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Corédacteurs**

James P. Waddell, MD, *Toronto*  
tel 416 864-5048  
fax 416 864-6010  
waddellj@smh.toronto.on.ca

Garth L. Warnock, MD, *Vancouver*  
tel 604 875-4136  
fax 604 875-4036  
gwarnock@interchange.ubc.ca

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## Getting to see the surgeon

In the February issue of the *Canadian Journal of Surgery (CJS)*, Dr. Waddell challenged *CJS* readers to consider the mismatch between physician numbers and patient demand and to reflect on ways to make access to surgery sustainable.<sup>1</sup>

A useful approach to this problem is to examine the association between the need for health care and the use of services provided by doctors. Nabalamba and Millar<sup>2</sup> recently reviewed public access to doctors in Canada, as determined by the 2005 Canadian Community Health Survey.<sup>3</sup> In this survey, the authors reported on Canadians' access to generalist and specialist physicians, based on the following 3 factors of need: state of health and illness acuity, predisposition to using services (e.g., age, sex, ethnicity) and enabling factors (e.g., education, income, and access to health providers and health facilities).<sup>4</sup> Data for access to specialists merits attention, since they project the demand for services from our surgical colleagues. The data showed that 77% of Canadians aged 18 to 64 years and 88% of seniors reported consulting with a general practitioner (GP) in the previous year; corresponding numbers for specialists were 27% and 34%. It is reassuring that individual health need was a strong determinant for the use of services provided by doctors. When need was taken into account, physician consultations were independently associated with age, sex, household income, ethnicity, language, place of residence (rural v. urban) and having a regular GP. People over the age of 75, rural residents, visible minorities and Aboriginal people had low odds of obtaining specialist consultations. What does this portend for surgical specialists in the future?

In concordance with health need as a strong determinant of access to surgeons, the article by Gaudet and others<sup>5</sup> in this issue of the *CJS* shows that patients treated earlier with total hip replacement surgery had higher symptom scores.<sup>5</sup> This demonstrates that prioritization of care for services with priority scoring tools and wait-time targets will play a role in resource allocation for surgical care in the future. Surgeons need to familiarize themselves with these tools to support quality and timely access.

Interestingly, Gaudet and colleagues<sup>5</sup> showed no association of age, sex and occupation with wait-time for arthroplasty care. The report by Nabalamba and Millar<sup>2</sup> shows different data. Elderly people were shown to have access to family physicians, but their access to specialists was proportionately low. The aging baby boom population is not likely to tolerate this pattern. Specialists can expect this population to have high demands for such problems as fragility fractures and osteoarthritis. These have recently been addressed through wait-list funding to augment surgical services; however, targeted interventions impact on other surgical services that do not receive augment funds. This translates to surgeons operating from multiple sites (including private care facilities) instead of traditional hospital sites. These practice changes must be met by surgical teamwork and careful patient care handovers. In academic centres, the impact on surgical trainees must be taken up by innovative teaching, such as simulation.

A chief enabling factor that facilitates access to specialists is ready access to a regular GP. However, it is estimated that 3.5 million Canadians do not have a regular GP. This issue

has been addressed by increasing medical undergraduate and post-graduate enrolments and by the development of new models of medical education, for example, the distributed medical education programs at the Northern Ontario School of Medicine and at the University of British Columbia. Strategically aimed at improving access to family physicians in remote communities, distributed medical education programs will bring new pressures for surgical specialists. Developing education programs may conflict with the need for high service volumes, unless funding is also provided for quality education for new trainees and time is permitted to enable surgeons to teach their trainees in the operating room. Surgeons may be altruistic when offering to teach, but pressures to deliver ser-

vice add new responsibilities. Can alternative providers such as nurse practitioners and physician assistants help to ensure the best navigation throughout the system? These training programs also are meeting challenges in keeping up with demand. This will require sophisticated professional communication with surgeons, and issues over liability must be tackled.

The dialogue will continue into the future to ensure that the *Canada Health Act* will maintain access to publicly funded, medically necessary health care that is free of financial or other barriers. Surgeons must accommodate novel models to deliver their services based on burgeoning health need as well as predisposing and enabling factors that determine Canadians' wishes for optimal health

care. Hopefully, this can occur without "burnout"!

**Garth L. Warnock, MD**

Coeeditor

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## Réussir à voir le chirurgien

Dans le numéro de février du *Journal canadien de chirurgie (JCS)*, le Dr Waddell a mis les lecteurs du *JCS* au défi de réfléchir à l'asymétrie entre les effectifs médicaux et la demande des patients, ainsi qu'à des moyens de rendre l'accès à la chirurgie viable.<sup>1</sup>

Une façon utile d'aborder le problème consiste à analyser le lien entre le besoin de soins de santé et l'utilisation des services des médecins. Nabalamba et Millar<sup>2</sup> ont étudié récemment l'accès public aux médecins au Canada, tel que déterminé par l'édition 2005 de l'Enquête sur la santé dans les collectivités canadiennes.<sup>3</sup> Dans cette enquête, les auteurs ont évalué l'accès pour la population canadienne aux médecins généralistes et spécialistes à partir des trois dimensions suivantes du besoin: état de santé et gravité de la maladie, prédisposition à l'utilisation des services (p. ex., âge, sexe,

origine ethnique) et facteurs habilitants (p. ex., éducation, revenu et accès aux prestataires de soins et aux établissements de santé).<sup>4</sup> Il faut se pencher sur les données relatives à l'accès aux spécialistes puisqu'elles projettent la demande des services de nos collègues chirurgiens. Les données ont révélé que 77 % des Canadiens âgés de 18 à 64 ans et 88 % des personnes âgées ont déclaré avoir consulté un omnipraticien (OP) au cours de l'année précédente. Les chiffres correspondants dans le cas des spécialistes s'établissaient à 27 % et 34 %. Il est rassurant de voir que le besoin individuel de soins de santé a constitué un solide déterminant de l'utilisation des services des médecins. Lorsqu'on a tenu compte du besoin, on a établi un lien indépendant entre les consultations de médecins et l'âge, le sexe, le revenu du ménage, l'origine ethnique, la langue, le lieu de résidence (milieu

rural ou urbain) et le fait d'avoir un OP régulier. Les personnes de plus de 75 ans, les habitants des régions rurales, les membres des minorités visibles et les Autochtones avaient de faibles chances de consulter un spécialiste. Qu'est-ce que ces chiffres augurent pour les spécialistes de la chirurgie?

Conformément au besoin de soins de santé comme solide déterminant de l'accès aux chirurgiens, l'article de Gaudet et ses collaborateurs<sup>5</sup> publié dans ce numéro du *JCS* montre que les patients traités plus tôt pour une arthroplastie totale de la hanche présentaient des indices de symptômes plus élevés.<sup>5</sup> Cela démontre que l'attribution d'une priorité aux services au moyen d'outils d'évaluation des priorités et les cibles relatives aux temps d'attente joueront à l'avenir un rôle dans l'affectation des ressources aux soins chirurgicaux.