SGIMBC Member Survey Report, 2021

Responses collated by Dr. Graham Lea on behalf of the SGIMBC, January 13, 2022

Preamble/methods

Google Survey distributed to members of the SGIMBC by email, with answers accepted roughly between December 1st and 31st, 2021. Anonymous responses were accepted.

There were 243 members of the SGIMBC as of December 31, 2021. In estimating the total number of members that would ostensibly reply “yes” to a particular question, the survey respondents are assumed to be a representative sample of the entire membership. An assumption of binomial standard error was carried to arrive at estimated ranges of survey answers, within a 95% confidence limit. Numbers were rounded to the nearest power of 10 to signify the appropriate precision of the estimates.

1. Do you have a primary place of practice?

Primary place of practice	Percent of SGIM members	SGIM members
Yes	90-100 %	210-240
No	6-10 %	15-24

1a. Where is your primary place of practice located? (optional)

Primary place of practice	Percent of SGIM members	SGIM members
VCH/PHC	30-50 %	70-110
Fraser Health	18-29 %	40-70
Island Health	13-22 %	30-50
Interior Health	13-22 %	30-50
Northern Health	1-3 %	3-6

Discussion:

This would suggest under-representation among the North, among survey respondents. Notably, this survey was conducted during the COVID-19 pandemic, a time of increased demands on health care workers. Time may not have permitted timely response to the survey.

2. Do you locum in multiple places?

Do you locum?	Percent of SGIM members	SGIM members
Yes	17-27 %	40-70
No	70-90 %	170-210

Sites of locums:

- Vancouver General Hospital
- Surrey Memorial Hospital
- Penticton
- Vancouver
- Royal Columbian Hospital, Mount Saint Joseph's Hospital, Vancouver General Hospital
- Duncan
- Vancouver
- Fraser Health
- Fraser Health and Northwest Territories
- Kamloops
- Yellowknife
- Ontario. Occasionally Richmond
- Pretty much everywhere in the province
- MSJ

Discussion:

This would suggest that there is a pool of approximately 40-70 members of the SGIMBC who locum in the province.

3. How many years have you been in practice?

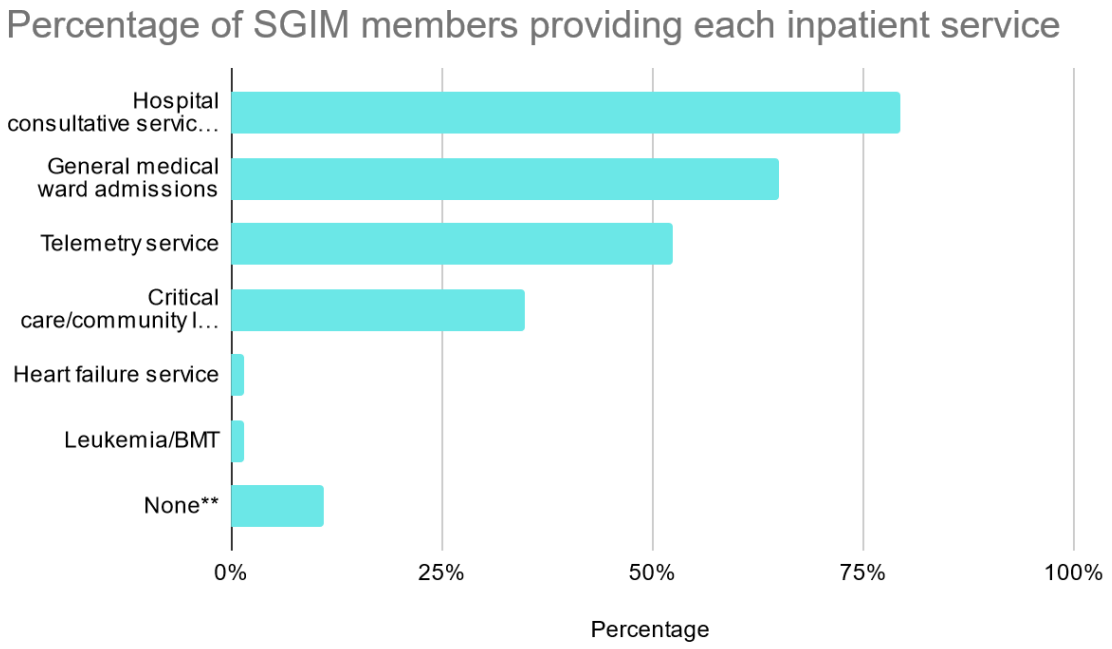
Years in practice	Percent of SGIM members	SGIM members
I haven't started*	0-1%	0-3
0-5	17-27 %	40-70
5-10	30-40 %	70-100
10-15	11-18 %	30-40
15-20	10-16 %	20-40
20-25	6-10 %	15-24
25-30	1-2 %	3-5
30-35	1-2 %	3-5
35-40	1-2 %	3-5
40+	2-4 %	6-10

Discussion

The assumption that the survey respondents are representative of the entire membership is challenged here. We know that we have many members who have not yet started practice, yet zero members replied to the survey. We also suspect that our members are less concentrated in the career stage of 0-10 years suggested by this survey.

4. Which of the following inpatient services do you provide?

Inpatient service	Percent of SGIM members	SGIM members
Hospital consultative service (without being MRP)	70-90 %	170-210
General medical ward admissions	60-70 %	130-180
Telemetry service	40-60 %	110-150
Critical care/community ICU*	30-40 %	70-100
Heart failure service	1-2 %	3-5
Leukemia/BMT	1-2 %	3-5
None**	8-14 %	20-30



5. Which of the following outpatient services do you provide?

Outpatient service	Percent of SGIM members	SGIM members
I have my own clinic	50-70 %	120-170
I work in a hospital-based rapid access clinic	40-60 %	90-140
I work in another hospital-based clinic	30-50 %	70-110
I teach patients how to start insulin/other subQ meds	7-12 %	18-29
Therapeutics Initiative	2-4 %	6-10
None	2-4 %	6-10
COVID-19 immunizations	1-2 %	3-5
Regulatory and administrative work for the CPSBC	1-2 %	3-5
Stroke Clinic	1-2 %	3-5
Outpatient cardiology consults	1-2 %	3-5
Work in a clinic owned by someone else	1-2 %	3-5
GI endoscopy	1-2 %	3-5
Pain management	1-2 %	3-5

6. Which diagnostic procedures do you regularly perform?

Diagnostic procedure	Percent of SGIM members	SGIM members
Reading and publishing results of ECG's	60-80 %	140-190
Exercise stress tests	60-80 %	140-190
Holter monitor reading	60-70 %	130-180
Point of care ultrasound (POCUS)	30-50 %	80-120
Persantine infusions for MIBIs	30-40 %	60-90
Extended cardiac event monitor reading	20-40 %	60-90
24 hour blood pressure monitors	17-27 %	40-70
Pacemaker interrogation and programming	11-18 %	30-40
Dobutamine infusions for MIBIs	10-16 %	20-40
Spirometry	6-10 %	15-24
Overnight oximetry	5-8 %	12-19
6 minute walk test	4-6 %	9-14
Pulmonary function tests	2-4 %	6-10
Diagnostic transthoracic echo	2-4 %	6-10
Polysomnogram interpretation	2-4 %	6-10
Echo stress test	1-2 %	3-5
HSAT testing	1-2 %	3-5
Transesophageal echo	0-1%	0-2

7. Which of the following invasive procedures do you feel comfortable performing?

Invasive procedure	Percent of SGIM members	SGIM members
Diagnostic paracentesis	70-90 %	170-210
Diagnostic thoracentesis	70-80 %	160-200
Lumbar puncture	60-80 %	150-200
Internal jugular central venous access	50-70 %	120-170
Electrical cardioversion (emergent and elective)	40-60 %	110-150
Femoral central venous access	40-60 %	110-150
Therapeutic thoracentesis with catheter insertion	40-60 %	100-140
Therapeutic paracentesis with pigtail insertion	40-60 %	90-140
Rapid sequence intubation	30-50 %	70-110
Arthrocentesis	30-50 %	70-110
Skin biopsy	30-40 %	70-110
Administering procedural sedation	30-40 %	60-90
Modifying ventilator settings	20-40 %	60-90
Subclavian central venous access	20-31 %	50-80
Bone marrow biopsy	13-21 %	30-50
Delivery of chemotherapy	6-10 %	15-24
Bronchoscopy	4-6 %	9-14
Upper endoscopy	4-6 %	9-14
Lower endoscopy	1-2 %	3-5
Liver biopsy	1-2 %	3-5

8. Do you have any of the following medical trainees in your practice?

Trainee type	Percent of SGIM members	SGIM members
Internal medicine residents	70-90 %	160-210
Other residents	60-80 %	140-190
Internal medicine fellows	60-80 %	140-190
Medical students	60-80 %	140-190
UBC FLEX students	1-2 %	3-5
None	6-10 %	15-24

Discussion

In hindsight we should have included an option for counting members who are part of CTU. Furthermore, upon review with current and past leaders of the post-graduate training programs, these estimates seem very generous, given the difficulty in recruiting preceptors for clinical rotations that they have experienced. It is possible that many members only have medical trainees for a limited number of weeks per year, but that this would still be a positive response to the survey.

9. Which of the following aspects of your practice do you manage?

Practice management	Percent of SGIM members	SGIM members
Submitting your own billings	70-90 %	170-210
Doing your own bookkeeping	50-70 %	120-170
Addressing your own billing rejections	30-50 %	80-120
Hiring clinic staff	30-40 %	70-100

10. What diagnostic codes would you choose to add to 311? (select up to 3)

New 311 codes proposed	Percent of SGIM members	SGIM members
Fatigue (780.71)	50-70 %	120-170
Elevated liver enzymes (577.3)	50-70 %	120-160
Obesity (278)	40-60 %	100-150
Drug overdose (977)	22-34 %	50-80
Sleep apnea (780.57)	22-34 %	50-80
Abnormal loss of weight (783.2)	18-28 %	40-70
Pain (338.2)	11-18 %	30-40
Seizure (345)	10-16 %	20-40
Osteoporosis (733)	10-16 %	20-40
Pancreatitis	4-6 %	9-15
Substance use	2-4 %	6-10
Polypharmacy	1-2 %	3-5
Lymphadenopathy	1-2 %	3-5

Discussion

The membership seem to have a general preference towards adding certain diagnostic codes to the 311, presumably due to the frequency with which they see these conditions and the expertise that they feel they bring to patient care. Attempts at adding “fatigue” in the past have been unsuccessful due to the complaint being “too broad”. Nonetheless, this list (and the following list) is useful in case there is an opportunity in the future to modify the diagnostic codes under the complex fee codes.

11. Which three 311 diagnostic codes from the current list do you use the LEAST? (select up to 3)

Least used 311 codes	Percent of SGIM members	SGIM members
Other HIV infection (044)	70-80 %	160-210
Pulmonary fibrosis (515)	40-50 %	90-130
Rheumatoid Arthritis (714)	30-50 %	80-120
Systemic Lupus Erythematosus (710)*	30-40 %	70-110
Non infective enteritis and colitis (557.1)	20-32 %	50-80
Senile dementia, presenile dementia (290)	9-14 %	20-30
Purpura, thrombocytopenia and hemorrhagic… (287)	7-12 %	18-30
Asthma allergic bronchitis (493)	7-12 %	18-30
Septicemia (038)	5-8 %	12-20
Thyroid disorders (246)	5-8 %	12-20
Neoplasm of uncertain behaviour… (238)	5-8 %	12-20
Other bacterial pneumonia (482)	4-6 %	9-15
Congestive Heart Failure (428)	2-4 %	6-10
Diseases of the aortic and mitral valve (396)	2-4 %	6-10
Cardiac dysarrhythmias (427)	2-4 %	6-10
GI hemorrhage (578)	2-4 %	6-10
ARF (584)	2-4 %	6-10
Disorders of fluid, electrolyte and acid … (276)	2-4 %	6-10
Syncope (780.2)	2-4 %	6-10
DM including complications (250)	1-2 %	3-5
Disorders of Lipid Metabolism (272)	1-2 %	3-5
Anemia, unspecified (285.9)	1-2 %	3-5
Essential hypertension (401)	1-2 %	3-5
Coronary atherosclerosis (414)	1-2 %	3-5
Cerebral atherosclerosis (437)	1-2 %	3-5
Emphysema (492)	1-2 %	3-5
Chronic liver diseases and cirrhosis of the liver (571)	1-2 %	3-5
CRF (585)	1-2 %	3-5
Venous thrombosis and embolism (453)	1-2 %	3-5
Acute confusional state (293)	0-1%	0-3

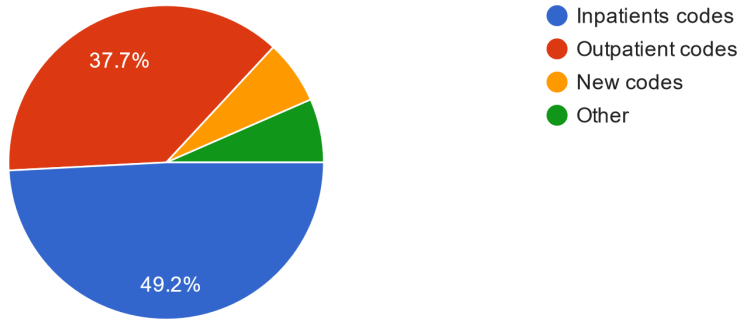
* Also specified as "Connective tissue disorder, NYD"

Discussion (question 11)

Again, this list is illuminating for the types of ICD codes that are infrequently used by SGIMBC members. An editor's note: ICD9 code 710 is alternatively specified as "Connective tissue disorder, NYD" and ostensibly covers a broad range of connective tissue/rheumatologic disorders.

12. Which of the below do you think the SGIMBC Executive should focus on increasing?

61 responses



13. Are there any other changes you would like to see to the MSP fee guide/fee codes?

Below is a summary of replies, grouped by topic, with the most common replies or themes being listed first.

Inpatient fee codes

- Increases to inpatient follow-up codes (numerous replies)
- Increase the number of days where complex follow-ups are permitted
- Better remuneration of inpatient work to encourage MRP hospital work
- Better codes for goals of care discussions

- Request for remuneration for multiple daily visits for inpatients
- Remuneration for addressing new issues or acute clinical deterioration in inpatients already being followed
- Remuneration for family meetings
- Time modifiers for follow-ups
- Remuneration for answering overnight phone calls from nurses

Follow-up limits

- Increase permitted duration of complex follow-up codes beyond 6 months (perhaps indefinitely)
- Remove 10 day limit for inpatient follow-ups
- Increased number of directive care visits (e.g., 32206) that can be billed in one week
- Allowing time modifiers for prolonged follow-up visits

311 ICD codes

- Request to Change language to reflect what we would more commonly label the diagnoses listed as acceptable 311 ICD codes in practice
- Increase the number of ICD codes permissible under a complex fee code; in particular, request to add obesity as an ICD code for which complex consults can be billed
- 2 system fee code

Procedures

- Numerous voiced frustrations over the difficulty in billing a procedure and a follow-up visit on the same day, e.g., stress test, pacemaker reviews, bedside procedures, etc.
- Numerous frustrations over poor remuneration for procedures in general, such as:
    - Paracentesis
    - Thoracentesis
    - Cardioversions
    - Lumbar punctures
    - Bone marrow biopsy

New fee codes

- Desire for the following new fee codes:
    - Limited complex fee code (i.e., after which a complex follow-up could be billed)
    - 2 problem fee code and follow-up fees

Complex care

- Desire for further fee code modifiers for particularly complex patients, e.g., 4+ active problems
- Better remuneration for goals of care discussions with complex medical patients
- A request for fees for “collaborative work”

Unpaid work

- Several respondents raised concerns over “unpaid work”, e.g.:
    - Fee codes for delivering or receiving handover
    - Answering phone calls overnight from nurses
    - Time-based modifiers for work
    - Remuneration for paperwork
    - Fee codes for patients who don’t have MSP

Repeat consults after 6 months

- There were a few requests to clarify the situation with repeat consults vs. follow-ups after 6 months. [The Doctors of BC website recently published guidance in this regard: https://www.doctorsofbc.ca/managing-your-practice/practice-supports/consultations-referrals-and-re-referrals]

Telehealth

- Conflicting opinions regarding remuneration for telehealth. Direct quotes:
    - *“I also feel that the fee codes for telephone consult and virtual follow up should go down after covid. It would be ridiculous if they stay the same as in person consults or visits”*
    - *“continue support of telehealth fees mirroring in person fees”*

After hours care

Two replies referred to improved “after hours” fees, including a modifier for follow-ups/rounding on weekends and holidays.

Miscellaneous comments:

Clarify/appropriately restrict GIM codes to people who are actually GIM

Consideration of % of the fee code to a pensions fund, individually or for group

Consolidate all GIM consults into a single code, with a pay rate close to 311 rate.

I would like to see more GIM involved in MAID - but that is not a fee code issue

equality in fee codes

Existing fee codes should become permanent and not provisional.

All 311

I'm now largely retired but I have greatly appreciated the 311 code for the complex patients I treated - almost never an easy consult

Clarification around critical care codes, ie telemetry patients

no I am happy overall with reimbursement

14. Who do you use for Transcription service, if anyone?

Transcription service	Percent of SGIM members	SGIM members
Dragon	30-40 %	60-110
Hospital services	20-30 %	50-80
M*Modal Fluency	15-27 %	40-60
None	8-15 %	20-40
Pulse Medical Transcription	2-3 %	4-7
Canadian Transcription	2-3 %	4-7
Tele touch	2-3 %	4-7
Accuro	2-3 %	4-7
Personal EMR	2-3 %	4-7

15. Who do you use for Billing agent services, if anyone?

Billing agent	Percent of SGIM members	SGIM members
Dr. Bill	12-20 %	30-50
Dedicated billing agent	8-14 %	20-30
Office staff	7-12 %	18-29
Accuro	5-8 %	12-19
Spouse or family	4-6 %	9-14
Medbill	1-2 %	3-5
Input Health	1-2 %	3-5

16. Who do you use for EMR services, if anyone?

EMR	Percent of SGIM members	SGIM members
Accuro	30-50 %	80-120
Plexia	17-28 %	40-70
Oscar	10-16 %	20-40
Health Authority	8-14 %	20-30
MedAccess	5-9 %	13-23
Input Health	4-7 %	10-17
Arya	3-5 %	7-11
None	3-5 %	7-11
iClinic	3-5 %	7-11
Wolf	1-2 %	3-6

17. Who do you use for other office services, if anyone?

Granards for yearly corporate AGM documents. SRFax for virtual fax line

I had a part time "MOA" who worked mostly on weekends - and enjoyed help from hospital clinic receptionist

Accountant, online payroll payworks.ca

Unite

Like what? [n.b., numerous similar responses – apologies for the unclear question.]

18. What do you think a strategic priority for the SGIMBC should be for 2022?

The replies to this question are paraphrased and grouped into topics below:

- Disparity: numerous requests to improve disparity within the PMA negotiations, with respect to equalizing remuneration between procedural specialties and GIM physicians
- Fee code improvements, which are essentially summarized above
- Clarifying the stance on 4 vs. 5 year GIM's and fee code eligibilities [Note: the SGIM BC declared their stance on this at the 2021 AGM. In brief, we will continue to advocate for equality of fee code access between 4 year and 5 year graduates]
- Training:
    - advocating for improved rural GIM training
- Education of the public:
    - Increasing awareness of what general internists do
    - Increasing awareness of how expensive healthcare is, and that only a small proportion of this is actually paid to physicians
- Provision of clinical practice support
    - advice on EMR's, FESR, billing software, telehealth
    - preparing for a potential departure of healthcare workers from hospital work post-pandemic, including physician departures, e.g. GP's
    - support for internists providing critical care
- Supporting longitudinal care by internists and fair remuneration for doing so, given the strains on primary care. Consideration of interdisciplinary model.
- Wellness for general internists
- Protection of cardiodiagnostic privileges for general internists