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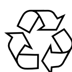

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Dissatisfaction: how it has grown

Recent developments have highlighted the "greying" of health care providers in Canada. Not only are there fewer physicians and nurses available to deliver care, but those who are working tend to be older. The effect of this on health care delivery remains to be seen, but the number of people who are there to provide care, and their ability to continue to work the long hours necessitated by the growing demands of an aging population, are predicted to diminish.[1]

This situation results from an unfortunate constellation of events beginning with the decision over a decade ago to reduce the number of training positions in Canadian medical schools. Since almost all provinces tie the number of postgraduate training positions to the undergraduate positions extant in that province, this produced a net drop in postgraduate training positions across the country. The practice of family medicine requires postgraduate training, and many provincial governments elected to perpetuate their family-medicine training positions, retaining either the numbers or their proportion from preceding years. This further curtailed training positions for surgical specialties.

While this was going on, licensing requirements at the provincial and Royal College level decreased the number of foreign medical graduates eligible for licensure and practice in Canada.

Also at the same time, decreased transfer payments from the federal government to the provincial governments for health care resulted in serious resource issues for many hospitals. Faced with rising costs and a fixed budget, many hospitals chose to reduce resources provided for elective medical and surgical treatment. This has prolonged waiting times for diagnostic and therapeutic interventions as well as intensified stress among physicians who have been trying to balance the increasing demand for care (brought on by the growing needs of patients and shrinking numbers of physicians) with scarcities in hospital resources.

The aggregate result has been dissatisfaction with surgical practice among those of us involved in day-to-day patient care, caused by frustration at our inability to provide the type of care we feel patients deserve. This dissatisfaction has been manifest in several ways, including migrations of physicians between provinces or to the USA. Surgeons with large elective practices have often closed them to new patients intermittently until the waiting list could be reduced; this antagonizes referring physicians and frustrates people who are seeking care. Medical students witnessing the frustrations of attending staff may (not surprisingly) find surgery an unattractive option if they think their entire professional life will be a series of setbacks combined with a dearth of professional fulfillment.

Provincial governments have recognized that one of our fundamental obstacles to delivering appropriate care is our inadequate number of younger physicians trained in this country. They therefore approved increases in medical school registrations. The Royal College of Physicians and Surgeons of Canada, in conjunction with provincial colleges, has begun to address the impediments to licensure that often prevent appropriately skilled physicians from practising in this country. But these

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initiatives are inadequate to address the current situation, which sees millions of people unable to access family physicians and further thousands of patients unable to obtain ready access to specialist care.

Several jurisdictions have attempted to address the immediate problem in various ways, including regionalization of care in an attempt to avoid duplication of resources, "hotspot" funding to recruit and retain specialist physicians in certain specialties, and additional funding to address specific waiting-list issues.

What do all these initiatives mean for surgeons in Canada? In the short term, there is no relief in sight to address the current and continuing shortage of surgical specialists in this country. In the longer term, one can only hope that the current crisis in will result in a more comprehensive and cohesive program for the delivery of patient care.

Surgeons should be at the forefront of this discussion. The first problem has been addressed: there are more medical school training positions now than 10 years ago. We should nonetheless be engaged in ongoing discussions with the Royal College, universities and provincial colleges to ensure that our concerns are given appropriate weight when decisions are made. We must increase the number of training positions for specialists in surgery in Canada. Furthermore, we have to be certain the Royal College and provincial colleges have an appropriate mechanism for determining which immigrant physicians would be able to deliver care after appropriate refresher training and evaluation. I feel that much of the current unsatisfactory situation has developed because practising physicians were not consulted when policies about postgraduate training and hospital resource allocation were made. This error should not be repeated.

I would appreciate any comments, suggestions or ideas the readership may have about this important issue.

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Competing interests: None declared.

Reference

1. Shipton D, Badley EM, Mahomed NN. Critical shortage of orthopædic services in Ontario, Canada. *J Bone Joint Surg Am* 2003;85-A(9):1710-5.

Histoire d'une insatisfaction croissante

De récents événements ont mis en évidence le «vieillissement» des prestateurs de soins de santé au Canada. Non seulement y a-t-il moins de médecins et moins d'infirmières pour dispenser des soins, mais les effectifs ont tendance à être plus âgés. L'effet de ce vieillissement sur la prestation des soins reste à voir, mais on prévoit une diminution à la fois du nombre de personnes chargées de dispenser les soins et de leur capacité de continuer à travailler les longues heures imposées par les exigences croissantes d'une population vieillissante.

La situation découle d'une convergence malheureuse d'événements qui remontent à la décision prise il y a plus d'une décennie de réduire le nombre de postes de formation dans les facultés de médecine du Canada. Comme presque toutes les provinces relient le nombre de postes de formation postdoctorale à celui des postes de formation prédoctorale, le nombre net de postes de formation postdoctorale partout au Canada a diminué. Pour pratiquer la médecine familiale, il faut une formation postdoctorale. Beaucoup de gouvernements provinciaux ont décidé de perpétuer leurs postes de formation en médecine familiale et de garder le nombre ou le pourcentage des années précédentes, ce qui a réduit encore davantage le nombre de postes de formation pour les spécialités chirurgicales.

Pendant ce temps, les exigences relatives au permis d'exercice à l'échelon des provinces et à celui du Collège royal ont réduit le nombre de diplômés de facultés de médecine étrangères admissibles au permis d'exercice et à la pratique au Canada.

En même temps aussi, la baisse des paiements de transfert du gouvernement fédéral aux provinces au titre des soins de santé a causé de sérieux problèmes de ressources à de nombreux hôpitaux. Face à la montée des coûts et à un budget fixe, beaucoup d'hôpitaux ont choisi de réduire les ressources consacrées aux traitements médicaux et chirurgicaux électifs. Ces réductions ont prolongé les temps d'attente pour des interventions de diagnostic et de traitement et alourdi le stress imposé aux médecins qui tentaient d'établir un équilibre entre la demande croissante de soins (découlant de la montée des besoins des patients et de la chute du nombre de médecins) et les maigres ressources des hôpitaux.

Il en a découlé globalement une insatisfaction face à la pratique de la chirurgie chez ceux d'entre nous qui soignent des patients au jour le jour, insatisfaction qui découle de la frustration suscitée par notre incapacité

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