

Family Medicine in Newfoundland & Labrador

A T E N Y E A R V I S I O N



NEWFOUNDLAND AND LABRADOR
MEDICAL ASSOCIATION



Faculty of Medicine

NEWFOUNDLAND AND
LABRADOR COLLEGE OF
FAMILY PHYSICIANS



LE COLLÈGE DES MÉDECINS
DE FAMILLE DE TERRE-
NEUVE-ET-LABRADOR

A CHAPTER OF THE COLLEGE OF FAMILY PHYSICIANS OF CANADA
UNE SECTION DU COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA



Cover photo (L-R): Memorial University Faculty of Medicine students
Josh Lehr, Hilary Strong, Jillian McCarthy, Ahila Karunanithy and Jinessa Lane

INTRODUCTION

Family medicine is widely regarded as being at the heart of the health care system. A family physician's practice includes diagnosis and treatment, disease prevention, health promotion, and advocacy on behalf of their patients. Their speciality is not defined by a specific disease, organ or body system. Nor is it defined by the age or gender of the patient or by the setting in which care is provided. Family doctors practise in private community-based clinics, in hospitals, patients' homes, nursing homes and other community facilities. Their patients encompass all ages and have a myriad of health issues, illnesses and chronic diseases.

Family doctors in Newfoundland and Labrador see worsening practice conditions that create risks for their patients. They see thousands of orphaned patients who are struggling without access to a family doctor. They see growing levels of complex and sick patients who require more physician time and other resources to cope with chronic diseases. They see physicians with extraordinary stress trying to cope with the patient load and the strains of operating a viable practice. They also see a lack of respect and support for their critical role in the health system.

Despite the challenges, these family doctors are inspired by their patients and passionate about making a life in this province. They want to build a better health system where all citizens have access to the primary care they require and the quality of life they deserve. They want to tackle these problems in partnership with other health professionals.

The Newfoundland and Labrador Medical Association (NLMA), the Newfoundland and Labrador College of Family Physicians (NLCFP), and the Discipline of Family Medicine (DFM) regularly consult family physicians and medical learners about the challenges and opportunities in family medicine. The three parties decided to release this vision paper in May 2018 to coincide with World Family Doctor Day on Saturday, May 19. The paper describes the forces that are creating the current problems, the strategies that are already working well, and the next steps needed to move family medicine forward. The paper also includes a series of vignettes that highlight the personal experiences of family doctors working in Newfoundland and Labrador. The vision set out in this paper can be achieved by all partners in the health system working together.

Roger Butler

It's no secret Newfoundland and Labrador has an aging population. Perhaps no one knows that more deeply than Dr. Roger Butler, who has been dedicated to providing geriatric medicine since the 1970s.

"The biggest proportion of anybody's practice in this province today is geriatrics," Dr. Butler said.

"We've got a big geriatric population that's increasing, and we have one of the oldest populations right now, over 65, in the country. By 2028, if my calculations are correct, we'll probably have the oldest proportion of people over 65 on the planet."

Dr. Butler started his family practice in the late 70s. In 1985, He was hired by Memorial University as a clinician — and he's never looked back. In addition to his academic career, Dr. Butler also provides call for The Dr. Leonard A. Miller Centre and for many years was the physician for the Veterans Pavilion.

"I've regarded it as a privileged position; I love the patients. But in my lifetime, I've seen a geriatric explosion take place," he said.

"I received my training in 1977. Back then if you didn't do obstetrics and pediatrics you weren't a full scope general practitioner. Now if you don't do geriatrics, you're not a full scope general practitioner."

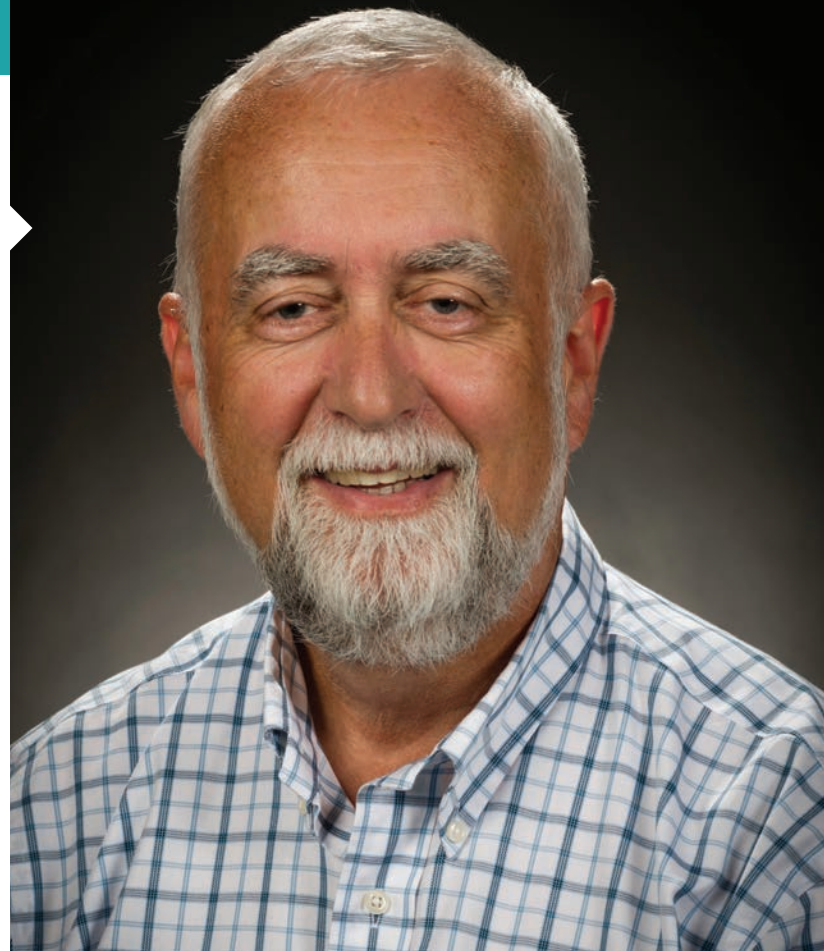
With an aging population comes patients with complex needs, and it can be tough treating them. Dr. Butler argues that an appropriate fee code is needed for geriatric assessment.

"You can't look at a complex elderly patient in under a half an hour. You can't do it justice," Dr. Butler said.

Among the challenges facing family doctors in this province is the lack of cohesion amongst physicians, Dr. Butler said. He believes the team concept within primary care is a problem that has to be solved.

"What we need is more interprofessional respect shown to family doctors. And the way that family doctors do that is they've got to get reengaged in the hospital system. When we got squeezed out of the hospital, we lost that mutual positive regard that was held between the consultants and the GPs, and to get it back once you've lost it is really, really difficult," he said.

"There's a whole lot of complex stuff that family doctors do that's totally underrated ... we are the most underappreciated, undervalued group in the system."



For Dr. Butler, it's the people of Newfoundland and Labrador that keep him here — despite the challenges — doing the job he has considered a privilege all these years.

"The patients are fantastic. The older patients are so respectful of your time and of the littlest thing you can do for them. And the need is so great," he said.

"In life, the things that make you happy are the things that give you purpose and meaning. It's not the size of the car and it's not the big trip you're taking. At the end of the day, do you go home and do you feel good about what you just did. And I still feel good about what I did. I've been blessed to have wonderful colleagues around me and wonderful support staff. I've got a province that I dearly love. I've got a population that I want to give excellent care to, but it frustrates the hell out of me to see how uncoordinated things are."

Dr. Butler says it's the future family physicians of the province that keep him optimistic.

"I have hope," he said.

"I get frustrated some days ... and then I have this student that comes into my office, and I have them for an hour or two, and I see their enthusiasm and their joy of being in medicine, that's what keeps me going."

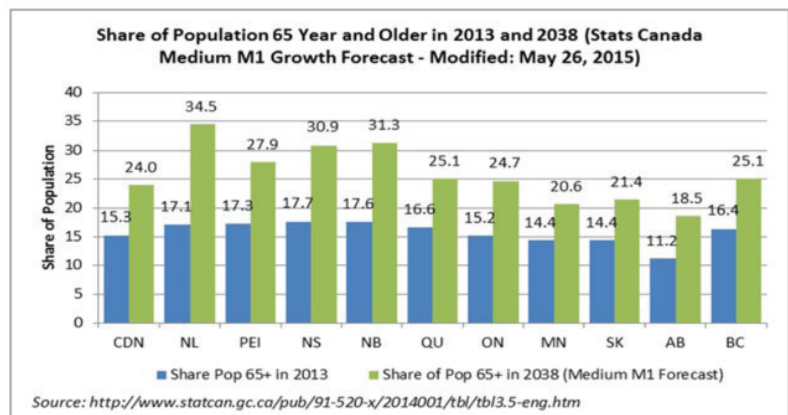
THE PROBLEM

The current challenges of primary health care are being driven by the aging of the population, the fiscal circumstances of the provincial government, and the persistence of physician human resource policies that have not only failed to solve current problems, but are also fundamentally ill-suited for the future. Our province cannot afford to spend more on healthcare. What we need is a government commitment to the ongoing renewal of family medicine.

The NL population is aging faster than in other provinces.

By 2038, Statistics Canada expects that more than one third of our population will be 65 years of age and older.ⁱ This represents about double the proportion of seniors in our province than we have today. Doctors are already witnessing the exponential increase of complex health care needs associated with older adults. This situation is creating distinct challenges for primary care that our health system is not prepared to manage.

NL already has the highest incidence of chronic disease in Canada. We have the highest prevalence of obesity of any Canadian province, and we lead the country with the highest rate of Type 2 diabetes.ⁱⁱ We know that people with chronic health conditions use a larger proportion of health care resources than those without them, and that many seniors have multiple chronic health conditions. As the population becomes older and the incidence of chronic disease grows, there will be a corresponding increase in demand for medical services.



Mari-Lynne Sinnott

Dr. Mari-Lynne Sinnott believes the beauty of family medicine is building meaningful relationships with patients.

After finishing her residency she wasn't sure what she wanted to do, so she took time to explore her options and spent the first six months of her medical career doing locums in rural Newfoundland and Labrador and in the Northwest Territories. But the call to home was just too strong and locuming didn't allow her to fulfill the reasons she got into medicine in the first place.

"A big part of the reason why I wanted to do family medicine was because I wanted the patients to be mine, to get to know them over time and through their lifetime, and consistently build that relationship," she said.

In January 2016, Dr. Sinnott, along with Dr. Kelly Monaghan, opened Clinic 215 in downtown St. John's, a neighborhood family practice that provides care for people within vulnerable populations. Dr. Sinnott's niche at the clinic is serving the LGBTQIA2S+ community.

"The idea of serving in an underserved area was very appealing to me," Dr. Sinnott said.

While she originally thought serving an underserved area meant practising in rural and remote communities, Dr. Sinnott soon found the need is great close to home, too.

"What was quite interesting to me was the realization that there are huge numbers of vulnerable and underserved populations in St. John's. There's a lot of work that needs to be done right in our city," she said.

In addition to the work at Clinic 215, Dr. Sinnott also works part-time at The Gathering Place, a community service centre that promotes equality and provides nourishment to meet the needs of vulnerable people in St. John's.

Working in these areas, Dr. Sinnott quickly learned you can't always do everything "by the book."

"When you're dealing with vulnerable populations and people whose lives are chaotic and messy and difficult, you have to practise medicine in the context of their lives in a way that makes it accessible to them," she said. "We're trying to offer some meaningful change to a person who just doesn't fit the typical patient profile."

The biggest challenge Dr. Sinnott faces as a family doctor is lack of time.



"Because, unlike any other specialty, we're dealing with every aspect of people's lives," she said.

"Am I seeing enough people to be able to pay my overhead and pay my bills and live? How many people do I need to see today to be able to keep the lights on?" That's a much different number than how many people I would want to see so I can spend the time with them that they deserve, and the time that I need to do the best job that I can do."

Managing patients' expectations and finding work-life balance is also a challenge, Dr. Sinnott said.

"The problem right now is that we are all so overworked and struggling to keep our heads above water, so it probably doesn't seem like a very appealing lifestyle. I think in a lot of ways the province sells itself and the people sell themselves, but the workload is a challenge," she said.

"And I think feeling a lack of support from the government in particular this year has been very challenging. We seem to have come to this point where it feels like we're not truly supported in a lot of the difficulties that we face. I don't think people get the sheer volume of work that's involved in being a family doctor."

Despite the challenges, Dr. Sinnott isn't planning on jumping ship.

"I'm committed to my patients. I know that the services we're providing have changed people's lives. I would never be able to just walk away from that," she said.

Family physicians need support to provide high quality care to underserved populations.

In addition to older patients with complex needs, family physicians are increasingly caring for vulnerable patients from underserved populations. In our province, this includes increasing numbers of patients with mental health and addictions issues, a growing refugee community, Indigenous populations, the LGBTQIA2S+ community, and incarcerated individuals.

More needs to be done to support family doctors who provide care for vulnerable patients. One promising solution is supporting physicians to work in interdisciplinary teams where they can collaboratively meet the complex health care needs of these patients.

NL's health system is facing serious financial risks.

The critically serious financial situation of the provincial government has a direct impact on primary health care. The need to address high levels of health spending as part of the government's overall budgetary dilemma is well understood. However, a health system plan that approaches the problem in a rational way, and supports a long-term vision for primary health care is needed.

The government has been trying to live within a fixed, \$3 billion health budget for the last three years, which actually means that health care is being cut and trimmed everywhere to move money around to cover inflation and new priorities. That is why seemingly random decisions are being made to cut physician fees for flu shots, cut physician recruitment incentives, slash the benefits of academic physicians, eliminate salaried physician jobs when they become vacant, squeeze savings from the locum replacement budget, and reduce the hours of some rural emergency departments and diagnostic imaging units. None of these decisions are part of a plan with a clear vision for making the system better.

The government's budget projections for the next five years predict worsening conditions. The Provincial Budget forecasts a government-wide expenditure reduction of \$450 million, which means a \$200 million

reduction in health care if the impact is spread on a proportionate basis. More ad hoc budget reductions can be expected without a health system plan, and that will impact patient care. Vulnerable patients, like the older and more complex, need to be protected from deep cuts to health care.

Unless doctors have a hopeful vision for the future, where restraint is equitable and planned, health care needs are transformed in a rational way, and patient care is supported, doctors will look elsewhere for fulfilling professional opportunities.

Physician recruitment and retention needs to become a priority.

Like the general population, NL's physician workforce is aging. In this province, a large proportion of our older family physicians run community-based Fee-For-Service (FFS) practices. Currently, 14% of these family physicians are 65 years of age or older, which is up from 8% in 2012. As older doctors with large patient panels retire, there is a risk of patients who currently have a regular family doctor becoming 'orphaned' if the system doesn't have the capacity to accept them into a new family practice. This situation is already occurring regularly around our province.

Currently, there is no provincial physician human resource plan that identifies the appropriate number and placement of family physicians to meet the province's current and future primary health care needs. The province also lacks a provincial recruitment strategy for community-based family physicians.

Access to family doctors: the gap. Ten percent, or 50,000, of the people in our province do not have a regular family doctor.ⁱⁱⁱ NLMA-commissioned public polling suggests the proportion of the population without a family doctor could actually be as high as 13%.^{iv} Our family physicians are spread across a large geographic area. Many are employees of regional health authorities, located in areas where populations are small. And there are geographical variations in access across the

Yordan Karaivanov

Bulgarian-born, Labrador-living Dr. Yordan Karaivanov has been practicing family medicine in Happy Valley-Goose Bay for almost two decades.

"I feel very well-respected in the community," he said. While adapting to life as an IMG (International Medical Graduate) can be tough at first, Dr. Karaivanov has some ideas on how to make it work for both physician and patient. In particular, adjusting unrealistic expectations.

"People coming from other countries expect to be respected from day one, and really we know that respect is not given, it's earned. And rural communities are very, very quick sometimes to write-off people from other places who slip in communication, who really don't somehow connect very well to the community from day one," he said.

"I think if both sides are a little bit more patient with each other, I think that many more people will stay."

Staying wasn't a problem for Dr. Karaivanov. He says he doesn't think of leaving because he has no reason to. His children are in high school and have grown up in Happy Valley-Goose Bay. He has a stable medical team and after 17 years in the rural community, he is the Chief of Staff. He also finds his work highly gratifying.

"Practising with an Indigenous population is very rewarding because those people are very resilient. They are generally very good people ... And at the same time, a lot about their situation is very tragic," he said.

"I have seen kids become young parents; I have seen fit people succumb to chronic disease; I have seen suicide. In many ways there is a dramatic element to practising in an Indigenous community because so much is happening. It's quite interesting, quite rewarding to practise in a place like that. This is part of the reason why I'm still here."

Another reason Dr. Karaivanov chooses Labrador is because of the nature of rural medicine. Dr. Karaivanov and his team have a wide scope of practice, including procedures not often done by family doctors, like obstetrics.

"It's not for everyone. You have to have clinical courage," Dr. Karaivanov said. "It's not easy to do."

The senior physicians in the community also place a high



value in providing mentorship to the new-to-practice doctors, and in finding balance between personal life and their professional obligations. Dr. Karaivanov says he almost never turns down a request for leave.

"The reason why we can do that is because as a group we have decided that the need for work-life balance is important, so we recognize that there will be times when we'll be doing more work because we want to be able to take leave when we want to," he said.

According to Dr. Karaivanov, the key to ensuring that family medicine thrives in the province is for government to support and recognize generalism. He believes the more a physician can do, the better.

"The way to go forward is for family doctors to really consciously try to maintain as broad a practice as possible ... Let's sustain generalism, because this is shown to work," he said.

"There is this tendency for society to think the more specialized you are the more valuable you are. I couldn't disagree more with that. I think there is value in specialists, nobody doubts that ... But there is also value in versatility, in the ability to provide care to whomever comes to the door."

province. Some parts of our large province have difficulty maintaining an adequate supply of family doctors: one third of patients in Labrador and approximately 15% of patients in Central Newfoundland report that they do not have a regular family doctor.^v

In 2016, the NLMA commissioned Corporate Research Associates Inc. (CRA) to survey Newfoundlanders and Labradorians about their access to family doctors. While 64% of those who had a family doctor were satisfied with the wait time to get an appointment, 27% of the province's residents said they find it difficult to get an appointment when they need one. About 47% of residents, or nearly half, reported waiting between 3-7 days to get an appointment with their family doctor, while 14% wait between 8-14 days and 11% wait more than 14 days. Only 27% of those with a family doctor reported having access to same or next day appointments.

When they are unable to get an appointment in a timely manner, 31% of patients go to a walk-in clinic, another 30% go to an emergency room and 13% go without making an appointment altogether. Approximately 60% of people without a family doctor said they rely on emergency departments for their primary health care needs and 40% reported they also rely on walk-in clinics.

The 2016 survey also revealed that many patients often lack longitudinal attachment with their family doctor due to physician turnover. About 54% of residents in the province reported having at least two family doctors in the past five years and 14% reported having at least three. The number one reason for changing family doctors was due to the physician moving out of the area (41%), followed by their doctor retiring (23%).

Turnover, out-migration and the role of Memorial.

The Faculty of Medicine at Memorial University has made significant efforts to train family doctors for practise in rural communities in the province. They have been recognized by the Society of Rural Physicians of Canada, who awarded the Discipline of Family Medicine their seventh Keith Award in 2018, for producing the largest number of graduates practising

in rural areas 10 years after graduation. Despite their accomplishments, without strong recruitment efforts in the health system and appropriate supports for doctors, there will continue to be instability and significant turnover of doctors in NL.

In 2016, Newfoundland and Labrador had the highest net out-migration of family physicians of any province; 4.2% of family doctors in 2015 had moved to another province in 2016. The actual out-migration is even higher, given that this calculation is based on out-migrants minus in-migrants. This instability includes all categories of doctors, whether they are graduates of Memorial, other Canadian medical schools, or from outside Canada. Saskatchewan, the only other province with a higher reliance on foreign-trained medical graduates than Newfoundland and Labrador, lost fewer doctors to other provinces (2.9%).^{vi}

Retention of Memorial graduates in the family medicine workforce is the best way to provide stability and reduce turnover in NL, but the retention record is not good. There were about 33 family medicine residency positions at Memorial each year between 2011 and 2016. Residency positions are filled through a national matching system in which medical graduates often train in a different province than where they received their Doctor of Medicine (MD). On average, only 15, or just under half, of Memorial's family medicine residency positions were filled by Memorial medical graduates. It is a hopeful sign that in 2018, 23 of the 33 positions will be filled by Memorial graduates, but it is not yet clear whether this upward shift is permanent.

While filling a greater number of the Memorial residencies with Memorial graduates would be a significant boost to recruitment and retention, there is value in the national matching process, which creates opportunities for recruitment and retention from across the country. Residents from out-of-province come to train in Newfoundland and Labrador, and can potentially be recruited to the areas in which they train. They also become ambassadors for NL amongst their colleagues from other provinces.



After residency, it is critical that the province retain the maximum possible number of these physicians within the province. Recent experience is that an average of only 13 doctors per MUN medical class, who completed their family medicine residency training either at MUN or elsewhere in Canada, are currently practising family medicine in Newfoundland and Labrador. Moreover, according to the 2017 CMA Physician Workforce Survey, Newfoundland and Labrador has the highest proportion of physicians who plan to relocate to another province in Canada. Fourteen percent of NL physicians said they plan to leave for another province within the next two years compared to the national average of 3.1%.

The question, then, is why are we not attracting more of our own doctors to stay in the province and stabilize the coverage for the population? The inability to retain these doctors is a central problem for other members of the physician workforce, whose practices bear the pressure from thousands of orphaned patients and the illness that accumulates in the population where so many people cannot receive longitudinal and comprehensive care from a family doctor.

These circumstances can also lead to physician burnout. The 2017 CMA Physician Workforce Survey found that physicians in Newfoundland and Labrador have the highest rate of dissatisfaction in the country when it comes to the balance between their personal life and professional commitments. About 36% of survey respondents from this province said they were not satisfied with their work-life balance compared to the national average of about 26%.

New graduates are being taught in different ways.

The Faculty of Medicine at Memorial University trains undergraduate students and family medicine residents with a comprehensive rural-focused approach to primary care. This is different from the way many family physicians were trained in the past. Memorial trains family physicians to have a generalist ability to practise in rural and remote areas, where they will often

be practising without other specialty support. These graduates are trained to provide high quality care, in line with research and best practices, which may mean seeing a lower volume of patients in order to spend more time providing comprehensive care to complex patients. New graduates quickly discover this is a way of practising family medicine that is not consistent with the fee-for-service payment model that pays physicians according to the number of patient encounters. Another area where our health system is not keeping up with medical education is primary care teams: Memorial trains physicians in interdisciplinary teams, but these aren't always available to new graduates as they move into practice.

New doctors want to practise in different ways.

Community family medicine is associated with working long hours to meet the needs of large, and increasingly complex, patient panels, all while struggling to operate an efficient business within the limits of the FFS episodic billing model. Barriers cited to taking over the practice of a retiring solo practitioner include high patient loads, high numbers of older patients with complex needs, a substantial learning curve to get to know a new panel of patients, and potentially needing to modernize an older practice by shifting from paper files to an electronic medical record (EMR).

Family physicians in Canada under age 35 are more likely to choose to practise in hospital settings, emergency departments, community clinics, walk in clinics, and universities than family doctors over 35. Those physicians who do choose community family medicine prefer to join interprofessional or group practices, over traditional solo practitioner clinics.^{vii} Despite this preference, Newfoundland and Labrador has the lowest number of physicians who participate in a collaborative practice when compared to other provinces. The 2017 CMA Physician Workforce Survey found that about 26% of all doctors in this province report working in some form of a collaborative practice compared to the national average of 44%.

Jody Woolfrey

Dr. Jody Woolfrey has been practicing family medicine in Botwood for more than two decades. Originally from Lewisporte, he moved to Botwood as a young doctor eager for experience. Rural medicine offered a chance to practice within the broad scope of medicine. He knew he would have independence and gain the sense of reward accompanied by comprehensive family practice — working in the emergency room, long-term care, palliative care, in addition to caring for all age groups in the office.

Over the course of his 20-year career, he has witnessed many changes that have impacted the delivery of primary care services in his community, including a decline in population and industry. Like many small communities in rural Newfoundland and Labrador, it is becoming increasingly difficult to attract new physicians to care for the growing proportion of seniors, which has resulted in decreased access to family medicine.

“I came here at age 28, quite naïve and enthusiastic, and the economics of medicine was something I had little regard for,” he said.

“I was happy to have a job. I knew I would make a living and that was all that mattered. I did the work that had to be done, regardless of how I was paid or what I was paid. It is more than just a job, it is very much a calling, and many of us who have stayed long in smaller communities have paid a personal price,” he said.

While there are many positive, non-monetary rewards — like respect and appreciation from patients and families — rural family physicians often face demanding workload and intense call.

“Our families have to be very patient, because many times we miss out on things due to demands of the job.”

A real challenge for rural family medicine, according to Dr. Woolfrey, is patient access.

“The biggest thing that I lose sleep over, for most rural communities, is access to family medicine. There simply is not enough access. Many individuals do not have a



family physician and are frustrated dealing with a system that does not seem to respond to their needs,” he said.

“So patients are having to go to the emergency department for primary care, knowing it is not the ideal venue. Many individuals may be simply giving up and not seeking care.”

“To be realistic, I think there has to be adequate support, recognition and appreciation for the complexity of the work being done, plus competitive remuneration. This might enable young, adventurous physician graduates to go to Harbour Breton, Burgeo, Port Saunders, or similar underserved communities,” he said.

“A challenge in Newfoundland and Labrador is the barrier posed by a remuneration system which fails to recognize that the scope of practice is different and the risk higher in rural and remote settings. This should be addressed, as it has been in other rural and remote jurisdictions in Canada, with the result that communities receive the care they deserve.”

Fourteen percent of NL physicians said they plan to leave for another province within the next two years compared to the national average of 3.1%.

In 2012, the National Physician Survey focused its polling solely on physicians completing their residency training. When Canadian family medicine residents were asked what type of practice set-up they would prefer, only 1% said a solo practice. About 24% said they would prefer a group practice of more than one physician, while 68% said they would prefer an interprofessional practice set-up.

The majority of family physicians in this province work within the fee-for-service payment model. Yet, the 2012 National Physician Survey results revealed that, if given a choice, the number one payment model preferred by family medicine residents in Canada is a (blended payment model (35.1%), while only 10.8% said they prefer to be salaried and only 9.8% said they prefer the fee-for-service model.

The overhead costs for running a private family practice clinic include occupancy costs like rent, utilities and maintenance, staffing costs associated with medical office assistants and other health providers, various professional services, licenses, fees, IT systems, medical equipment and other costs associated with running a small business. Overhead costs can be significant: in NL, FFS community-based family physicians spend, on average, a third of their income, or \$82,496 annually per physician, on overhead expenses. These costs are higher in rural areas, the parts of our province that are in the greatest need of family physicians, and average \$94,532 compared to \$76,556 in urban areas.^{viii}

As private professionals, FFS physicians receive no sick leave benefits, no annual leave pay, no health or dental benefits, no life insurance, no employment insurance benefits and there is no pension waiting for them when they retire.

Frederick Jardine

After more than 30 years of practising family medicine in Conception Bay South, Dr. Frederick Jardine is thinking about the next chapter.

"I always wanted to be a family doctor. I didn't have any aspirations to do anything different. And 35 years later, I can honestly say that I was glad that I entered family medicine. My patients now are really concerned about my attrition plan. What's going to happen when I leave? That's their big concern. Some of my patients I have been seeing for 35 years, and that's the nature of our practice," Dr. Jardine said.

"I've counselled people on retirement for 35 years, but I forgot to do the course myself. Letting go and just leaving is difficult. Really difficult."

The idea of retirement can pose a challenge for many family physicians in the province. While for some, like Dr. Jardine, being a family physician is their identity and it's hard to let go. Others are ready to make the move to retirement but cannot find replacements to take on their patients.

At Dr. Jardine's clinic there are five family doctors covering 10,000 active charts. Dr. Jardine estimates about 3,000 of those charts are his patients.

"They say that you need at least one-and-a-half full-time physician equivalents now to take care of a patient panel that size," he said.

To accommodate the transition of his retirement in the coming years, Dr. Jardine is looking for a sixth doctor to work at his clinic. These six will take over the patient load that five used to cover. Finding another doctor to add to the team can be a real challenge. Dr. Jardine admits they've had trouble.

"I think it comes down to the fact that there are very few people to choose from." Dr. Jardine said.

"There's just nobody around."



At the 2017 NLMA Annual General Meeting, Dr. Paul Bonisteel echoed this sentiment when he shared his experience of trying to find a family physician to replace him.

"I recruited actively for the final 10 years I was in practise. And to use a salmon fishing analogy, I had several on the hook but never managed to get one on the net. And in fact, I ended up leaving the practice," he said.

Despite his recruitment efforts, a replacement physician was never found.

"Recruitment, I know, is not just a rural problem. It's a problem. Rural, urban, right across the country," Dr. Bonisteel said.

"There's too much work for too few physicians and that's a big, big problem."

CURRENT STRATEGIES TO ADDRESS THE PROBLEMS

Family Practice Renewal Program (FPRP)

The FPRP, with an annual budget allocation of \$4.5 million, is an important foundational program for primary health care reform in NL. With a specific focus on family medicine, FPRP has three core initiatives:

- **Family Practice Networks (FPNs):** As not-for-profit physician-governed corporations, FPNs will provide a mechanism through which physician groups can address issues facing family medicine in their communities, as well as local population health needs, in collaboration with their Regional Health Authorities. FPNs will provide real influence to family physicians at the regional level.
- **Fee Code Initiatives:** Enhancements to the FFS schedule through a Fee Code Initiatives program will be designed to achieve patient, physician, and health system benefits, such as comprehensive care, collaboration with other providers, and improvements in patient access.
- **Practice Improvement Program:** This program will provide physician practices with education and support to help address clinical and workflow issues.

The spread of the EMR program helps to make family practices more effective, with greater quantities of timely information on patients available at a physician's finger tips.

Provincial EMR Program: eDOCSNL

On October 30, 2015, the NLMA signed a Memorandum of Understanding with the Department of Health and Community Services and the Newfoundland and Labrador Centre for Health Information (NLCHI) on the governance and cost-sharing of a provincial electronic medical record (EMR) program for physicians.

The spread of the EMR program helps to make family practices more effective, with greater quantities of timely information on patients available at a physician's finger tips. The EMR also has significant potential for linking family physicians with other primary health care practitioners, facilitating the emergence of true interdisciplinary team care based on the sharing of patient information within the circle of care.

Gordon Stockwell and Sarah Small

Drs. Gordon Stockwell and Sarah Small love being family doctors, but find the FFS model doesn't value the time they spend with their patients.

The husband and wife team entered medicine by way of music. They met while attending Memorial University's music school. He studied violin and she piano.

"There's a lot of overlap in the skills between music and medicine, so I found that I could work hard in music school and then really, at the same time, explore some of the opportunities in medicine and really what that career would look like," Dr. Small said.

"And along that road I think I influenced Gordon."

They were both accepted to medical school and following rewarding residency experiences in Clarenville, the two decided the town was a good fit for them — appealing to their outdoor and active lifestyle, while providing them with diversity of practice.

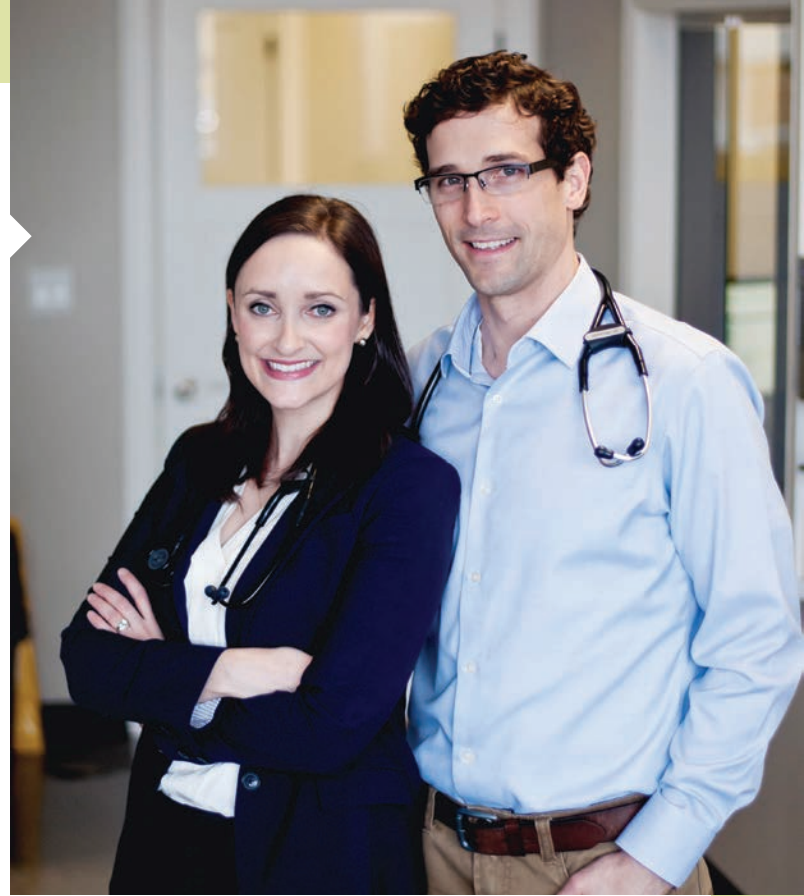
"We have a passion for teaching, community involvement, and advocating for change. St. John's is our home, but we chose to move to Clarenville in 2017 after seeing the potential for a varied and well-rounded medical career," Dr. Stockwell said.

In addition to their private clinic, Dr. Small and Dr. Stockwell also provide on-call hospitalist and emergency room services at the Dr. G.B. Cross Hospital.

"It's difficult to describe the complexity of family medicine. The layered complexity of managing multiple chronic diseases with routine ailments in a single visit while keeping in mind the patient's social, financial, and cultural determinants can be challenging. In a rural area, these visits often come after a busy weekend on call taking care of 30 hospital inpatients or stopping on the way to work to check on a palliative care patient," said Dr. Stockwell.

"On day one of the job, we also suddenly became CEOs of a business. What the general public perhaps doesn't see is that 60% of our time is spent seeing patients, 20% doing paper work associated with those visits, and another 20% running a business."

As new physicians, they say they often get branded as the 'lifestyle generation' or as physicians who are working less than the older generation of doctors.



"We find that so frustrating," Dr. Small said.

"Are we seeing fewer patients? Of course. Family medicine has evolved and the job is much different than it once was. We are trained to focus more on patient education and informed decision making by using evidence based medicine and guideline based care. We are taught to involve patients in their care while making responsible decisions to reduce harm and to be fiscally aware."

Both doctors agree that physicians who provide this level of comprehensive care are not always financially rewarded for their time in a fee-for-service model.

"While our volume is less, we feel there's value in the extra time spent with our patients. We're trying to do the very best job we can for patients while at the same time advocating for family medicine and positive change in the province. But it's not enough. Family medicine is a team sport. We believe in a multi-disciplinary team-based approach to patient care that appropriately recognizes guideline and evidence based medicine," said Dr. Small.

"Investment in quality primary care now will prevent the financial strain associated with poorly managed chronic disease in the future."

As of April 2018, there were 174 active eDOCSNL practitioners (including 117 fee-for-service family physicians, 18 salaried family physicians, and five nurse practitioners). An additional 145 practices were in the queue waiting for installation. There were 130,000 unique patient records within eDOCSNL at the time of publication. Regional health authorities have also been active in connecting broader groups of primary health care employees onto the EMR platform. For example, the primary health care site in Bonavista was the first to join the program.

Complementary initiatives to the EMR include: HEALTHeNL, the provincial electronic health record (EHR), which transfers patient-level information from the hospital-based Meditech system into the EMR; and, eConsult, which is a web-based tool that allows family physicians to submit patient-specific questions to a participating medical specialty.

Distributed Learning in the Faculty of Medicine

The Faculty of Medicine at Memorial University continues to develop its rural-focused distributed approach to family medicine training, based on the College of Family Physicians of Canada's Triple C Curriculum:

- **Comprehensive** – Family medicine residency programs have a responsibility to society that requires them to educate physicians to meet community needs through the delivery of comprehensive care.
- **Continuity** – There must be continuity of patient care to maximize patient outcomes and education, which includes supervision, environment and curriculum.
- **Centred in family medicine** – The learning experience must occur primarily in the context of family medicine settings in collaboration with teachers and contexts outside of family medicine. The content must be relevant to the needs of family medicine trainees to aid the development of their foundational competencies and identity as family physicians.

Part of the Triple C approach is providing comprehensive care of patients, including vulnerable populations. Memorial trains family physicians to work with underserved groups. These physicians play an important role in our communities, meeting the needs of patients who may not be able to get the care they need from other parts of the health care system.

Through the 'Streams' model, in which formal educational regions across the province are recognized to support local implementation of medical education curriculum, Memorial is building partnerships with regional health authorities and communities. This provides a robust and varied learning experience, and builds connections between learners and the communities in our province, which can support recruitment and retention goals.

Recent research suggests that Memorial's deliberate, coordinated focus on rural generalist training results in graduates who are more likely to establish practice in rural areas compared with the national average, and who are more likely to establish practice in NL.^{xi} The absolute numbers, however, are still low, and are not meeting the needs of our province.

The Newfoundland and Labrador College of Family Physicians (NLCFP) works to enable family physicians through advocacy, leadership, research, and education to engage their patients and communities to improve the health of all people in Newfoundland and Labrador. The NLCFP advocates for strong and well-supported family practices as a critical part of the province's health care system, articulated by the Patient's Medical Home framework (described in Section 3), and providing "seamless care that is centred on individual patients' needs, within their community, throughout every stage of life, and integrated with other health services."^x One way that the NLCFP is enabling family doctors to step up and improve our province's health care system is through the training program Practising Wisely, which promotes good healthcare stewardship.

Wendy Graham

For the past 18 years, Dr. Wendy Graham has been practising family medicine in Port aux Basques. She entered medicine as a profession of service; she wanted to work with people and was fascinated with science and human behavior. Dr. Graham saw medicine as a way to bridge arts, science, and psychology — a way to connect with people and to help them.

Dr. Graham works in the community, in hospital acute care and long-term care settings. She also sees patients in the emergency department and in their homes.

“I work where I do because I see how a broad scope of practice makes a difference to the people in my community. People are healthier when they have good relationships with their health care team, when they have access to quality care, and when there is continuity of care. I work where I do because I get to practise a huge range of skills in an interdisciplinary setting. I get to raise my children in a safe, caring, inclusive, and accepting environment.”

While she considers it an honour and a privilege to be a part of the intimate lives of patients, and to be trusted by them at all stages of life, she says being a family doctor can be challenging.

“It’s a beautiful career, but right now it’s really tough. It’s not sustainable. We need change. We need support. Our system is old and not integrated. How can anything function without a plan?” asks Dr. Graham.

“The system is not designed for the patient. The system is designed for the system. There is no strategy for how services come together. This creates much redundancy in the system, service gaps, and stress to individuals. We have new providers, new technology, and patients are living longer with more morbidities, but we make decisions about services willy-nilly. It comes at a great cost to the system and with great risk to the patient,” she said.

She says the health care system in its current form is unsustainable.

“Too often family doctors are stretched beyond realistic expectations. Family doctors should work in team-based settings. But a system that cares for a patient in silos and expects family medicine to fill every gap is destined to collapse.”

She points to the need for a strong and integrated primary health care system with team-based care and



alternate funding models. She believes this is the key to improving the primary care system and tackling the challenge of physician recruitment and retention.

“It comes with less risk to the patient, improved care and a lower cost to society,” said Dr. Graham.

As co-chair of the provincial Family Practice Renewal Program, Dr. Graham is excited about the work FPRP is doing to implement Family Practice Networks throughout the province. She says they have the potential to improve the delivery of primary care services in communities, while giving family doctors a unified voice.

In their essence, Family Practice Networks offer formalized structures and tools to enable community-based family physicians, in collaboration with their regional health authorities, to identify and address common health care goals and gaps in local communities.

“Our hope is that Family Practice Networks will start to create processes and assist with the architecture to have the right conversations with regional health authorities, support family doctors with staff who have additional skillsets, and help communities meet their own health needs,” said Dr. Graham.

The provincial government has initiated, in partnership with regional health authorities, primary health care projects at several sites in the province.

Primary Health Care Initiatives of the Provincial Government and Regional Health Authorities

The provincial government has initiated, in partnership with regional health authorities, primary health care projects at several sites in the province. Some sites are comprehensive, regional approaches, such as in the Bonavista region, and others are issue-specific, such as the ideas proposed in Corner Brook (orphaned patients) and Botwood (care of the elderly). These initiatives incorporate EMR as a fundamental building block of improved team care. As of yet, there has been no formal dialogue with the NLMA on models to incorporate physician teams into these settings.

Appropriate Use of Resources

Family physicians are committed to the appropriate use of health care resources to help achieve a sustainable health care system. Unnecessary prescribing, testing or interactions with patients should be eliminated to the extent possible through greater emphasis on physician education, awareness, business process improvement, and changing the incentives in the system. The NLMA and the Faculty of Medicine are partners in the Choosing Wisely NL initiative and facilitate the collection and transmission of data to physicians about their ordering and testing activity. The NLMA also supports the provincial government committee on Appropriate Use of Resources. The NLCFP has sponsored a training program called Practicing Wisely, delivered twice in 2017, that delivers practical education on how to eliminate unnecessary use of resources from physician practices. The Family Practice Renewal Program contains new fee codes that will allow use of telephone interactions with patients and shared care with other professionals, both intended to make care more appropriate and cost-effective. Transformation in family medicine must occur alongside continued emphasis on best use of health care resources.

PRINCIPLES FOR TRANSFORMING FAMILY PRACTICE AND PRIMARY HEALTH CARE

The vision for primary health care transformation over the next 10 years must be rooted in rich soil and tended with regular care and attention. There is rich soil in Newfoundland and Labrador, in part from established principles of primary care renewal that exist in the agreement between the Government of Newfoundland and Labrador and the NLMA that establishes the Family Practice Renewal Program. These principles are as follows:

GUIDING PRINCIPLES FOR PRIMARY CARE RENEWAL^{xi}

1. Patient-Centered Services and Supports
2. Collaborative Multi-Disciplinary Teams
3. Coordination of Care
4. Comprehensiveness of Care
5. Access to Appropriate Services and Supports
6. Attachment and Longitudinal Relationships
7. Communities of Practice
8. Continuous Evaluation and Evidence-Based Decision Making
9. Community Engagement and a Local Focus

Important among these principles is the need for attachment and longitudinal relationships between patients and providers. This principle states:

Primary health care providers should be supported to build long-term patient/provider relationships that foster the development of trust and respect between the patient, the family physician or practice, and other health care professionals providing services and supports to the patient. Physicians should be encouraged to act as the most responsible provider for their patients and ensure that care is coordinated, consistent, and the patient's long-term needs are considered.

A Patient's Medical Home will provide continuity of care, relationships, and information for its patients.

The FPRP principles were derived in considerable measure by examining the College of Family Physicians of Canada (CFPC) prescription for primary health care renewal, called The Patient's Medical Home (PMH).^{xii} The key goals of the PMH are:

Goal 1: A Patient's Medical Home will be patient centred.

Goal 2: A Patient's Medical Home will ensure that every patient has a personal family physician who will be the most responsible provider (MRP) of his or her medical care.

Goal 3: A Patient's Medical Home will offer its patients a broad scope of services carried out by teams or networks of providers, including each patient's personal family physician working together with peer physicians, nurses, and others.

Goal 4: A Patient's Medical Home will ensure i) timely access to appointments in the practice and ii) advocacy for and coordination of timely appointments with other health and medical services needed outside the practice.

Goal 5: A Patient's Medical Home will provide each of its patients with a comprehensive scope of family practice services that also meets population and public health needs.

Goal 6: A Patient's Medical Home will provide continuity of care, relationships, and information for its patients.

Goal 7: A Patient's Medical Home will maintain electronic medical records (EMRs) for its patients.

Goal 8: Patients' Medical Homes will serve as ideal sites for training medical students, family medicine residents, and those in other health professions, as well as for carrying out family practice and primary care research.

Goal 9: A Patient's Medical Home will carry out ongoing evaluation of the effectiveness of its services as part of its commitment to continuous quality improvement (CQI).

Goal 10: Patients' Medical Homes will be strongly supported i) internally, through governance and management structures defined by each practice and ii) externally by all stakeholders, including governments, the public, and other medical and health professions and their organizations across Canada

The Family Practice Renewal Program and Patient's Medical Home principles can help guide us along the path to strengthening Newfoundland and Labrador's primary health care system.



Solutions are needed in family medicine to improve recruitment and retention so the 50,000 people in our province without a family doctor can find one.

A TEN YEAR VISION

Patients deserve an accessible and sustainable primary health care system. They need to be assured that family doctors and other primary health care providers will be there when they are needed. They deserve health care professionals who know them well and with whom they've built ongoing relationships.

Solutions are needed in family medicine to improve recruitment and retention so the 50,000 people in our province without a family doctor can find one. We need to act now, before the retirement of older physicians leads to the orphaning of tens of thousands of additional patients, and before graduates of our own medical school turn away from NL because of better opportunities elsewhere.

We need new practice models so that young doctors can practise how they were trained, serving the complex needs of patients in an interprofessional practice, without worrying when the government will cut their pay or impose extra costs. They need to work in a respectful environment where government and regional health authorities are partners in making family practice a desirable and sustainable career, competitive with opportunities elsewhere in Canada.

Using the principles and goals of the FPRP and PMH as frameworks for action, the following directions for the next 10 years of family practice in the province have been identified:

Payment Models:

Across the country, there is a shift away from FFS as the main compensation model for family doctors. FFS does not fully support the integrated teams that we see as the future of our health care system, and the way that today's family physicians want to practise:

- Doctors want to spend more time with patients who have complex conditions, or would benefit from preventive care, but this isn't adequately compensated through FFS.
- FFS doesn't support physicians to coordinate and integrate care with other providers. An alternative model could remunerate physicians for building and supporting a team environment, including activities like interprofessional consultations, team meetings, leadership roles, and group rounds.

Ontario, an early leader in this area, offers several alternatives to FFS for family physicians. Alberta, British Columbia and New Brunswick have all recently developed new compensation models that blend elements of FFS with capitation, and BC has also developed a population-based capitation funding model. These models can provide NL with examples of how to design an appropriate physician compensation model to attract physicians who want to practice in this fashion and support integrated team-based care.

Vision: To establish an additional payment model based on blended capitation, to complement the FFS and salaried models, that will help attract and retain new family doctors, and establish a foundation for interdisciplinary team-based care.

Respect and Support from Government:

Family doctors in this province feel undervalued by government. Incomes and benefits have been cut without warning or justification. In addition to the random and arbitrary cuts to clinical compensation by the provincial government, noted in Section 1, the federal government has changed the rules for taxation of the many physicians whose practices are incorporated.

The key problem is that as overhead expenses of physician practices continue to rise, and the government adds more burdens, physicians do not have the same ability as other professionals to raise prices because their fees are controlled through the Medical Care Plan. Physicians are in a vice, being squeezed ever harder, without support from the provincial government.

Family physicians believe that their role in the health care system is not understood or appreciated.

Vision: To establish a respectful relationship with the provincial government built on trust and shared goals, and where the future of the health system is planned through partnership and a full awareness of the valuable role of family physicians.

Investing in Family Practice Renewal:

The existing Family Practice Renewal Program contains many of the key ingredients to transform primary health care in the province. The new Family Practice Networks will allow family doctors in each region to work collectively, and with regional health authorities, to fill gaps in services for patients and create new services where they do not presently exist. They also provide a way to connect family doctors in the community with other health care providers within the RHAs, laying the foundation for interdisciplinary care. The Fee Code program allows the FFS model of payment to be renovated and improved so that physicians who choose to remain FFS can spend time on the services that improve primary care and have the greatest impact on patient outcomes. The Practice Improvement Program will work with physicians to expand access for patients to their services, and to organize physician services in the most efficient way possible.

At the present time this program is funded at \$4.5 million per year. It will not realize its potential without increased funding. Of course, increased funding must be based on evidence of success.

Vision: That the NLMA and the provincial government will continue to provide FPRP investments with priority consideration over 10 years to achieve the potential of this program.

Interdisciplinary Team Care:

All the partners in health care have embraced the concept of team-based care - interprofessional teams are a key plan of the Patient's Medical Home - but very few concrete steps involving physicians have been made along this path in NL. At present, many salaried family physicians (and some FFS physicians) are co-located with other health care providers in public health facilities, producing many opportunities for dialogue and shared care conversations, but there is no systematic model to ensure team care is actually occurring. Physicians often continue to operate in a silo from nurse

practitioners, community nursing, social work, mental health, pharmacy and other healthcare professionals. The current effort by the provincial government and the RHAs to establish new interdisciplinary teams is a step in the right direction, but the technique for integrating physicians has still not been articulated or negotiated. Some family physicians have built their own team-based care approaches by hiring nurses or nurse practitioners within their community practices, but this approach is rare as it has financial risks for the physicians and needs to be facilitated by practice improvement training that helps doctors and nurses adopt the best practice model.

Vision: That within 10 years every family physician will have the opportunity to work as part of a primary health care team where they can work with other health care providers to provide a patient's medical home. The basket of services and composition of the team may vary somewhat from region to region, based on the needs of the community, which should be regularly assessed. The governance structure for each team will vary as well – some may be RHA-based with salaried physicians and other RHA employee-providers; some may be RHA-based where physician fee-for-service groups affiliate with an RHA and provide a basket of services defined in a contract; and some may be provider-governed with physicians and other providers directly contracted by the practice. Whatever the governance arrangement and payment model, the vision would be that each region would have reasonably comprehensive services available from a team, each member of which is working within a scope of practice that optimizes efficiency, access and excellent patient outcomes.

Technology:

Family medicine is being revolutionized through technology, and Newfoundland and Labrador is still in the early stages of realizing these benefits. The strong start that has been made with the EMR program needs

to be continued and made available to all doctors. The EMR also needs expanded functionality including e-prescribing, e-referral, patient-initiated online appointments, and patient portals so they can view their own personal data. Technology will also enable sharing of patient information within the circle of care so that care is timely, better informed, and higher quality. The physicians and other providers in the Bonavista Health Centre were the first to witness the transforming effect of many providers recording patient data on a single patient record, creating a more integrated team at that site than ever before.

Physicians also want to have data to compare their own patient panels, practices, prescribing, and test ordering with their peers. Knowledge from these comparisons will help drive improvements in efficiency and the quality of care. The regional health authorities and the provincial government will also be able to use data to better plan the service profile of the health system and the priorities for public health programs.

Vision: That within 10 years all family physicians who want to adopt EMRs in their practice are using the provincial EMR, and that all physicians in the province are using the provincial electronic health record HEALTHeNL when appropriate. The provincial EMR's functionality should incorporate prescribing, referrals, e-consult, and patient portals. The EMR should be used to link primary health care teams so that patient information can be used within the circle of care. The data from EMR should also be used to create a system of peer comparison and learning.

Appropriate Use of Resources:

Family doctors want the health care system to be sustainable. One of the most important ways to achieve that goal is to ensure that precious health care resources are used wisely. There are many indicators of high use of resources greater than the national average. A better understanding of the reasons for higher usage is needed

in order to develop a comprehensive strategy. Is it linked to the training of our physicians, the age and health profile of the population, the expectations of patients, or the rules and norms within the regional health authorities? This self-reflection is necessary to define the extent of unnecessary care that exists in this province, and to set a goal for eliminating unnecessary care to the extent possible.

Vision: That within 10 years, indicators for measuring resource utilization in the primary health care system in Newfoundland and Labrador attain a record better than the national average for eliminating unnecessary care in Canada. The setting of goals should be based on a careful examination of the extent of unnecessary care that currently exists and the key reasons. All partners, including the NLCFP, NLMA and the DFM, should participate in the strategy to reduce unnecessary care, including expansion of continuing medical education opportunities.

Physician Human Resource Planning:

If we have the right payment models, the respect and support of government, investments in the Family Practice Renewal Program, a framework for interdisciplinary team care, a technology agenda and a commitment to appropriate use of resources, there will still be a critical ingredient missing. A physician human resource plan must be developed. Strategies to attract family physicians to Newfoundland and Labrador need to be deliberate and must involve government consultation and collaboration with communities, the NLMA, Memorial University and the NL College of Family Physicians.

First, we need to know the projected demand for family physicians in the province. Under new models of payment and team care, how many family physicians are needed in each region and sub-region to meet the forecasted medical needs of the people of the province? Right now, decisions in the public system are ad hoc.

Rather than having a plan, decisions to refill salaried physician vacancies occur only when a position is vacant rather than on the basis of a model and a forecast. Very little attention is given by government or RHAs to the flow of new doctors into community practices, even in rural areas. With a plan, decisions can be made with certainty. Jobs can be offered in this province when medical students and residents are being courted by other provinces. Strategies and incentives can be used for hard to fill jobs in remote areas, to maximize the supply of physicians from our medical school.

Vision: That within one year a recruitment and retention study will be completed to produce recommendations for ensuring our tools and tactics for recruiting and retaining doctors rival the best in Canada. Within two years a physician human resource plan should be completed that forecasts the demand for physician services based on population need and new models of care. Within 10 years Newfoundland and Labrador will have a stable physician workforce that replenishes itself with an optimal share of graduates from MUN, and other sources of supply.

Family Practice Medical Education

The vision of the medical school states that “through excellence we will integrate education, research and social accountability to advance the health of the people and communities we serve”. The CFPC’s Rural Road Map for Action describes the need to implement policy interventions that align medical education with workforce planning. Early research has already shown that a rurally focused medical education pathway has positive results with regards to recruitment and retention of family physicians in rural areas.^{xiii}

To this end, family medicine education needs to be supported to continue to develop an education model that is regionally distributed. This will ensure sufficient exposure for and competence in our graduates to practise comprehensive family medicine in rural, aboriginal and

other underserved communities in NL. Ongoing research to determine the changing health care needs within our province is essential to ensure that our family medicine education can adapt to those needs. Training needs to meet, and preferably exceed, national accreditation standards. This needs to occur within the same interdisciplinary team care/patient medical home contexts in which learners will be practising upon graduation.

Strategies and incentives can be used for hard to fill jobs in remote areas to maximize the supply of physicians from our medical school.

Vision: That within one year Memorial University, including clinical faculty, will review and advocate for the necessary resources to deliver a nationally accredited family medicine education program. Within three years the number of family medicine residency training placements will be aligned to the completed physician resource plan. Within five years there will be sufficient established distributed teaching sites in family medicine, specifically supported to deliver comprehensive, continuous and interprofessional education in rural, urban and underserved primary care contexts.

Conclusion

We will all need to work together to address the problems outlined in this document. This vision for the future of primary care in Newfoundland and Labrador can shift the system: a new blended-capitation payment model, a respectful relationship between government and family physicians, continued investment in the Family Practice Renewal Program, primary health care teams, increased availability of technology like the provincial EMR, appropriate use of resources, a deliberate and collaborative approach to physician human resource planning, and continued development of family practice medical education.

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