Perceived Barriers to Full-Service Family Practice: A Survey of Family Practice Residents (UBC, Nanaimo Site).

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Abstract

Objective

The overall proportion of family physicians engaged in Full Service Family Practice (FSFP) in the traditional domains of family practice outside of the office, including inpatient care, residential care, obstetrics, and home visits, has been steadily falling in British Columbia and elsewhere in Canada. There is a paucity of information in the literature examining the cause of this decline. Our aim is to explore the barriers to entering FSFP perceived by resident physicians.

Design

Qualitative design involving focus groups with family practice residents.

Setting

Participants were sequestered with a facilitator for 90-120 minutes of discussion in a designated teaching room at the Nanaimo Regional General Hospital.

Participants

First and second year Family Practice Residents in the Nanaimo and Vancouver Island Indigenous programs. A total of seven R1s and seven R2s participated.

Method

Focus groups were facilitated by the study authors. Audio recordings were made of the focus group discussions, which were transcribed, and anonymized. Thematic analysis was performed to identify major and minor themes.

Main Findings

Four major and three minor themes were identified. These themes are supported by direct patient quotes. The four major themes were identified as work-life balance, financial considerations, practice structures and supports, and inadequate training experiences or exposures. The three minor themes identified were lack of mentorship and modeling, administrative burdens and billing, as well as overall competence in multiple domains.

Conclusions

Residents identified several key perceived barriers preventing them from going into FSFP upon graduation. Given the small sample size, larger qualitative and quantitative investigations would be necessary to determine if these themes are consistent across a larger population of residents. However, these findings would suggest that there are multiple factors leading to the decline in residents pursuing FSFP, and that interventions in the formative training years may be a solution to help reverse this trend.

Key Words (Mesh headings): family practice, full service, residents, barriers

Word Count: 300

Introduction

Primary care is generally considered the foundation of the Canadian healthcare system.[1] Family doctors are often the first point of contact for individuals with a new health concern. They manage a very broad range of illnesses, refer patients to specialists, and act as stewards of limited resources.[2] Continuity of care has long been a valuable component of practice. In fact, Mazowita and Cavers (2011)[1] define Full Service Family Physicians as practitioners "who provide primary care throughout a patient's lifespan." This has traditionally included office care, hospital inpatient care, obstetrical care, home visits and residential care.

The decline of Full Service Family Practice (FSFP) in Canada is well-documented [1] and multifactorial. Several provinces have made efforts to understand and reverse such trends. In British Columbia, one of the primary examples of these efforts is encapsulated by the General Practice Service Committee (GPSC) which was established in 2002 to support full service family practice with a variety of initiatives.

Although the decline of FSFP has been well documented, there is a lack of information as to 'why' this is happening. A review of the literature was carried out. Unfortunately, most studies focus on identifying why *existing* FSFP doctors decide to narrow their practice. Mazowita and Cavers identified "overwork, burnout and dissatisfaction" as being motivating factors.[1] However,

we were unable to find any commentary on the decisions being made by physicians as they entered practice as new graduates. A report by Benjamin Chan in 2002 compared the increase in “office-only physicians” to the decline in providers of out of office care in Ontario from 1989 - 2000.[3] He describes a decline across the board in the provision of “out of office services”. He found that new graduates were “more likely to do emergency work, but they were less inclined than established physicians to perform obstetrics, inpatient hospital care, house calls, and nursing home visits.”

Lavergne et al. in 2014[4] reports on the decline in FPSP between 1991-2010. The percentage of physicians providing any kind of out-of-office care fell from 95.8% to 58.9% between 1991-1992 and 2009-2010.The fall in the number of physicians providing ER care, hospital care, home and long-term care home visits, was even more dramatic: from 64.6% to 22.6% in the same period. They did not report when these physicians graduated, but it seemed young and older physician groups had similar withdrawals from FPSP. This was also noted in older Ontario figures.[3] This might suggest newly minted family doctors in BC are not adopting FPSP, despite expensive interventions by the GPSC.

Using focus groups for data collection, we hoped to explore what the perceived barriers to entering full service family medicine are for resident physicians in their first and second years of training in the UBC Family Practice Nanaimo and Vancouver Island Indigenous sites.

There has been significant investment by the province, especially in the GPSC initiative, to encourage and support the provision of FSFP. Yet, the most recent available evidence would suggest that newly graduated physicians are generally not broadening the scope of their practices. We propose that understanding why resident physicians are reticent to providing FSFP upon graduation may be useful for guiding interventions, as decisions regarding practice patterns may be made in advance of graduation. We hope our qualitative analysis of the focus group responses can provide a launching point for further assessment of the barriers that resident physicians perceive when considering FSFP. Ideally, this could allow the exploration of targeted policy interventions to encourage soon to graduate family physicians to consider FSFP.

Methods

Our study design was the arrangement of focus groups. We selected this study design as we thought it was the most effective way to collect qualitative data on this topic.

Our study population focused on the resident group in Nanaimo and the Indigenous program sites on Vancouver Island. Fourteen residents were interviewed from these two populations (seven R1s and seven R2s).

Data collection was achieved by the conduction of focus groups with audio recordings, lead by the study authors. Confidentiality was discussed prior to starting and consent to participate was documented. The interviews were approximately 90-120 minutes in length, and the participants were separated into the R1 and R2 cohorts. A facilitation guide with open-ended questions was used to help guide discussion. Audio recordings were transcribed to text format with no descriptive features in order to keep participants' responses confidential and anonymous.

The data was analyzed using narrative and thematic analysis. The two study authors reviewed the material and mutually decided on the major and minor themes. These themes were determined by the frequency in which they were discussed, as well as the extent and length to which they were discussed. These themes are supported by quotes from the focus groups. Quotations were lightly edited for punctuation and clarity. Areas where contextual clarification or where words were added have been identified by square brackets in the text and tables.

Findings

Review of the focus group data revealed four major and three minor themes. These are exemplified by quotations listed in the tables 1-7.

Work-Life Balance

One of the strongest themes to emerge in both cohorts with regards to perceived barriers, was the effect the FSFP model may have on their quality of life (QOL), or "work-life balance." The perceived negative impact on QOL represented, for some, a barrier to joining or setting up a practice. A participant offered the idea that "*You're not going to buy into a practice unless you*

want to work and stay there for some [time, as] you're making a conscious commitment to staying in a community for a number of years. That has major implications for your family, for your life... It ties you down." Participants felt that, in contrast to longer practicing physicians, "*people value independence and flexibility far more [now] I think; there's this different emphasis placed on that, than there was in previous generations.*" While many emphasized that the principle of continuity of care was important to them, the stress and a fear of burnout secondary to providing inpatient care whilst managing a busy office schedule was frequently identified. "*I think it's much more difficult to balance personal life and things like that when you integrate some of the logistical challenges of trying to offer inpatient care",* such as "*the unpredictability of the scheduling... not really knowing day to day how many inpatients I'm going to have. Even if you start your day being half an hour or an hour late... you're playing catch up the whole day and that just adds that extra [stress]."* The reality of being continuously on call for your own patients, especially in obstetrics, was felt by several participants to negatively affect their wellbeing, remarking that "*I'm not considering obstetrics, and it's not because I don't enjoy it. It's because I value not getting called frequently in the middle of the night*." One participant remarked their experience of stress during their educational process had already affected what choices they would be making in regards to their future practice, adding: "*I was pretty burnt out by the end of med school, and the biggest priority [that] kept me going in medical school was actually having a life outside of medicine and seeing [my family]..Being on call all the time... and [not] being able to do things with my family out of fear of being called away [does not appeal to me]."*

Finances

The second major theme identified was regarding finances. Within this topic there was noticeable shared concern around graduating with high debt loads: *"We're all exhausted from all of this work, and we're all in debt, and we're all sort of in a stage in our life where there's so much change going on that it's sort of hard to commit to a community [style of practice]."* Additionally, there was doubt among many residents that pursuing traditional FSFP would provide them with the compensation needed to quickly pay off this debt. There was a perceived feeling that FSFP physicians were inadequately compensated for the care they provided. One resident stated, *"I don't feel like the current funding model supports doctors in doing [FSFP], and I believe that the current funding models are pushing people towards becoming a hospitalist, as opposed to becoming a family doctor who offers inpatient care. It's more flexible, and it pays at*

least as well, perhaps better." The idea emerged that there may be more lucrative areas to practice with better compensation: *"In Nanaimo a lot of people get a message [from] the hospitalist crew that [hospitalist work] is such a financially lucrative thing to do. A lot of people from this residency program end up as hospitalists because that's what they're exposed to. We do so much hospitalist [work that] you're kind of bound to be drawn in by that, especially with all of the debt that most of us have."* However, overall, there were many residents that felt they were not able to make well informed decisions about their financial goals regarding different practice styles, due to the lack of knowledge and transparency of different fee structures and compensation mechanisms: *"I honestly don't know how much people get paid for different things. So that lack of familiarity with [payments] certainly doesn't incentivize me towards [FSFP]. I think that having a little more understanding of what the different models are, [and] how they are remunerated [is] important, because we do have a lot of debt."*

Structures and Support

A further collection of perceived barriers amongst the residents who participated in these focus groups revolved around the professional environment that surrounded their day-to-day working lives. While many affirmed their interest in some form of out of office longitudinal care, the models of full service care observed and experienced by participants left them feeling that something different is needed. One remarked that, "*I'm interested in full service family medicine, but I haven't seen a model yet that I think is workable … or attractive." Also, "The reality is that [the current model] is failing. We can all see that ... There are a few diehards that hang on [in my clinic], but I think those that finally give up their privileges, once they don't have that need to avoid the cognitive dissonance of admitting that it's a broken system, [are] willing to acknowledge that it isn't working."* Several remarked the decline in local physicians providing inpatient care was also a deterrent, and that *"I would worry about a town this size, with fewer and fewer people doing [inpatient care], whether I would be supported enough, whether I would have other people to take call when I wanted some time off."* Finally, some participants reported, *"being in an office alone can be isolating,"* and a potential deterrent from practicing in an office-based setting. In hospitalist practice, *"You don't have to think about running an office. You've got all these friends and colleagues around and it's collegial."*

Exposures and Experiences in Training

The final major theme regarding perceived barriers to providing FSFP was a concern their exposure and experiences during their residency training would not leave them adequately prepared. Several residents expressed they were less likely to pursue and adopt certain areas of FSFP, based on the quality of their individual experiences, and lack of exposure to these areas of care in their residency years. This was echoed by one resident: *"I'm a bit worried about providing residential care and house calls. Those are two things that I would like to provide. My concern is that I haven't had any exposure to either in my residency so far; so I've never done a residential care visit in residency. I've never done a house call, and as part of my clinic, we do not round on our patients in the morning. So I wouldn't feel comfortable offering those things in my care."* Another resident similarly stated, *"If I had exposure in residency to managing inpatients as part of my daily thing, or even just like specifically on my family medicine rotation, and if I had exposure to seeing patients in residential care and doing house calls, I would be much more comfortable with [providing care in those areas]."*

The three minor themes that were identified on review of the focus group responses were also significant. Several participants identified that a lack of mentorship or positive modelling of FSFP acted as a barrier for them when they considered whether to provide those aspects of care once graduated. The realities of the administrative burden, management of staff, overhead, and the unpredictability of a fee for service billing model also acted as significant deterrents for several participants. Finally, several participants described lacking confidence in their ability to be adequately competent in the multiple domains required to provide full-service care, regardless of the training opportunities made available to them.

Despite it not being the focus of the discussion facilitation, it is pertinent to note that despite the many concerns and perceived barriers discussed in the focus groups, many of the participants repeatedly affirmed that longitudinal and comprehensive care was a laudable aim, and something they still considered providing, given the right circumstances. This is exhibited in several of the quotations listed in the Tables section.

Discussion

The purpose of this study was to explore, in a qualitative fashion, the barriers that UBC Family Practice Resident Physicians in Nanaimo perceive when considering the provision of full service family practice. The study authors identified four major, and three minor themes which broadly encapsulated these perceived barriers.

The first major theme identified in the analysis of participants' responses was the perception that providing FSFP care could potentially have a detrimental effect on their ability to maintain a healthy balance between their work and the rest of their lives. There has been little specific investigation in the available literature exploring family physicians' motivations for narrowing their scope of practice, but Mazowita and Cavers[1] identified that burnout and overwork were significant factors for existing physicians deciding to relinquish those domains of care. Our results certainly suggest that resident physicians place a high value on a healthy balance between the demands of their profession and other aspects of their lives once they are in independent practice. Presuming FSFP is of benefit to patients, this suggests that creative solutions are needed to allow physicians to provide longitudinal care, with a high priority of flexibility, while providing adequate boundaries to their work requirements to allow career longevity, and avoid burnout and overwork.

The financial considerations facing newly graduating physicians was the next major theme. It is well known that pursuing a career in medicine leaves you with a large debt load at the completion of training. This, compounded by years of being out the workforce, leaves many residents feeling behind, and stressed financially. It was clear from the dialogue in our focus group that being able to pay this debt off in a timely fashion was of great importance, and would shape their decisions on career choices once graduated. There was a general shared view that providing FSFP was not as well compensated as working in more focused areas, such as hospitalist or urgent/acute care. However, most did admit they were unfamiliar with the remuneration of FSFP. It therefore stands to reason that if there was more education provided on how FSFP physicians are compensated, residents may feel more confident that they can pay down debt in an efficient manner, if they choose this style of practice. There is also an inherent problem with the financial burden of pursuing a career in medicine. Strategies to reduce this

cost would likely be an important factor in persuading residents to make career choices based on interest and career satisfaction, with less concern for debt and finances.

A further major theme was the need for clinical structures and a professionally supportive environment to provide FSFP. The contrast between working as an isolated solo practitioner and working as part of a care team in a collegial environment was an identified barrier for many. The decline of Nanaimo physicians providing in-hospital care was seen as a barrier, as a collective community that values full service practice is a crucial support for a new physician. As noted by Lavergne et al.[4] the primary efforts to encourage FSFP in BC have been "operational, rather than structural," primarily via incentives within the fee-for-service system. This major theme of inadequate structural and collegial support for FSFP as a barrier suggests this response may be inadequate on its own.

The final major theme residents shared was a feeling of lack of experience and exposure to clinical learning in certain areas of FSFP. Many felt that if they did not experience a particular aspect of family medicine in their primary care clinics, they would be much less likely to include this in their practice upon graduation. An example that came up consistently was the lack of primary care preceptors with hospital privileges. As a result, residents felt they were missing out on this key component of learning and experience, and did not feel confident providing in-hospital care. It is impossible to give all residents the same learning experience and exposures during the short two year residency period. However, the decline of in-hospital care by the primary preceptors of this focus group does cause some concern that this will be mirrored by those they are mentoring. It stands to reason that in-hospital care provided by family physicians is a very valuable component of FSFP, and therefore there needs to be a focus towards ensuring this educational experience for residents is supported and emphasized.

In addition to the major themes of perceived barriers, three minor themes arose. These were: inadequate mentorship, the administrative burden of independent practice and billing, and a sense of inadequate competence to practice across such a broad spectrum. Each of these suggests that remediating interventions at the residency stage might have a significant impact on the practice patterns that new physicians decide to adopt.

A significant limitation of this study was its inherently small sample size. The study authors felt this was necessary to provide the depth of qualitative analysis required for the goal of the study. However, this question would need to be posed on a much broader scale before it's applicability to the provision of FSFP in British Columbia could be accepted. The authors hope this initial foray into the subject could be used as a template for future focus groups in multiple locations, and/or the basis for a survey that could be distributed more broadly.

There are several potential sources for bias in the interpretation of this material. One is that the study authors know and work with the participants, and acted as the facilitators in the focus groups. This may have resulted in a reluctance of participants to fully disclose their thoughts due to concerns about ramifications in the workplace. The authors' role as facilitators also introduces a source of bias as the discussions could have been directed towards specific subject themes. The authors attempted to mitigate this source of bias as much as possible by using preset open-ended questions.

Conclusion

There are multiple barriers perceived by resident physicians in Nanaimo and adjacent training sites on Vancouver Island in regards to adopting a practice pattern consistent with FSFP. The major themes that were identified included effects on work-life balance, financial considerations, a lack of supportive structures and practice environments, and insufficient exposures and experiences during training to ensure competence in all domains of FSFP. Further qualitative and quantitative investigations would need to be undertaken to identify whether these themes could be further generalized to family practice residents across the province. The cause of the decline in the comprehensiveness of family practice care is likely multifactorial, and these results suggest that any efforts to ameliorate the decline would likely need to address multiple issues rather than a single approach. The results also suggest that exploring interventions during the residency training phase may have a significant impact on practice patterns as many of these decisions have been made by the time new family physicians are embarking on independent practice.

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Table 1. Major theme and supportive quotes: Work - Life Balance

R2
"You're not going to buy into a practice unless you want to work and stay there for some…so you're making a conscious commitment to staying in a community for a number of years. That has major implications for your family, for your life..you know, it ties you down if you're committing yourself to getting into a practice."
"One of the downsides {of setting up a practice] is you sacrifice a certain amount of freedom and mobility when you do that,"
"people value independence and flexibility far more [now] I think; there's this different emphasis placed on that than there was in previous generations".
"getting unscheduled interruptions in your personal life – that would be I think the biggest thing for me"

"And I think it's much more difficult to balance personal life and things like that when you integrate some of the logistical challenges of trying to offer inpatient care."

"I'm not considering obstetrics, and it's not because I don't enjoy it. It's because I value not getting called frequently in the middle of the night"

"And then, you know, what we talked about before, where it's just a lifestyle of lots of calls So you know, to add the 2 together, and that was….pretty much a deal breaker. [In reference to being frequently on call for your patients]"

"[Being] a part of a group of GPs that are doing similar things ~~I think~~ is really valuable and important. ~~And I think~~ for me, if those groups don't exist, I think it would make things a lot more challenging in terms of work/life balance."

R1

"the unpredictability of it would impact [my decision], and it doesn't make it easy necessarily…. Even if you start your day being half an hour or an hour late, that carries over to the entire day. You're playing catch up the whole day and that just adds that extra stressful piece to it."

"[I'm interested in] doing what my preceptors do, which is that they share a practice, [which] I think would be attractive. if I can have the option of doing a day of the inpatient doc as part of the patient medical home, then I don't have to necessarily do it every day and have that unpredictability every day. So my days on I will have to go in the morning and do my rounds, but I won't have to do it every day of the week. So that's sort of what I think as a possible option, if that would hopefully allow me to enjoy medicine just as much. As well as maybe have a little bit less of that burden of every day being, you know, 13 hours or 12 hours."

"the unpredictability of the scheduling is one thing I'd like to figure out a way that would make it a bit easier. The one thing I dislike about that idea is not really knowing day to day how many inpatients I'm going to have. I don't want to feel that pressure of having to have a full

clinic booked for 9, and [then to] have 5 people to see in the hospital, and I had zero the day before so I couldn't really predict that."

" I think [I have] struggles in terms of the time crunch, particularly with inpatients. If we're going to do our own inpatients, that's really hard, and I think it also affects your patients at your clinic if you're always continually late for clinic"

"[I've seen preceptors doing the] 24/7[OB] call model, where if somebody goes into labour or needs to be induced, they will postpone or drop that day's clinic and rearrange it, which doesn't really appeal to me, and I'm not sure how to work around that. The idea of being on call like 24/7 is not attractive for me."

"I was pretty burnt out by the end of med school, and the biggest priority [that] kept me going in medical school was actually having a life outside of medicine and seeing my [my family]. The idea of being on call all the time and not having enough flexibility, and being able to do things with my family out of fear of being called away [does not appeal to me]."

Table 2. Major theme and supportive quotes: Financial

R2

"The funding models is really the key thing I think for me. The way the funding model works for family doctors who are on call is that they essentially get paid for coming in, and they get fee for service for seeing the patients within their call group, but if there are overnight calls on a pager or something like that, then they would be responsible for that, but they're not really paid extra for doing that on call work"

"I don't feel like the current funding model supports doctors in doing [FSFP], and I believe that the current funding models are pushing people towards becoming a hospitalist, as opposed to becoming a family doctor who offers inpatient care. It's more flexible, and it pays at least as well, perhaps better."

"[It would be better to] not having exorbitant cost to be getting into the hospital, like privileging costs."

"[The] current funding situation and political government situation are, if anything, disincentivizing doctors from doing family medicine, and doing fee for service care in general, because of the way that most fee for service doctors are rated [ie. paid]"

"We're all exhausted from all of this work, and we're all in debt, and we're all sort of in a stage in our life where there's so much change going on that it's sort of hard to commit to a community."

"In Nanaimo a lot of people get a message [from] the hospitalist crew that [hospitalist work] is such a financially lucrative thing to do."

"A lot of people from this residency program end up in hospitalist because that's what they're exposed to. We do so much hospitalist [work that] ł you're kind of bound to be drawn in by that, especially with all of the debt that most of us have."

"I honestly don't know how much people get paid for different things. So that lack of familiarity with [payments]–certainly doesn't incentivize me towards it. I think that having a little more understanding of what the different models are, [and] how they are remunerated [is] important, because we do have a lot of debt. Often we're starting a new phase in our lives, sometimes being the only person working in the family, and a growing family. And [finances] are really big things, but I don't know how to find out that information, other than the blue book in BC , but that doesn't show the full picture."

"If I did know the financial implications of the [different funding] models, yes I do think that that would play into it. Especially when deciding between 2 different things that I enjoy. If one is more lucrative, and I like it as much as the other thing, I think that it would help me decide between 2 options that I would enjoy equally or that would suit my lifestyle."

With the hospitalist [work], I'm using this as an example, the amount that you make is a lot more transparent because it's an hourly rate, and so it's easy to quote that. Whereas, the amount that you would make in a full scope practice is a bit more abstract. It really depends on the volume of your inpatients, if you're doing emerg, so it's a little bit in flux and it doesn't feel as transparent. I'm making an assumption here, [but] I think people are more likely to gravitate to something that they know out of residency."

“it’s just not transparent as far as how much they do or should make [in reference to FSFP work]”

“[Another cost is] getting additional skills that might be required in a larger center. ~~that~~ it’s also income lost, or getting those skills that are required sometimes even [to perform] full service. And I think that sometimes when people are recent grads that’s a really big decision. To take that time away from potentially earning a physician’s salary versus a resident’s salary. “

R1

“I want to provide continued care for all of my patients. it’s just every time I have a discussion about [continuity of care] iit becomes more and more apparent to me how much of my stress with trying to pursue the many roles that I like in family, comes from the model of [care] being incentivized on a day to day basis.”

“I feel there is [a] disconnect between the practice I want and the practice that is possible right now or typical of a fee for service position.”

“If I was a hospitalist, I’d go to work and I’d care about my patients, and I’d put my time in and make sure I work until the week is done, and then I’d go home. Versus the reality for me, which I’m not going to be [paid in that way], so I’ll constantly be faced with the frustration that I’m not making enough or maybe what I deserve or the amount that other colleagues are making. And I think that that is certainly a deterrent for me. So, less dollar amount, more method.[regarding the difference in payment models between hospitalist and community GP’s]”

“[The variability of] Fee for service is just crazy. You could take 5 doctors who all do the exact same, identical work, and just because of different billing practices all have different incomes. I just want to be paid for what I’m actually doing.”

"I think that one of the things I'd be frustrated by is that remuneration is an assignment of value. So I think that, to me, would be frustrating that if I'm doing good work I would feel less valued if I am making less."

".it's hard because a lot of the information I've collected is here say.[regarding what doctor's actually get paid]"

Table 3. Major theme and supportive quotes: Clinic Structures/Colleague support

R2

"things that would make me want to do more inpatient stuff I think would be having a conducive hospital, a supportive hospital environment, having a supportive call group. Having good specialist coverage[is important], because I think one thing that happens to family doctors is that sometimes you might admit a patient with a really unusual condition that's really complicated, and you get really really time consumed and overwhelmed with something that's very difficult, and outside of our scope of what we can do well."

"The call group [is important to me, because] that mitigates that issue with flexibility when you have a good call group that makes it more flexible for you."

"In Nanaimo, a lot of [residents] get a message [from] the hospitalist crew that [hospitalist work] is such a financially lucrative thing to do. You don't have to think about running an office. You've got all these friends and colleagues around and it's collegial"

"The hospitalists are in house all day, so if your patients decompensates at 1:00 in the afternoon, you're there. You're able to go see your patient. Whereas, I think you're more likely in a clinic to try to manage things over the phone, because you're aware acutely that you have a huge waiting list of patients that you need to see, [and are aware of] the impact financially and on your patients of cancelling your whole afternoon to go manage a sick patient in the hospital"

"I think that just the office alone can be isolating."

"I think [something that] helps people do full scope is having good support from the specialists in town. If you're in a place where [you're] in emerg and it's too big a centre where you don't know your specialists really well, then it makes you feel uncomfortable. [Also,] if there's not a lot of other GPs doing what you want to do, then it also makes it super hard. Because you need a group to provide care, and [to] advocate for the group."

"So when you look at that I think it's good, it's just a question of like how comfortable are you in your skill set, and who do you have available to support, and how far away are they? Yeah I think that's a big part, is who you have to support and how far away they are."

"I do inpatient work every morning. A lot of times there is a lot of pressure to get out [of the hospital]-and you don't have enough time in the mornings to see patients. So, I don't know if it would be program specific, but just maybe incorporating that set amount of time or….cause like you said, at the end of the day everyone wants to go home and you feel like it's rushed all the time. So, like, as part of your training…. As part of the training, yeah, to use some time like at the morning, like an extra half an hour or something. But yeah, I think that's one of the main things that is driving me away. Because it's so rushed and it backs everything up during the day."

"In Nanaimo, a lot of people get a message [from] the hospitalist crew that this is such a financially lucrative thing to do. You don't have to think about running an office. You've got all these friends and colleagues around and it's collegial. And I think that gets displayed a lot"

R1

"despite the fact that I believe in full service for continuity of care involving my patients and their essential care I don't know what an ideal system of care delivery would look like."

"Because I guess that's one of the lifestyle issues – is having that flexibility to be able to take vacation or be away for a weekend or whatever. So having a group of people that, you know they can cover for you relatively easily and you cover for them sometimes as well, and having a collegial atmosphere where maybe hopefully you know them and are friendly with them."

"It's probably one of the top I don't know, 5 reasons why I would want to work in a community like, or in a hospital like Nanaimo, because its, I just feel welcomed here and I feel like my

presence as a resident is valued, and my, like the way I see it's valued from my preceptors perspective, like just seeing their interaction with all the providers or specialists here. I think it's all been very positive. So I think it definitely incentivizes my willingness to want to work in full service and participate in a hospital setting."

"Yeah, I'd definitely agree to that. That's something that, like having done residency training here, and especially by the end of it, we all know the specialists that are handling…more comfortable…..it does make it more likely if I was going to do full service, I would do it here whereas if I moved somewhere else and I don't know anyone at the hospital, I feel like I'd be less likely to do it there"

"But I would worry about a town this size, with fewer and fewer people doing it, whether I would be supported enough. Whether I would have other people to take call when I wanted some time off."

"I'm interested in full service family medicine. But I haven't seen a model yet that I think is workable for me, or attractive to me."

"the reality is that its' failing. We can all see that. We're all aware of that. Like in my clinic, people are slowly, even in the short time that they've been there, people are giving up their hospital privileges, and that's because they all admit that its' not working. There's a few diehards that hang on, but I think those that finally give up their privileges, once they don't have that, need to avoid the cognitive dissonance of admitting that it's a broken system. But once they do give it up, they're willing to acknowledge that, yeah, it isn't working."

"The model of seeing patients before clinic starts has zero appeal to me. I don't function like that. Like if I'm going to do something in a day I need to put all my energy in and focus, and I think those patients in clinic deserve your focus. And if you're coming in an hour, hour and a half late that's not ok in terms of care."

"24/7 sort of call model where if somebody goes into labour or needs to be induced, they will postpone or drop that day's clinic and rearrange it. Which I don't, doesn't really appeal to me, and I'm not sure how to work around that. But the idea of being on call like 24/7 is not attractive for me."

"I think having other people in the community that as well, that understand the situation that you're in, and again coming back to that community is that the fewer people there are in your community doing it the less supported you are going to feel moving forward. Where you're in a community where fewer family docs are doing obstetrics and that's more ob's or it's more midwives and people that specialize in just that, the less supported you're going to feel. The fewer people you have to do continuing education with or to have discussion group or whatever, and I think that makes a difference too."

Table 4. Major theme and supportive quotes: Inadequate training/exposure, negative experience in training

R2

"I was way more confident that hospital work was going to be part of my practice than I am now. I'm still planning on doing it, but there's kind of medical things where it's hard to know specifically what provides better care for patients. And other people have mentioned that not being immersed in it all the time, you feel like your skills might not be as good if you're just seeing, like, 1 or 2 patients in the morning, versus doing 8 hour shifts – seeing like 30 right."

"I'm a bit worried about providing residential care and house calls. So those are 2 things that I would like to provide. My concern is that I haven't had any exposure to either in my residency so far, so I've never done a residential care visit in residency. I've never done a house call, and as part of my clinic, we do not round on our patients in the morning. So I wouldn't feel comfortable offering those things in my care"

"it seems like ER and hospitalist require extra training, and those….i'm just not comfortable…"

"I feel that now as there's more information that's available, that I can't provide optimal care to my patients across as broad a spectrum as perhaps …are able to because of …. And I want to ensure that I am very well versed on the services I'm providing to my patients, and I do not

feel that that's something that I'm well equipped to do in a family practice setting plus another setting."

"you have to be good at what you do as well and I found like I kind of had to pick between those 2 or else I would just feel uncomfortable doing both of them. So I picked emerg because I'm more comfortable in emerg and I like emerg, and obstetrics just seemed like I would need extra training and yeah…and based on the number of deliveries I wasn't super comfortable."

"The other reason would be that I don't think I got as much exposure that I think I would need, and experience in to keep my skills up."

"Adverse outcomes. Like way back in medical school I thought I'd be very interested in emergency medicine, and I even did like a rural clerkship so that I got extra training. But after having enough adverse outcomes in a rural community where I ultimately didn't feel supported and couldn't transfer patients out with PTN in a timely manner. That really discouraged me from doing emergency medicine. So that combined with not enough of the extra training to get that confidence to provide good care to patients has discouraged me from pursuing that and trying it again."

"In medical school in Victoria, I didn't feel like we were very well supported as learners in the [OB] …. So I think if the interest spark had been better cultivated, then I think I might be saying something different now. But I think if you get turned off something early then it's hard to kind of revitalize that interest."

"2nd year came around and we just felt like too much to be good at ob and emerg. Like how high the level of knowledge I guess….like to drop one thing to…do the other thing better, so….i dropped ob, but…"

"I feel that there is a limitation to what you can learn to a level that is appropriate. That being said, people can learn things super….but really broadly and I don't think that you're actually serving your patients… and even though I am interested in doing obstetrics, but do I feel that I will be the best person that….and the….outcome to mitigate that. I don't know. I think that someone who has 5 years training in that specialty, plus more, is better equipped to do what they do…at least 3 days a week. And I sometimes feel that the…..is sometimes not ethical"

"If I had exposure in residency to managing inpatients as part of my daily thing, or even just like specifically on my family medicine rotation, and if I had exposure to seeing patients in residential care and doing house calls, I would be much more comfortable with that."

R1

"I think the reason it's difficult is because I don't in actuality have continuity [as a Resident]"

"I still worry about our quality of care being compromised by saying I want to do 3 different things"

"I haven't been exposed to true, at this point, kind of longitudinal full service. At least what it can look like, in its kind of full form. Yeah, I think there's more that pushes me away from full service medicine than pushes me toward"

"I think in particular with obstetrics, you know, you do 6 weeks in your first year and 4 weeks in your second year. That's piddly to go and expect you to be on your own"

"*We do have the opportunity to tailor a bit in our 2nd year. The issue with that is knowing far enough in advance that that's actually what you want. That's a struggle that I have is I'm not ready to give anything up yet, and give up any opportunities in order to take new ones on."*

Table 5. Minor theme and supportive quotes: Mentoring/Modeling

R2

"I like emergency, but I think our community here doesn't really have that as an option with your average clinic based family doctor. It sounds like it used to be,when [some of our preceptors started here], that was just kind of how the emerg was run, but it seems like a bit more of an institutional change, at least in our size of community."

"Before I went into residency, I was really keen on doing some hospital work, but then seeing it incorporated into practice, I'm kind of hesitant now. Mostly because, during the day you kind of get bogged down in that work from the hospital too. You get calls during the day that really back up clinic. So you end up running 2 hours behind everyday almost. And my preceptors [are]-so there's lots of patients in hospital and nobody to cover during the day."

"it seems to be this taboo still, that you can't take the time or the opportunity to talk to a lot of preceptors about how to actually run a clinic. I think [it would be helpful to have]~~that actually~~ some dedicated time to that, where it's not tacking it on at the end of a day when people want to go home because they've already seen all these patients, and you're learning the medicine. That there [would be] a time to learn how to practice as a physician, and with remuneration, with choosing office staff, to choosing an office itself.

R1

"~~I~~n addition to that. And it seems [having inpatient and maternity privileges] can be very stressful at times. I mean, you may have to leave the clinic in the middle of the day even and miss out on lunch to go deal with something and then you've already got a full schedule booked"

"That mentoring piece is really important because , from what I've heard, you never feel confident, like nobody feels really confident or competent when they graduate.Whether you do 3 months extra training or whatever, it's pretty rare to get to that point where you're like "yes I am ready." I think it's really about seeing other people do it [FSFP] and know that, you know, they felt the same way."

Table 6. Minor theme and supportive quotes: Running a business/Admin burden

R2

"So that was a community that I really fit into and found some great role models that were able to….the kind of practice that would fit with me and both from a varied interest perspective as well as minimizing the burden in my mind of the clinical administrative"

"Then the other thing was remuneration. So I've never really been exposed to different pay models besides fee for service. I know there's a session on…like hourly rate, right…but I'm not sure how that would work and it seems, like from a business side of things, more….like you'd want to go into it just because there's no administrative things to worry about. So it's less about running a business. And I could definitely see how people are driven away from being in the office full time, mainly for me it would be running a clinic that I'm not really trained in…and managers and just, it's really scary even for me and I know that's what I'm going to be doing when I graduate."

R1

"Yeah. I don't want to study it. Like studying and memorizing this crap…like my mindset…when I see a person I don't want to be thinking oh I can bill a 00077. No, I want to be treating the patient. I don't even want to think about that stuff."

"Yeah I don't like billing. I dislike billing. But it is something that I'm willing to put up with because I want to do clinic medicine, and I don't want to be restricted to the clinic that I work in just because they do – like that's the way the clinic works and I can't get a salary or whatever – so I'm willing to do the billing even if I would rather not. "

Table 7. Minor theme and supportive quotes: Competence

R2

"it seems like ER and hospitalist require extra training, and those….i'm just not comfortable…"

"some people stay doing that [hospitalist or emerg] because then they feel like they de-skill, right. So if they started out doing emerg and they're not in clinic. Like if you're not in clinic then you're less likely to do that. So I think your choices right out of a residency matter quite a bit too. And a lot of people don't want to settle right into a clinic and kind of make that commitment right away, which then is another….giving you so many options right here…but I just feel like there's so many reasons that people don't choose clinic, but then they either de-skill or they get comfortable where they are."

"I still worry about our quality of care being compromised by saying I want to do 3 different things"

R1

"*I did clerkship at a very small place where it was only 2 GPs and it was full service so all the GPs took care of their own inpatients, but they were all part of the same maternity group. They all did emerg. And I thought I really like this because I really like mainly the variety of the practice, and the week is pretty different, and I don't think I'd get bored doing all of that. But then, now I'm worried that how am I ever possibly going to be competent in all of those areas and to stay up to date in all of those areas."*

"I worry about keeping skills up to date when you're pulled in 10 different directions and you only have so much time in a week to practice in different areas. I don't think I could do emerg and obstetrics and be competent in both of those, for sure"

" I'm one of those people that I would love to do full service because I just think it's such a rich practice style. I may end up doing just one or two things because of that, well, because of all the things that were previously mentioned – one of them being wondering if I'd be competent."

"To me, part of it might be just the education gap, in that Canada is a 2 year program. Lots of other places – nearly everywhere else in the world just isn't 2 years. I know that you never feel ready for it, but part of it is because it's definitely a crazy short program for what the breadth of medicine has to….and yeah, maybe 50 years ago it was who knows…and maybe somewhere more reasonable. But if you're trying to teach people to be proficient in all of those, in full practice medicine, I….there's a reason why people have this huge anxiety, and I don't know if it's unfounded."

Authorship

Distribution of work was equally divided between the 2 resident research authors. The ethics proposal was written and edited jointly by the 2 authors. The methodology and study design was established through collaboration and input of both study authors. The consent forms and recruitment materials were created by Dr. Jesse Wolfe, and Dr. Chris Yeker was responsible for distribution of the materials and interaction with the participants. Dr. Chris Yeker scheduled the focus groups and was the lead facilitator, with assistance from the Principal investigator, Dr. Derek Poteryko. The writing of all sections of the final manuscript was done jointly, with roughly equal distribution of work, by the 2 authors. Editing was performed by both research authors.

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