What does it mean to be a family physician?

Exploratory study with family medicine residents from 3 countries

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ABSTRACT

OBJECTIVE To explore the conceptions that family medicine residents from 3 countries have of the roles and responsibilities of family physicians in order to gain a better understanding of challenges that might transcend the specific contexts of different health care systems.

DESIGN Qualitative study using focus groups.

SETTING Resident training programs in France, Belgium, and Canada.

PARTICIPANTS A total of 57 residents in the last year of training.

METHOD Ten focus groups were conducted in 3 countries: 2 in France, 3 in Belgium, and 5 in Canada. All focus groups were held in different cities, with residents registered in different universities in France and Canada and with residents from the same university in Belgium. The study was informed by Abbott's conceptual framework on the system of professions. Each 90-minute focus group was moderated by the same researchers. The transcripts were analyzed according to the immersion-crystallization method.

MAIN FINDINGS Respondents shared common conceptions of the family physician's role: continuity of care and patient advocacy were seen as the foundations of the discipline. Respondents also shared a sense of discomfort about how accessible they were expected to be for patients and about the scope of family practice. They saw family medicine as flexible and reported that they strove for balance between their professional and personal life goals. All respondents strongly believed that their profession was undervalued by the medical schools where they trained.

CONCLUSION This exploratory study suggests that there are more similarities than differences in the understanding that future family physicians from different countries have of their discipline and of their careers. We observed a tension between a desire to develop a "new general practice" and the more traditional vision of the discipline. The culture in academic settings appears to contribute to the persistent low appeal of being a primary care physician.

EDITOR'S KEY POINTS

- Data from some countries suggest that newly trained general practitioners have conceptions of their roles that differ from what are generally considered the core features of general practice. This study aimed to explore how residents from Canada, France, and Belgium saw their new careers.
- Participants from all 3 countries expressed many similar views, but sometimes with varying emphasis. For example, although all participants believed the patient-physician relationship was important, European residents conceived of family medicine largely as a "profession of relationships," in which knowledge was not at the forefront as much as it was in other specialties, while Canadian respondents believed that the capacity to manage a broad scope of problems according to the latest practice guidelines was paramount.
- The most troubling finding was of the extent to which academic settings contributed to the low appeal of family medicine. All participants strongly believed that their profession was undervalued by the medical profession and by patients. They received this message clearly from the very start of training and through interactions with specialists during rotations, even when exposure to general practice role models was more extensive.

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Que signifie le fait d'être médecin de famille?

Étude préliminaire auprès de résidents en médecine familiale de 3 pays

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RÉSUMÉ

OBJECTIF Déterminer comment les résidents de médecine familiale de 3 pays voient leurs rôles et responsabilités comme médecins de famille afin de mieux comprendre les défis qui pourraient être communs aux contextes spécifiques à différents systèmes de santé.

TYPE D'ÉTUDE Étude qualitative à l'aide de groupes de discussion.

CONTEXTE Programmes de résidence en France, en Belgique et au Canada.

PARTICIPANTS Un total de 57 résidents en dernière année de formation.

MÉTHODE Il y a eu 10 groupes de discussion dans 3 pays: 2 en France, 3 en Belgique et 5 au Canada, tous dans des villes différentes, avec des résidents inscrits dans des universités différentes en France et au Canada, et avec les résidents d'une seule université en Belgique. L'étude respectait le cadre conceptuel d'Abbott sur le système des professions. Les groupes de discussion de 90 minutes était tous supervisés par les mêmes chercheurs. Les transcrits ont été analysés selon la méthode d'immersion-cristalisation.

PRINCIPALES OBSERVATIONS Les répondants avaient des idées communes sur le rôle du médecin de famille: la continuité des soins et l'intérêt du patient étaient considérés comme les fondements de la discipline. Les répondants partageaient aussi un sentiment de malaise à propos de la disponibilité que les patients attendaient d'eux et du large spectre de la médecine familiale. Ils voyaient la médecine familiale comme flexible et disaient chercher un équilibre entre leurs objectifs professionnels et personnels. Tous les répondants croyaient fermement que leur profession était sous-évaluée par la faculté de médecine où ils avaient été formés.

CONCLUSION Cette étude préliminaire suggère qu'il y a plus de similitudes que de différences dans l'idée que se font de leur discipline et de leur carrière les futurs médecins de famille de différents pays. Nous avons observé une certaine opposition entre le désir de développer « une nouvelle pratique générale » et la vision plus traditionnelle de la discipline. La mentalité qui règne dans les milieux universitaires semble contribuer à maintenir le peu d'attrait à l'égard de la carrière de médecin de première ligne

POINTS DE REPÈRE DU RÉDACTEUR

- Les données de certains pays suggèrent que les médecins nouvellement formés conçoivent leur rôle différemment de ce qu'on considère généralement comme les caractéristiques fondamentales de la pratique générale. Cette étude voulait examiner l'idée que se font de leur nouvelle carrière les résidents du Canada, de la France et de la Belgique.
- Plusieurs des opinions exprimées par les résidents des 3 pays étaient semblables, mais avec parfois des différences d'intensité. Ainsi, même si tous les participants croyaient que la relation médecin-patient est importante, les résidents européens voyaient la médecine familiale plutôt comme une « profession de relations » dans laquelle les connaissances n'avaient pas la même importance que dans les autres spécialités, tandis que les répondants canadiens estimaient que la capacité de traiter un large éventail de problèmes conformément aux plus récentes directives de pratique était de la plus haute importance.
- L'observation la plus dérangeante était que les contextes académiques contribuaient substantiellement au faible attrait exercé par la médecine familiale. Les participants étaient tous convaincus que leur profession était sous-évaluée par la profession médicale et par les patients. Ce message leur parvenait clairement dès le début de leur formation mais aussi dans leurs relations avec des spécialistes durant leurs stages, même quand ils étaient plus exposés à des modèles d'identification en médecine générale.

Cet article a fait l'objet d'une révision par des pairs.
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As industrialized countries are strengthening their primary health care sectors, the profession of family medicine is losing its appeal.[1-5] Data from some countries suggest that newly trained general practitioners have conceptions of their roles that differ from what is considered the core of general practice: a commitment to ongoing care for a population of patients and the maintenance of a diversified scope of practice.[6-8] In addition, in order to ensure that available expertise is used optimally, professional roles are changing. The question "But what *is* a family physician?" is being asked more often than ever by decision makers, the public, and family physicians themselves.[9] In response to this situation, many general practice organizations have revisited their definitions of the discipline.[10-12]

The educational system strongly determines the development of professional identity.[13,14] Nevertheless, few studies have explored how trainees in family medicine view their profession by the end of their training.[8,15] The idea for this study arose when some of us (M.D.B, D. Pestiaux, B.G.) worked on the French version of the definition of general practice and family medicine for the World Organization of Family Doctors.[16] As many of the challenges facing family medicine are universal, we wanted to explore to what extent residents from our respective countries shared common conceptions of their discipline. Our objectives were to identify similarities and differences among the conceptions and experiences of trainees from France, Canada, and Belgium and to explore how those observations could help identify universal challenges in the training of general practitioners.

METHODS

Design

We used a qualitative design using focus groups. Focus groups allow the collection of a range of views with a modest investment of time and money. They also promote interaction and debate among participants, giving rise to rich discussions and a better understanding of the opinions expressed. At least 3 focus groups in each category of respondents are needed to assure saturation of findings.[17]

Context

We approached the European training programs with which we had affiliations. Canadian training programs were chosen to reflect Canada's 5 regions. All focus groups were moderated by the same researchers, who were not on faculty at any of the participating training programs and who were not known by any of the residents who participated. To minimize any biases in the analyses as a result of our deep involvement in the issues under investigation,[15] the team included researchers from a variety of disciplines as well as a general practice trainee.

Participants

Three focus groups were conducted in Belgium, 2 in France, and 5 in Canada. The Canadian focus groups were part of a larger study on the training of family physicians and other specialists.[18] The comparative analysis of the interviews with the European and Canadian family medicine residents was planned from the outset as a distinct study. To be eligible for the study, residents had to be in their final year and to have completed their general practice rotations. We used a purposive approach to sampling to assure a balance between men and women and to take into account the diversity of the family medicine teaching practices of each university. The latter criterion meant that all participants in a given focus group had to come from a different teaching practice. All 92 final-year general practice trainees at the Université catholique de Louvain in Brussels, Belgium, were first contacted by mail. Twenty responded to the invitation and were invited to participate, but 4 could not attend on the date set for the focus group. For the French and Canadian focus groups, invitations were extended only to eligible residents available on site at the time of the study (ie, those not on rotation in remote settings).

Conceptual framework and interview guide

The interview guide was similar for the European and Canadian studies and was informed by Abbott's conceptual framework on the system of professions.[13] It focused on the concept of professional identity and exploring trainees' conception of their discipline's tasks and roles. The semistructured interview guide explored participants' vision of the discipline, how they envisaged their careers, and how they thought their training prepared them for these careers. No definitions of general practice were provided; as such, all opinions about the discipline were spontaneous.

Focus group sessions

The focus groups lasted 90 minutes and were held at the participating universities. In Belgium, they were held in 3 communities where general practitioners affiliated with the Université catholique de Louvain hosted trainees (Brussels, Namur, and Charleroi). A 30-minute debriefing session between moderators followed each focus group.

Analysis

Analysis was based on interview transcripts. Debriefing session transcripts were used for triangulation. Because our objective was to compare similarities and divergences in the perceptions spontaneously expressed by our European and Canadian respondents, we first conducted a within-group analysis. The analysis of the European component of the study has been published previously.[19] Researchers then reread the 10 focus group

transcripts. We compared the themes according to the 3 dimensions explored—participants' vision of the discipline and of their roles, their vision of their future careers, and their opinion about how their training had prepared them to become family physicians—keeping in mind what themes were common to both categories, whether certain themes were more preponderant, and what new themes emerged. Each author analyzed the transcripts independently according to the immersion-crystallization method,[20] which involves repeated cycles of immersion in the data to uncover recurrent themes, progressive discovery of hypotheses for the findings, and linking the findings with theoretical frameworks from the literature. We did not systematically code the transcripts with qualitative data analysis software.

Because of distance, we shared interpretations in a variety of ways. First the Canadian researchers (M.D.B., G.R., L.B., and M.R.) met; then the European researchers (V.D., D. Pestiaux, and D. Pouchain) met with M.D.B. Finally a conference call was held between the European and Canadian teams; M.D.B. integrated the results of the 3 meetings and shared them with all the researchers by e-mail.

The study received ethics approval from the Ethics Research Committee of the Centre de recherche of the Centre hospitalier de l'université de Montréal in Quebec and from the Ethics Committee of the Cliniques universitaires Saint-Luc of the Université catholique de Louvain.

RESULTS

In Europe, 28 trainees participated (18 men, 10 women; mean age 28.0 years). In Canada, 29 residents participated (12 men, 17 women; mean age 26.3 years). There were more similarities than differences in the themes expressed by both categories of respondents, and no new themes emerged from the comparative analysis of the European and Canadian samples. We report the results according to the 3 dimensions of our analytical framework: the discipline of family medicine, the career, and the training.

Discipline and roles: agreement and discomfort

There was convergence in the representations of the cardinal features of general practice captured under 3 dominant themes: the relationship built over time between physician and patient; the capacity to solve a variety of problems at the primary care level; and the integration and coordination of the patient's care. However, the 2 categories of respondents attributed different importance to these features. The discourse of our European respondents put more emphasis on the relationship component of the discipline. They expressed a strong sense of responsibility for being available to ensure continuity of care. The words they used conveyed the impression that they conceived of family medicine largely as a "profession of relationships," in which knowledge was not at the forefront as much as it was in other specialties.

> First and foremost [family physicians play] a social and human role, before any medical intervention. My idea is of a physician who listens to people first and then responds medically if necessary. (Woman 1, France; authors' translation)

The European trainees we interviewed, however, considered that the expectations of accessibility and continuity of care that they believed were implicit in the general practitioner role were not realistic within the current context of general practice (ie, solo practitioners committed to their clientele). Many expressed with emotion that they considered themselves to be caught between highly valued relationships with their patients and the burden these relationships imposed on their personal lives. Their solution was to seek different models of practice, such as group practice.

> I'm sure I'll work in a group practice. Not alone. Not to be eaten up. Not having to go home late at night. Not to be stressed out. We have the impression of not really listening to people, of missing certain things. (Woman 3, Belgium; authors' translation)

Our Canadian respondents also considered continuity of care to be central. However, their discourse revealed that they perceived that the capacity to manage a broad scope of problems according to the latest practice guidelines was paramount. "I'm nervous about not being able to keep up, especially depending where I choose to practice. Will I have access to a medical school?" (Woman 1, Canada)

They expressed more apprehension about the expertise expected of them to solve a vast array of problems than they did about the commitment to a clientele. For many, limiting scope of practice appeared to be a solution.

> I am feeling a little bit overwhelmed by all [the] aspects of family medicine. Therefore, I want to specialize. I am considering obstetrics, and annual family follow-ups, and probably palliative care. I do have adults in mind; I don't exclude them, but I would probably try to focus as much as I can on a specific population. Because doing everything just seems too much. Considering my ability to absorb information, I think that I could be a specialist instead of doing everything. (Man 3, Canada)

Although "specialization as a solution to the perceived burden on family practice" emerged as a theme

mostly in the interviews with the Canadian respondents, respondents from all 3 countries considered the possibility of developing a particular expertise while practising as a family physician to be an intellectual challenge and one of the added values of being a family physician. "We're generalists, but it's also an opportunity to be a little bit of a specialist while being a generalist .... I like the idea of knowing something a little bit more." (Man 3, Canada)

Entering a career with caution

Five themes emerged with the same importance among Canadian and European respondents about the career of family practice. First, all respondents saw family practice as demanding. While most respondents were enthusiastic about their new careers, 2 respondents in Europe confessed that they would not practise as family physicians because the profession was too demanding. Second, the flexibility of family practice emerged as the principal asset of the discipline. Both categories of respondents saw general practice as a career that could evolve over time and be adapted to one's interests and abilities. Many French and Canadian respondents preferred to delay setting up practices to keep their flexibility.

> [Y]ou lose a bit of the flexibility that you have if you don't have your own practice, so you need to find locums or people who can help with the hours that you don't want. So I think those are the kinds of barriers: you tie yourself down a bit. (Man 4, Canada)

One other theme that emerged strongly in both respondent categories was that of postponing engagement with a clientele until certain personal life issues were resolved (choosing a city, finding a spouse, etc). "You have to figure out for yourself what you want out of life, out of your practice, out of your different activities." (Man 3, Canada)

Another common theme, expressed equally frequently and forcefully by both men and women, was that careers should allow enough time to realize personal aspirations and balance professional and personal obligations. Being a general practitioner was seen more as a job than a vocation. "A major obstacle for me, I think, is going to be balance of family and work .... And medicine, like I said, it's a meaningful job, but it's a job." (Woman 1, Canada)

Finally, a last theme expressed in all the focus groups was disinterest in the administrative aspects of traditional fee-for-service practice in a group practice.

> I think starting from scratch would be incredibly difficult. Where I'm working now, they mentioned hiring me on as I end and there are a lot of advantages to that because then you don't have to worry about the overhead starting-up costs, which are huge, not knowing if you're in a good location or not ... all those sort of business-oriented aspects. (Man 5, Canada)

Training: a devalued profession and a generation gap

In general, European and Canadian respondents believed that their training prepared them to assume their functions as family physicians. They all spoke of tensions between their undergraduate training—hospital-oriented—and the specific training of their community-based residency programs, and of the adaptation initially required of them. This tension was more strongly expressed by the European trainees. Many from the 3 countries described negative experiences encountered during their training when interacting with specialists for patient care, or witnessed during rotations in specialized services. Many were told by specialist teachers that they were too bright to be general practitioners. One French trainee related the reaction of her specialist teacher when she announced she would not take the Internship Examination*: "And when I said, 'No, I'm not taking the Internship Examination; I want to be a generalist,' I really had the sense of being the ugly duckling!" (Woman 1, France; authors' translation)

Similar comments were heard in almost all focus groups. Participants were often compelled to assert their professional legitimacy, and their fight for legitimacy was seen to be on less solid ground than for specialist physicians.

DISCUSSION

Three main observations emerged from this study. First, respondents shared common perceptions about the family physician's role and saw the career of family practice evolving from a totally patient-committed "vocation" to a "job" that offers balance between personal and professional aspirations. It is interesting to observe, however, that the importance participants attributed to the 2 core attributes of their profession—managing a vast array of problems and ensuring accessibility and continuity of care for a clientele of patients—differed slightly on each side of the Atlantic. Because of the exploratory nature of our study, the differences that we found among residents might simply be the result of the particular samples we obtained in each country. However, because the practice situations of Canadian family physicians and those in France or Belgium differ, it is plausible that representations might differ according to the country of origin. In France and Belgium,

*In France, until 2 years ago, accessing a training position in a specialty was very difficult and depended on your success with the Internship Examination; general practice was accessible without a qualification examination.

family physicians still work in solo practices and few are active in hospitals. Family physicians in these countries have reported the growing burden imposed by the necessity of ensuring accessibility and availability to an increasingly demanding clientele.[8,21,22] It is not surprising that in Canada, where the practice of family medicine includes in-hospital care, the pressure of the scope of practice was felt more strongly.

Second, conceptions of the discipline introduced an uneasiness that led residents to consider restricting the commitment expected of them by engaging in practice styles different from those of their educators. This theme emerged in all the focus groups. Nonetheless, most respondents spoke of their future practices with enthusiasm and were confident in their abilities to develop practice profiles that would correspond with their aspirations. Group practice, remuneration schemes, practice organization that reduced administrative hurdles, and the possibility of developing some expertise in a field of interest appeared central to the vision of this "new way" to practise family medicine. The divide we observed between the desire of future general practitioners to develop a "new general practice" and the more traditional vision that is reiterated in most definitions of general practice and family medicine[9,11] has also been observed by others.[6]

Third, all respondents strongly believed that their profession was undervalued by the medical profession and by patients. They get this message clearly from the very start of training and through interactions with specialists during medical rotations—even in Europe, where exposure to general practice role models in postgraduate training is more extensive than in most Canadian medical schools. This phenomenon appears in the literature,[23] and anecdotes of students being told they are "too clever" to go into general practice are legion.

Limitations and strengths

This study is limited by its exploratory nature. It was conducted in a specific context and with a limited number of participants. It is likely that our approach to sampling in Belgium—a general invitation—led to the inclusion of students more interested in the issues. It is important to remember that generalizability was not the aim of the study. Rather, our objective was to document variations and common patterns of opinion on the discipline of family medicine among young general practitioners from the 3 countries. Obviously, there is a need for replication in different contexts, given the known effects of university structures and policies on trainees' attitudes toward primary care.[24] We consider that the international nature of the sample is a strength.

There are also limitations inherent in the focus group methodology. Exploration of opinions is more superficial because of the small number of participants. It is also sensitive to group dynamics, or *group censoring*.[17] We used many approaches to counter this phenomenon, frequently asking for input from around the table and serving as devil's advocate.[17] Saturation was reached, confirming the breadth of our findings. We strove for reflexivity and enriched the analysis by including researchers from different backgrounds in the investigator group.[20]

Conclusion

The question of professional identity is important. Professionals need a clear sense of their profession's identity and area of expertise to function effectively.[13,14] How family physicians define their roles in our changing health care systems will have a real effect on the roles and functioning of other professionals in the system.

Our results identify 2 issues that transcend specific health care systems that would need to be explored in more depth because of their importance to the discipline. The first is what seems like a quest of the new generation of family physicians for a "new family medicine." In Canada, as in France and Belgium, new policies to modify the organization of primary care are being implemented. It would be interesting to explore to what extent those new models of practice correspond better to the aspirations of the new generation of family physicians.

The second issue is a considerable concern: academic settings contribute substantially to the persistent low appeal of being a primary care physician at a time when the primary care sector is widely recognized as the cornerstone of any health care system and when health authorities are struggling to initiate extensive primary care reforms. The divide between primary care and specialized medicine in day-to-day practice is becoming an important cause for concern, as it has been proven to not only contribute to the declining appeal of a career in primary care but also to jeopardize patient safety and quality of care.[25,26] We concur with opinions expressed by others that leaders in medical education must become advocates of primary care.

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Contributors
All authors contributed to the concept and design of the study and interpretation of data, revised the article critically for important intellectual content, and approved the final version to be published.

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None declared

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