

BEYOND MEDICALIZATION: AN INTERNATIONAL VIEW OF MD ROLES IN LONG TERM CARE

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- **Potential for conflict(s) of interest:**
 - **Joel Lexchin** has received **None** from **None**.
 - **Bob James** has received **None** from **None**.
 - **Margaret McGregor** works as a physician in a long-term care home and participates in a Committee that is implementing a Residential Care Improvement initiative in British Columbia
 - **None** a product that will be discussed in this program: **None**.

Outline of Talk

- Describe project
- Roles and responsibilities of doctors in Canada and internationally
- What else should doctors do
- How can doctors work better
- Promising practice in Canada

Our Project

- Seven-year project looking at promising practices in long-term care in Canada (four provinces), Germany, Norway, Sweden, United Kingdom, United States
- Led by Pat Armstrong, Distinguished Research Professor of Sociology, York University
- Funded by Social Science and Humanities Research Council

Source of Data

Location	Code	Doctors (#)
Canada		
British Columbia	CA/BC	3
Manitoba	CA/MB	1
Ontario	CA/ON	2
Nova Scotia	CA/NS	1
Germany		
North Rhine-Westphalia	GM/NRW	1
Norway		
Pilot	NW/Pilot	1
Oslo	NW/Olso	1
Bergen	NW/BG	3
Sweden		
Stockholm	SW/Stklm	2
United Kingdom		
Bristol	UK/Bristol	1
United States		
California	US/CA/Pilot	1
Texas	US/Texas	1
Total		18

Role of the MD in Nursing Homes in Canada

- Legislation in at least four Canadian provinces requires a medical director
- Doctors needed for medical decision-making
 - Some could be done remotely by RNs but doctors would be uncomfortable if they were not physically present some of the time
 - In some provinces NPs can fulfill much of the doctor role
- Can sometimes help avoid hospitalizations and their complications

Role of the MD in Nursing Homes in Canada and Internationally

- Doctors typically do things such as admission physicals, annual reviews and medication reviews
- Ideally provide pro-active longitudinal care & develop relationships with residents & families
- Provide care for acute events on a 24/7 basis
- Medical directors
 - In Canada coordinate work of all doctors
 - Don't exist in: Norway, Sweden, Germany, or the UK
- In some Canadian LTC homes Medical Advisory Committee generates medical policy
- Internationally homes tended to be smaller than in Canada
 - Does this facilitate movement to “house physician” model for doctoring?
- Communication
 - With senior nursing staff usually face-to-face
 - With other staff through “communication book”
 - With other parts of the health care system (e.g., hospitals)
 - With families

How Are Doctors Paid

- Most doctors in Canada are paid partially or completely on a fee for service model
- Other places – salary or sessional fees for house doctors
- Does fee for service versus salary affect:
 - Time spent with residents
 - Quality of care
 - Job satisfaction
 - Accountability to facility

Full-Time versus Part-Time Work

- Still an issue both in Canada and internationally
- House physician model versus family physician following patients into long-term care facilities
- Training & working as a full-time long-term care specialists versus working as a general practitioner with some extra training in long-term care
- Insider versus outsider
 - Insider – understands in detail how the home functions
 - Outsider – perspective of someone not caught up in day to day work

Palliative versus Curative Care

- In all places, physicians reported that an important part of their job was to clarify the goals of residents' care, which included addressing end-of-life care
- Clarity and consensus about the goals of care were essential to avoiding unnecessary medicalization
- Goals-of-care conversations were not happening as early or routinely as they could

Reducing Polypharmacy

- All physicians saw this as part of their role
- Several physicians reported that pressure to medicate came from non-physician staff
 - Encouraging staff to adopt behavioural approaches or verifying this had been attempted was presented as an important part of physicians' responsibility
- Regulatory requirement or facility policy at all sites
- A number of conditions were observed to support physicians' efforts to appropriately reduce medication
 - Having enough time, including time with residents and staff
 - Norway and Sweden, where there were house physicians, this was expressed as having a "good physician to resident ratio"
 - UK, the physician was supported by a primary care liaison service that allocated community psychiatric nurses to the home
 - Access to specialists, such as geriatric psychiatrists or neurologists, was important

Medical versus Social Role

- Internationally (Germany, Norway, UK) MDs actively involved with promoting and integrating social programs, e.g., music program in Norway, “butterfly” program in UK
- Families pushed physicians to attend to and integrate a diversity of perspectives, broadening their lens beyond the conventional biomedical domain
- Physicians derived satisfaction from working with families
 - Families also commonly represented as challenging, requiring physicians to adopt a “social worker hat”

Additional Responsibilities versus “Just Being a Doctor”

- Should doctors be encouraged to take on additional responsibilities, e.g., participating in quality improvement efforts?
- Should doctors just deliver primary care?

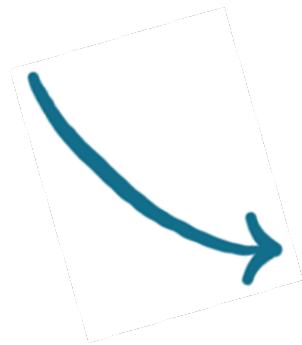
What Makes It Possible for Physicians to Work Better?

- Better staffing ratios internationally than in Ontario and other parts of Canada
- More role flexibility for staff, e.g., nursing staff performed some housekeeping and kitchen work
- Closed-model of physician employment increased physician presence and thereby reduced hospitalizations
- Regulations become the ceiling rather than the floor
 - More evident in Canada than internationally
 - Less flexibility in how facilities operate

BC, Canada – promising practice

Province-wide creation of local plans to deliver dedicated family physician services for Residential Care patients with a defined Standard of Care.

Program initiated – July 1, 2015 – Ministry funding to family physician nonprofit societies in each community (Divisions of Family practice)



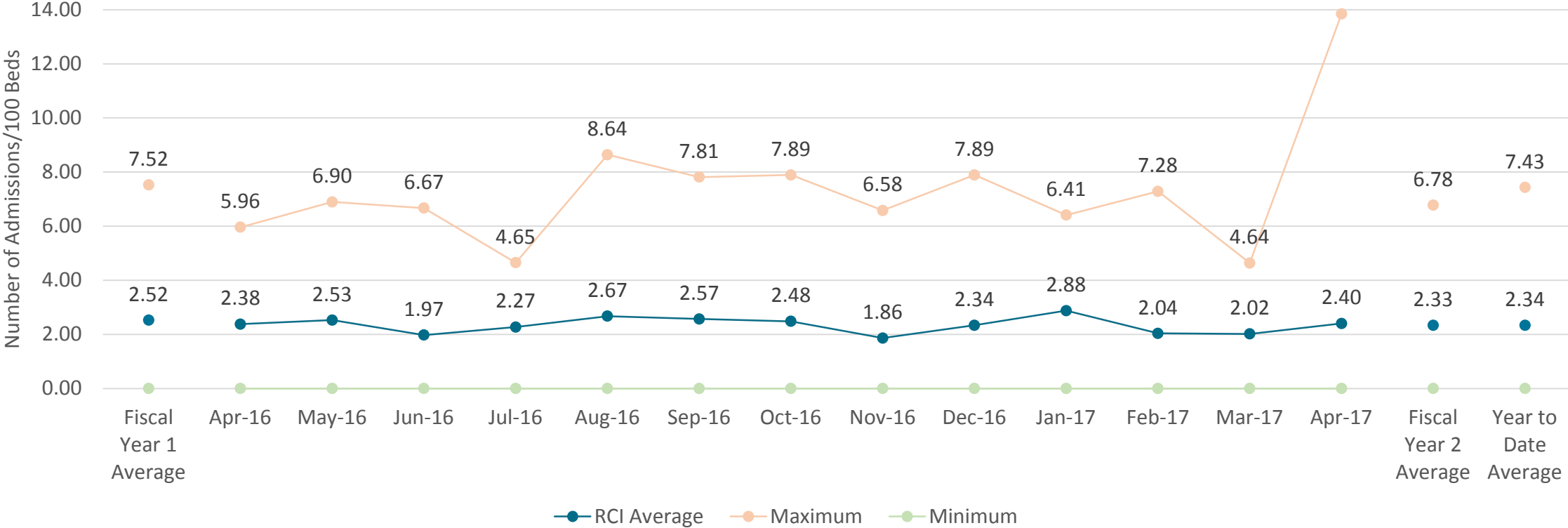
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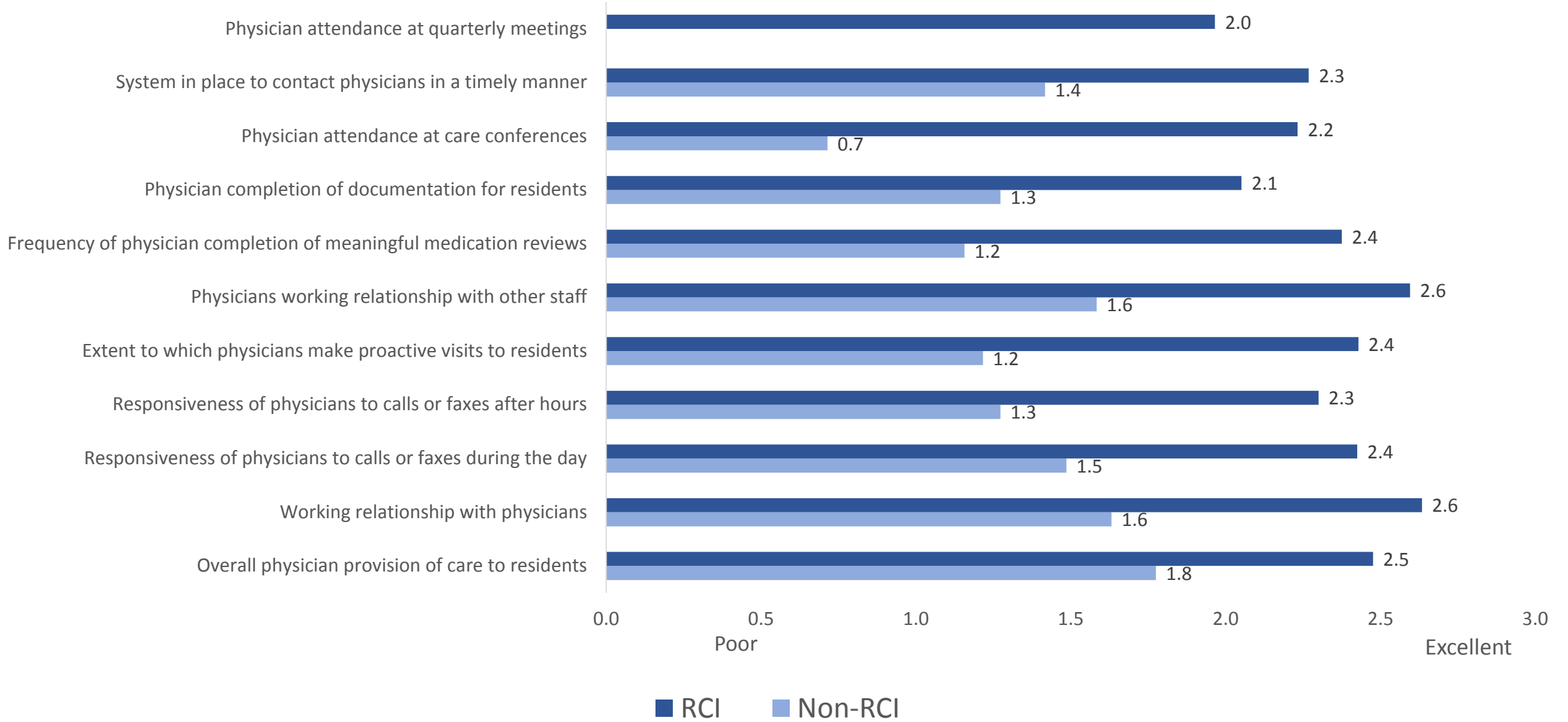
1. 24/7 availability and on-site attendance
2. Proactive visits to residents
3. Meaningful medication reviews
4. Completed documentation
5. Attendance at care conferences
6. Quarterly meetings to review data and work on quality improvement projects

System Level Outcomes

Number of Admissions to Acute Care per 100 Beds



Leadership: Average Satisfaction of RCI and Non-RCI Physicians



“We survey our residents annually and the indicator for medical treatment went from 77.7% in 2015 to 90.7% satisfaction in 2016.” (Facility Leader)

“Families and residents do not tell me during resident council that they can't see their doctor, a complaint that was heard before.” (Facility Leader)

We now have “a unified team approach to addressing gaps in practice and processes in regards to care outcomes for our residents.” (Facility Leader)

Other promising practices in Canada

- Calgary – sessional payment to physicians
“To provide the kind of medical care needed in a residential care setting, you have to do it within the team—it can’t be done under a system of payment that encourages the doctor to do the most number of services within a certain time” (Quail, 2015)
- Nova Scotia – “Care by Design” – sessional payment, dedicated family physician for each floor working to a defined standard (Barry Clarke)
- Long-term medical directors listserv (Paddy Quail)
- Toronto, some training sites in BC, Calgary - mandatory exposure to community geriatrics training
- Core curriculum for LTC medical directors (Moser & Williams)

Germany

- A good example of how things can be different

Questions?