Introduction

Cross-cultural perspectives are important to boost innovation in services and healthcare is not an exception. It is an important element to inspire thoughts “out-of-the-box,” or, more practically, to find new ways of organizing and correcting problems otherwise not considered. At a time when there is a debate of reforming the Portuguese health-care system, the Canadian system, though different, may provide answers to some of the questions that are being asked. This article is based on a report on a 1-month observership in family medicine that took place in March 2013 in Edmonton, Alberta, Canada.

The work of a family physician in Canada

Patients are free to pick their family physician in Canada. Every Canadian citizen is assigned a personal health number (PHN) which guarantees free access to health care at any health institution in Canada.

On the first approach, this may prove to be difficult regarding organizing healthcare resources; however, patients usually choose one doctor as their family physician, thus guaranteeing the continuity of care. Most physicians accept only patients without a family doctor and will not accept patients with physicians already.

It rests on the physician to decide whether or not he is willing to accept new patients, giving him freedom of choice regarding the number of patients, he is willing to see and follow (usually between 1500 and 2000 patients). This decision might not only be settled at individual level but also at organizational level as is it possible for a clinic to refuse new patients usually if their panel is full. Furthermore, physicians are also allowed to refuse to treat a patient further in case the patient-physician relationship and interaction are compromised.

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Besides regular patients, there are also the “walk-ins,” which are patients who require medical examination due to an acute situation. Here, again, the physician may choose to see “walk-in” patients or the clinic is allowed to state that it does not accept any “walk-ins.” For this matter, there are specified “walk-in” clinics that center their care on acute conditions and usually have easier accessibility due to longer opening hours. Many clinics have specified walk-in times for their patients on top of booked appointments.

As for the articulation of primary care and secondary care, it is quite well established in Canada. Usually, primary care physicians reference patients to a specialist by letter, which is registered in the computer system. The waiting time to get an appointment varies from 1 to 6 months; however, in case it’s urgent, the primary care physician may also phone the specialist and book an appointment for the very same day.

The whole reference process happens at individual level, that is, the primary care physician references a patient to a specialist, individually. Therefore, it is also possible for the patients to choose the specialist they wish to go to.

In case it is required, the primary care physician may also phone the specialist and discuss a patient’s case with him or her. In case it’s urgent, the specialist on call at the hospital can always be contacted by phone for advice.

All physicians usually work at the hospital or at a clinic (a building where physicians may rent an office to practice in). For the latter, it is required that physicians cover the rent and any expenses they may have with personnel, such as nurses and secretaries. Medical services are always covered by the provincial government, so the patient is not required to pay for the visits.

In case of an acute onset of symptoms, patients may go to their family physician, to the walk-in clinics, or directly to the hospital emergency room. At the hospital, patients are triaged by a nurse and if wait times are long and the patient is triaged low, they may choose to book an appointment with his family physician instead.

Describing the activity of the family physician, visits most commonly last between 10 and 15 min. Their approach is family-centered, rather than at individual level, as the patients physicians accept are members of a family.

Risk groups (children, pregnant women, diabetic patients, etc.) are seen in a special type of appointment throughout the day. Other types of special appointments include the “general physical examination,” which consists in a yearly evaluation, from head to toe, of the patient’s overall health. During this visit, it is normal practice to review the patient’s personal history and habits to keep track of any change that may have occurred. In case, the patient suffers from a common chronic condition (e.g. Hypertension, diabetes, chronic obstructive pulmonary disease, asthma, etc.) the physician prepares a “Complex Care Plan” together with the patient. It includes the problem list, lifestyle issues, the current medication, the involvement of other health care professionals, the advised scheduling of medical services throughout the year, end of life discussion, and the goals set by the patient and the physician. It is reviewed on a yearly basis and is expected to help the patient get a better grasp of his condition and manage medical visits accordingly.

Patients are advised to book their appointments according to their condition and their motive, always having the possibility of booking an appointment on the same day in case of an acute condition. Home visits are optional, but most family doctors do not perform them.

If the clinic has the necessary conditions, family physicians are also able to perform deliveries, small surgeries (e.g. circumcisions, vasectomies, cyst removers, ingrown toenail incisions), biopsies (includes endometrial biopsies), casts, use of liquid nitrogen, insert intrauterine devices, aspirations, and joint injections. With special training, family physicians are allowed other procedures, such as performing c-sections or anesthesia. Family physicians also have the option to become involved in hospital care and stay responsible for a ward of 20–25 patients. Every major hospital has family medicine wards that admit patients with different types of pathologies such as hip fracture, delirium, sepsis, congestive heart failure, etc., The family doctor is responsible for these patients, having to check on them on a daily basis and if required, ask for the collaboration from another specialist. Hence, they need to be available 24/7.

In rural areas, family physicians can do emergency work as well without extra training. In the larger centers, family physicians require 1 extra year of residency training in emergency room medicine and are almost considered equivalent to a specialist Emergency Room physician.

Regarding medication, it is sold in units and physicians may, in one prescription, prescribe chronic medication that lasts for a year. As patients are advised to pick up their medication at the same pharmacy, physicians may call up the pharmacy at any point and discuss the patient’s medication with the pharmacist. What’s more, pharmacists may also renovate prescriptions (except for narcotics), which, consequently, make many patients not to go and see the doctor.

Nurses at the primary care clinics assist the doctors and have other duties, such as giving injections, ear wash, wart treatment, filling cognitive assessment forms, take away casts, review “chronic disease management plans,” collect the history in newborns, and obtain the ankle brachial index.

The Canadian health-care service is fundamentally public; however, clinics are owned by a physician. Physicians get their income according to a fee-for-service model, that is, the physician bills the government after seeing a patient. Afterward, the
physician has to pay about 30% of their income to the physician who owns the clinic, to cover staff salaries, rent, etc. Income taxes cover 38% of a physician’s income, and physicians have to pay their insurance fee. Physicians are considered self-employed; therefore, professionals do not have a right to pension or to sickness leave.

There are also some salaried positions in the public system (alternate relationship plan), but they are mainly reserved for academic physicians to promote research and teaching.

As for working hours, family physicians are free to plan their weekly schedule. This individual modeling could prove an obstacle for the management of the clinic; however, there is a record of each doctor’s activity plan together with the number of patients he or she is currently seeing and the patients the physician should be seeing.

In some provinces, there are initiatives to promote primary health creating structures such as the “Primary Care Network” (PCN).[1] A PCN may include one clinic with several physicians and support staff or many physicians in various clinics across a health region. Each network works toward developing programs and providing services to best meet the needs of local patients.

In a PCN, patients have access to multiple services such as geriatrics long-term, women’s health clinic, shared care maternity, pediatric asthma, cast clinic, and after-hours clinic. Overall, PCNs aim to provide better services and to engage the community in activities to promote the role of physicians within primary care.

Regarding continued medical education, it is required that every doctor submits 250 MAINPRO® (Maintenance of Proficiency) credits every 5 years - one credit is equal to 1 h of learning. These credits are authorized by the College of Family Physicians of Canada, and they can be gained in any scientific activity participated besides practice, i.e. research, teaching, courses, reading journals, certified podcasts, group sessions, congress attendance, master’s degree, etc.[2]

The work of a family physician in Portugal

Every Portuguese citizen has a health care number which allows them to have access to health care, after paying a token duty.[3] The latter does not apply in certain situations, such as patients that demonstrate financial hardship (it is mandatory to declare one’s income to the state) as well as their dependents, pregnant women and women in labor, children until the age of twelve, patients with an inability level of 60% or higher, transplant patients, military and former military personnel who have been permanently incapacitated due to their military service, and certain unemployed people. Blood, cell, tissue or organ donors, as well as firemen, are exempted of co-payment in case of primary care.[4] Demonstrating financial hardship proves a barrier to vulnerable groups such as homeless people as they have no means of proving they have a right to be exempted from the usual co-payment.

Furthermore, excepting emergency room visits, Portuguese citizens may only use health-care resources that are available in their living area. This rule also applies to primary health-care centers.

When a family physician starts working at a health-care center, he/she is given a list of about 1800–2000 patients, which is made out of members of various families.[3] The physician is expected to follow these patients throughout life, occasionally accepting a new family member by request from the family. Thus, there is a very little variation in the patients the physician usually sees. However, this assures the continuity of care, aids the physician to get more familiar with the patients, and to establish a closer patient–doctor relationship. In case a patient–doctor relationship is compromised, the physician may ask another physician, of the same health care unit, to see and follow a patient.

Because of the list system, there is a considerable amount of citizens that do not have access to primary care, let alone a family physician. As the Portuguese health-care system is a mix between a public and a private system, citizens with higher incomes opt to see specialists at their offices directly. However, patients have to pay out-of-pocket for the full amount of that visit as they are not covered by the state.

Some public health care subsystems have an agreement with some doctors and partially cover for the visits, but only specific groups of the population (such as police, firemen, military, and state workers) have access to them.

For those with fewer resources, access to health care equals, for the most part, paying a visit to the emergency room at the nearest hospital. Outside the hospital, there are some centers that offer a public health care service (“SAP”), but they only cover matters of an acute onset.

There has been an effort to cover the primary care health requirements of citizens that are not included in a family physician’s list. This is being accomplished by asking some family physicians to follow vulnerable risk groups, such as children and pregnant women, in addition to their usual clinical activity. Although not enough, this measure slightly helps to alleviate the difficult access to family physicians.

On the other hand, matters are quite different for citizens that have a family physician. In a health care practice, the physician’s schedule is organized by the type of visit and it includes allocated times for normal visits, urgencies, addressing risk groups (children, pregnant women, family planning, diabetes, and hypertension), and home visits. A visit usually lasts for 10–15 min and the patient may book a visit according to his current need.

There are also appointments that do not require the presence of the patient and thus have a lower token duty than the one to pay for a regular visit. They include the renovation of a prescription, prescribing exams, a telephone contact, or filling out any other
type of document that does not require the patient to be in the room.

The longest a medicine prescription lasts is 6 months, and patients need to go to their physician to get a refill. When prescribing, physicians may only prescribe a whole package of pills, which causes patients to store many packages at home. It is not customary for pharmacies to keep track of a patient's medication; therefore, there is no dialog with the physician on the patient's medication.

When it comes to risk groups, all visits start with an evaluation by the nurse, followed by the visit to the physician. Nurses play an important role in primary care as, besides giving injections and doing wound treatments, they are responsible for the teaching and giving advice to risk groups. They also perform home visits and in case they consider it to be necessary, may request the physician to reassess a patient. In some health-care centers, nurses may become a “family nurse” and work in partnership with one family physician. This means that a family nurse only follows the patients that are included in the physician's list.

Family physicians do not usually perform any surgical or invasive activities unless they underwent a specific training in that area. This is the case for very few physicians hence when required, most physicians reference patients to the local hospital through a computer program.

This application is the main means of referral between primary and secondary care as patients need to be referred through it, to have an appointment at a public hospital. When making a referral, the family physician chooses the required specialty instead of an individual doctor, and he may only refer to the local hospital. A patient is only transferred to a different hospital in case the local one considers it does not have the necessary means to provide the best care to the patient.

Apart from this application, the communication between primary and secondary care is scarce and difficult to establish. Reports from the hospital specialists have to be requested by special notice and most of the time; patients have to carry the notices themselves. Work is being done to establish a national platform on the internet for this purpose, but it is not yet fully functional.

A family physician’s schedule is made out of a weekly 40 h labor journey. Family physicians only work on weekdays and do not have to make night shifts. Like any other physician, family physicians are state workers and are paid a fixed salary at the end of each month, having the right for pension or sickness leave. The percentage of the salary that has to be paid to the state varies with the income of every physician.

Comparing the work of family physicians, the patients, a Canadian doctor sees and follows may vary more than in Portugal, which could pose a problem for continuity of care. In practice, however, patients tend to stay loyal to one doctor.

As for their abilities, Canadian family doctors are better prepared for surgical or other invasive activities. When they undergo a special training, they are allowed more complex interventions that could otherwise only be performed by a hospital specialist. Besides that, they also have to be on call 24/7 and prepared to follow a patient that is hospitalized, especially if they work in a rural area. However, most family physicians in Canada do not do any home visits, which is common practice in Portugal.

Nurses play a more active role in Portugal than in Canada as they complement the work of family physician. On the other hand, the collaboration with other health professionals (especially pharmacies) is more established in Canada than in Portugal.

Overall, one may consider the Canadian primary health-care system to be very good, and the way it is organized may inspire other countries that are experiencing difficulties in Primary healthcare delivery, such as is happening in Portugal.

Observing and experiencing other health-care services provides new insight on organization, planning, and structure of one owns health-care service. It is a highly valuable experience that enriches participants and actively contributes for the development and improvement of Primary Care.

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Conflicts of interest
Hereby, the author declares that she presents a conflict of interest as she has been involved in both the establishment and management of the “Family Medicine 360°” exchange program over the past years.

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