Physicians' access to primary care: results from the Canadian Medical Association National Physician Health Survey

Historically, the medical culture has promoted a climate of self-sacrifice, with a prioritization of patient needs above all else—including physicians' own self-care.[1] The 2017 Canadian Medical Association (CMA) National Physician Health Survey revealed 30% burnout, 34% depression (screening), and 19% lifetime suicidal ideation in Canadian residents and physicians ($N = 2947$).[2] These results are concerning and highlight the need to shift the medical culture to support self-care, and for occupational barriers to access be addressed. One way that physicians can prioritize their own health—both physical and mental—is by having a formal physician–patient relationship with a primary care physician (PCP) for continuity of care.[1,3] Several studies have examined physicians' access to health care.[3–5] For example, a review of 26 articles found that as high as 79% of physicians do not have a PCP, with many reporting self-diagnosis instead, though rates varied significantly owing to differences in health systems (average rate of physicians who do not have a PCP = 38%).[4] In Canada, the most recent national data concerning physician access to care (2007) showed that 67% of physicians have their own physician (CMA, personal communication). The purpose of this article is to present national data on how many Canadian residents and physicians report having a PCP, what their relationship with the physician is (e.g., formal physician–patient versus informal consult with friend, close colleague, or family member), and when they last saw them. The main reasons for not having a PCP are also reported.

A total of 2947 Canadian physicians and residents responded to an online survey (8.5% response rate). Full methodology is available here: https://www.cma.ca/sites/default/files/2018-11/nph-survey-e.pdf.[2]

Overall, 82% reported having a PCP (Table 1). Residents were significantly less likely than physicians to report having their own physician (72% vs 83%). Results of the χ^2 test of independence to compare differences in having a PCP according to practice status were the following: $\chi^2(1) = 25.27$, $p < 0.001$. Physicians had 92% increased odds to have a PCP compared with residents.

Among participants who have a PCP, 77% specified that it is a formal physician–patient relationship, whereas 16% indicated that they are a close friend. Three quarters of the sample with a PCP reported seeing them within the last year. Among participants who do not have their own physician, the top 2 reported barriers were lack of time (37%) and concerns about confidentiality (12%). A subanalysis found that participants who practiced in small town/rural/geographically isolated settings were significantly more likely to have confidentiality concerns than those in urban/suburban settings. Results of the χ^2 test of independence to compare differences in confidentiality concerns according to practice setting were the following: $\chi^2(1) = 10.02$, $p < 0.01$. Physicians/residents practicing in small town/rural/geographically isolated settings had 139% increased odds to have confidentiality concerns compared with those in urban/suburban settings.

The percentage of Canadian residents and physicians accessing a PCP appears to have improved in the last 10 years (67% in 2007 vs 82% in 2017). Although this is encouraging, there is still room for improvement, particularly among residents who were less likely to have a PCP, and who also reported significantly higher rates of burnout, depression, and suicidal ideation, as well as lower resilience compared with physicians (Table 2). Considering this, increasing access to a PCP in a collaborative care setting may be particularly important, as it has been shown to improve mental health outcomes.[6]

The barriers for not having a PCP are in line with previous studies.[4,5] For example, George and colleagues[5] also reported time as the most common health-access barrier (54%), followed by confidentiality (42%). These barriers should be considered, and appropriate change introduced, in order to increase physician access to health care. Recommendations include the following:

- Protected time should be offered for self-care, and leaders should actively encourage physicians to use this time to access a PCP. Leaders should also model these behaviours by prioritizing protected time to attend to their own health and wellness.
- A list of physicians in every province/territory who will take on medical patients should be developed. In the provinces that already have this resource, increased awareness is recommended to promote use.
- Training programs should be delivered on how to provide medical care to physician–patients involving education on dealing with unique challenges that may arise. Some physicians choose to avoid taking on physician–patients owing to these challenges.[7] Offering training programs might increase PCP's confidence and frequency in taking on other physicians, and could improve the quality of care provided, potentially increasing the likelihood of physicians accessing a PCP.

It is important to increase physician access to health care in order to improve both mental and physical health for physicians. Furthermore, this might extend to patient care, such that physician and patients relate better to the experiences of their own patients, having been one themselves.

In conclusion, the increasingly complex and stressful nature of medical training and practice highlights the growing importance for physicians to have access to, and optimal

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Table 1—Descriptive statistics from the Canadian Medical Association National Physician Health Survey on questions related to having a primary care physician, according to practice status

	Resident		Physician		Total	
	%	n	%	n	%	N
Do you believe it is important for physicians to have their own primary care physician?						
Yes	99	344	98	2392	98	2736
No	1	2	2	42	2	44
Total		346		2434		2780
Do you have a regular primary care physician?						
Yes	72	249	83	2015	82	2264
No	28	97	17	409	18	506
Total		346		2424		2770
If yes, who is this physician?						
Close colleague	2	6	18	373	16	379
Friend	2	6	7	151	7	157
Family member	1	1	<1	2	<1	3
Yourself	0	0	<1	2	<1	2
Formal physician–patient relationship	95	234	74	1536	77	1770
Total		247		2064		2311
If yes, when did you last see this physician?						
Within the last year	80	193	74	1420	75	1613
Over a year ago, less than 3 years ago	17	42	20	392	20	434
Over 3 years ago, less than 5 years ago	2	4	4	69	3	73
Over 5 years ago	1	3	2	32	2	35
Total		242		1913		2155
If no, what are your reasons for not having a primary care physician?						
Worried illness might be trivial	1	1	4	18	3	19
Worried about imposing on another busy colleague	4	4	11	53	10	57
Concerns about confidentiality	7	6	13	62	12	68
Can't find a neutral physician	10	9	10	50	10	59
No time to see one	55	50	33	159	37	209
No need for one, I can monitor and diagnose myself	3	3	8	37	7	40
Other	20	18	21	103	21	121
Total		91		482		573

Results in this table do not include nonresponse. Participants could select more than one response option for the question regarding reasons for not having a primary care physician.

Table 2—Rates of burnout, depression (screening), suicidal ideation (lifetime), and resilience in a national sample of Canadian residents and physicians

	Resident, %	Physician, %	Total, %
Burnout (high)	38	29	30
Depression (screening)	48	32	34
Suicidal Ideation (lifetime)	27	18	19
Resilience (low)	20	16	17

Information from this table was obtained from the Canadian Medical Association National Physician Health Survey: A National Snapshot.[2] Permission to replicate this table was obtained.

use of, primary care for physicians. Future work in this area should consider factors beyond basic access, including demographic differences and associated risk factors. Finally, when promoting primary care for physicians it may be important to understand the range of access barriers, including cultural (e.g., concerns regarding confidentiality) and occupational (e.g., lack of time). This is a conversation that needs to continue within the profession.

Supplementary Materials

Supplementary material associated with this article can be found in the online version at doi:10.1016/j.jcjo.2020.03.009.

Taylor McFadden,*,† Christopher Simon,* Bilal Kobeissi,* Caroline Gerin-Lajoie*
*Canadian Medical Association, Ottawa, Ont.; †University of Ottawa, Ottawa, Ont.

Correspondence to:
Taylor McFadden, MSc; taylor.mcfadden@cma.ca.

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