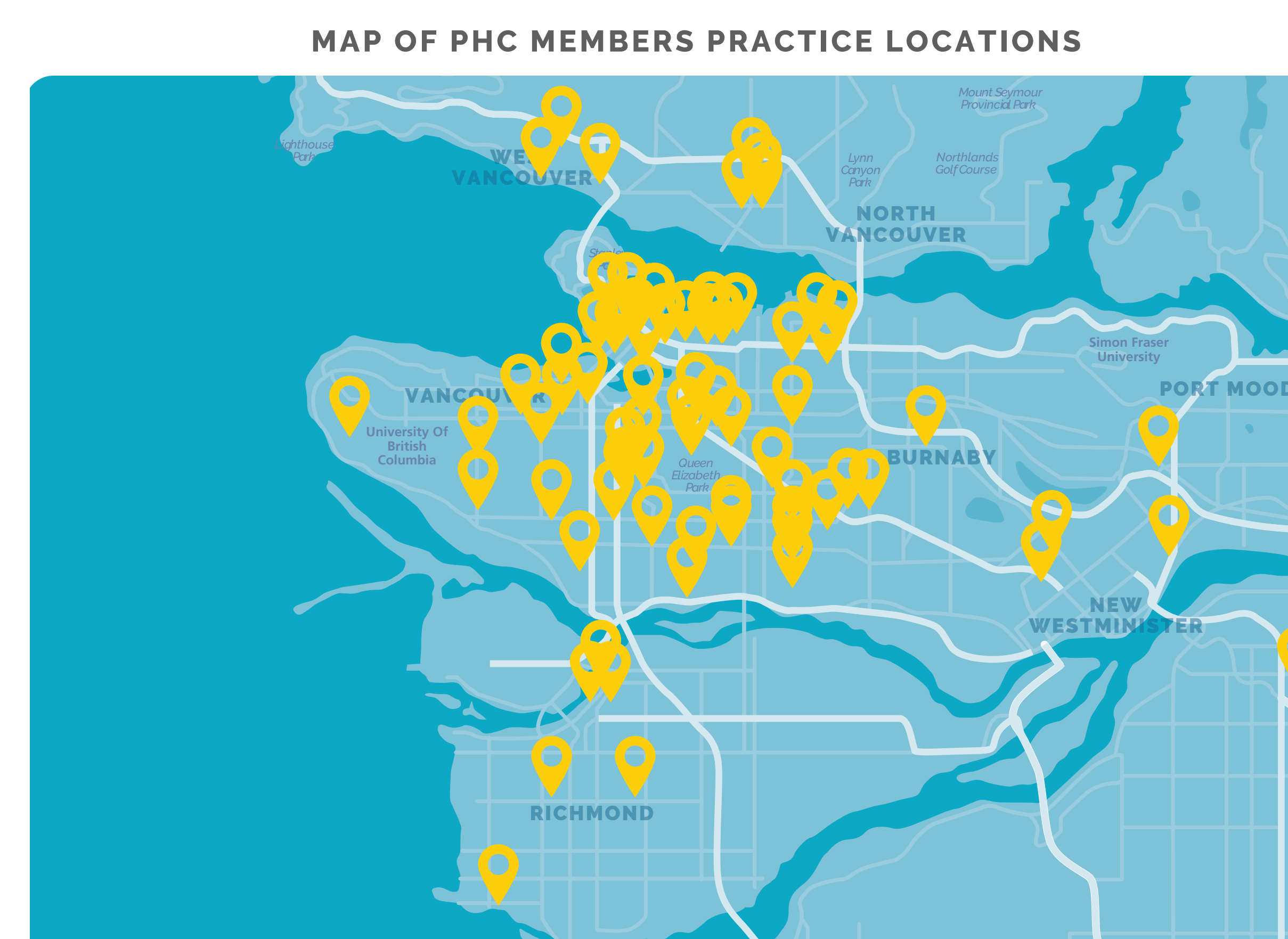
This family doctor only works in temporary locations.

- Most Locum Family Physicians are **male** (65%)
- Locum Family Physicians have the lowest median **MSP billings**
- Locum Family Physicians self-reported the **lowest weekly work hours**
- Locum Family Physicians have the highest percentage of **recent grads**. They also have the highest percentage of doctors who self-reported that they plan to **retire** in the next 5 years

RECENT GRADUATES

This category is defined by individuals 12 years or less away from medical school graduation.

- Most recent graduates are **female** (57%)
- Only 1/3 of recent graduates are paid by **fee for service**
- Most recent graduates practice at **2 or more locations** (59%)



LIMITATIONS

Physician self-report has known limitations in accuracy. Validating this data with billing and/or administrative data would provide an added level of confidence. However, to our knowledge, this study is the first to provide a description of primary care practices in British Columbia that fall outside of a provider working only at a single location. Future studies may be able to use these categories as a starting point and more accurately define delivery of primary care by all types of family doctors.

Categorizing physician practice based on self-reported panel size was an arbitrary first step and due to current planning initiatives regarding primary care reform that have included descriptions of "ideal" panel sizes. Other divisions of how family doctors design their work (such as number of practice locations) may also be relevant.

CONCLUSION

Urban family doctors have diverse scopes and styles of practice. Given this diversity and dynamism, our findings suggest that human resource planning for primary care policy and service delivery may need to evolve and respond to the variety of actual work patterns.

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