"A GP for Me": Will it work?

On 22 February the government of BC and the BCMA announced that they are partnering to improve primary care in our province through a joint program called "A GP for Me."

After pilot projects in a few communities the program went province-wide 1 April. Funding is available for family physicians to consult with patients by telephone, and incentives are provided for GPs to take on new patients and more patients with complex conditions such as cancer. Money is also available to local divisions of family practice to work collaboratively with health authorities to support better access to primary care.

Success has been achieved in the pilot communities through opening of new primary care clinics and the development of multidisciplinary teams. Apparently, 9000 patients without GPs have now been matched in these communities.

Now I don't want to rain on this parade, but most of the GPs in my community are working full out and don't have any room for extra patients. It's not as if a bunch of family physicians are sitting around killing time and now that these financial incentives have been announced they are going to cancel their afternoon golf and work harder.

I suspect the timing of this announcement and the funding behind it has a political basis, but I am happy for any peaceful, patient-driven collaboration with government. However, I am old enough to remember some of the poor decisions of previous governments. When I was in medical school at UBC the number of positions was decreased to save money. We were graduating 120 new physicians per year while our closest neighbor, Alberta, was graduating around 200 physicians yearly from their two medical schools. This shortsighted approach definitely contributed to the current shortage of physicians in our province. Granted, this has now been remedied by significantly increasing the size of our graduating classes through innovations such as distributed medical education and teleconferencing.

I suspect that the reason so many new patients were able to be matched to a family physician in the studied pilot communities was the use of allied health professionals to lighten the load for the physicians involved. Many of these matched patients likely have a GP but see a nurse practitioner or other health professional during many of their visits. I'm not saying this is a bad thing—just pointing out that family physicians should be recognized for the hard work they have done over the years without these resources. I am sure all of us would have loved to have a funded nurse practitioner or other allied health professional to help ease the load years ago.

I can see the biggest boon to my practice being the ability to call patients on occasion instead of bringing them in for an appointment to fulfill my current fee-for-service practice. I will participate in this initiative through my local division of family practice as this trend of utilizing our family physicians more efficiently is a good thing. After all, I am not only a "GP" but also a "Me."

—DRR

Who wants to be a department head?

One of my very good friends, who is brilliant, committed, and immensely capable, was given the honor several years ago of being made head of his hospital clinical group. It appears likely that when he resigns there will not be anyone willing to take up his stead. It is a job that in modern settings puts a clinician in an almost untenable position of frustration, blame catching, impotent budgeting, and impossible group management.

Another colleague with an advanced business degree tells me there is a defined difference between leadership and management. Leaders are supposed to motivate, inspire, and direct the progress of a group toward ideological goals they share. A manager, in distinction, plans, coordinates, and manages the practicalities of achieving those goals. I think in our present-day health care industry, those roles may not be in the best orientation. Regardless of the goodness, motivation, and business acumen of our administration and management colleagues, the flow of front-line driven medical direction toward the hand of management is often interrupted and in many cases completely reversed. In our organizational structure, the clinically active medical leadership is so far down the chart of real decision makers it is almost a falsehood to call it leadership. There is a person assigned to a "headship" role, but the ability to actually make meaningful decisions that "motivate, inspire, and direct progress" is often pre-empted by administrative managers in roles above. Clinical heads are asked to give input into staffing issues, equipment, education, hospital resources, site development, compensation, and wait lists. But they are really not in a position to make even close to a final decision or even prioritization. They also often must take the responsibility for the negatives of a different path someone else has determined their group must follow. I accept that no one group can have everything it wants considering the resource demands on the larger community, but frustratingly, even non-resource decisions seem to be treated this way.

I don't think it's the people. It's the culture and structure. The paths of communication are disconnected, shifted, and unequally powered. And there is so little trust and transparency in either direction that any perceived problems are magnified. So it often feels like big decisions are made autocratically in one silo and announced as *faits accomplis* to the people in another silo who live with the day-to-day consequences.

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Meetings are difficult. A surgical division head just cannot be counted on to come to a meeting scheduled by managers at 11 a.m. on 2 days' (or even 2 weeks') notice if it falls on an OR day. And after meetings with all stakeholders in the room, where we think a group decision has been agreed upon, very commonly a different decision will be announced once the issue is brought to a higher level of management.

I don't think for a second that managers and administrators are malicious or incompetent. Unlike most doctors, they are trained in administration; they do their jobs well. I have many respected friends in administrative positions. However, those who are the most effective in helping us achieve good patient care are the ones with a more balanced and open manager/clinical leader relationship, and to help us they often seem to need to sidestep the mandated structure of reporting and decision making. In my opinion, the modern anatomy of our hospital organizational system doesn't allow us to communicate with enough equality to consistently make fair decisions. In the past it seemed the practising medical leadership structure was closer to parallel with the administrative structure, and the decision-making positions met on a reasonably level playing field. Now, in our leadership structure, you have to go many levels down before you find an active clinician decision maker. And in the newer clinical headship contracts I have seen, the leadership component of the job is defined and remunerated as an administrative managerial position, answerable to administrative policy, and includes language about the head ensuring that the group follows administrative direction, not bringing clinical issues the other way.

Which brings us back to the difficulty in convincing clinicians to take on headship roles. In my hospital for some years we had a long-term "interim head" in almost every department. Few clinicians see much value in taking on these so-called leadership roles. There seems to be very limited ability to make change or solve problems that they identify. And many of them see the role bring real *harm* to their practice, their health, their relationships with their administrative and clinical colleagues, and the happiness of their families.

And we all pledged to "first do no harm."

—CV