

**THE NEW FACE OF MEDICINE:
SUSTAINING AND ENHANCING MEDICARE**

CANADIAN ASSOCIATION OF
INTERNES AND RESIDENTS

*Submission to the Commission on the
Future of Health Care in Canada*

October, 2001

EXECUTIVE SUMMARY

The Canadian Association of Internes and Residents (CAIR) is the national voice for doctors in training. We are a committed group of health care workers who are proud to be working around the clock, seven days a week, on the front lines of Canada's health care system. As medical residents, we simultaneously fill the roles of clinical providers, learners, teachers, and researchers. Our membership represents the diversity of Canadian society. We have been trained with a set of skills, attitudes and values that will help to sustain, enhance and reform our health care systems. We are the new face of medicine.

As a national body with deep provincial grounding, CAIR has a strong history of participation in health care reform discussions. We are children of Medicare and active participants in the system, from the initial debate over the Canada Health Act through to the current debate over how to sustain and enhance a system that is an integral part of our national and personal identities. However, we believe that changes - incremental and fundamental, systemic and local - are needed in order to preserve the ongoing quality and accessibility of Medicare.

CAIR advocates that reforms to the structure, funding, methods of payment and organization of our health care system deliver the kind of care our patients need -- timely, universal, accessible, modern, efficient, accountable and sustainable. Solutions should be flexibly designed and implemented, incentive-based, developed through a participatory process and appropriately evaluated. Change imposed through top-down coercive measures will only alienate health care providers, and their needed goodwill, expertise, morale and cooperation.

Our medical education and training system requires enhanced flexibility of training and licensure opportunities. It must also improve its capacity to train new physicians to practise with skills and in settings consistent with societal, community and patient needs. There is an urgent need to better resource teaching centres, including restructuring and increasing the funding for Academic Health Science Centres (AHSCs). At the same time, medical students and residents need immediate financial relief from the rapidly escalating costs of medical school tuition that is threatening accessibility, career choice and the diversity of our future medical workforce.

For physicians in practice it is time to explore and then comprehensively implement a series of reforms. We are facing a physician and health human resource crisis. There is a vital need to train, and recruit and retain, more health care providers, including physicians and nurses. We must also improve the conditions under which they work.

New physicians are open to actively participating in a variety of needed reforms. These include increased choice in methods of physician payment, encouraging group practice, promoting physicians collaboratively working alongside other health professionals, improving information

technology as part of primary care reform and throughout the health care system and implementing a variety of incentive and structural initiatives to improve physician distribution.

We believe that the unique training, skills, attitudes and values which new physicians bring to the health care system should be regarded as an integral element in the success of the reform process. For this reason, we also believe it is critical that any reforms be designed and implemented so as to preserve patient access to new physicians, and that new physicians have an equal opportunity to practise within Medicare without discrimination and on the same terms as established physicians. Certainly, as new physicians, we are committed to playing a vital role in sustaining and enhancing our health care system.

New doctors are up to facing these challenges.

We value the principles of the Canada Health Act -- Enhance them.

We want to develop skills that are needed -- Establish training models that permit this.

We are being discouraged from becoming physicians -- Regulate tuition and provide financial aid.

We need access to varied training opportunities -- Allow for career change and re-entry.

We want to work where we are needed -- Create necessary incentives and supports.

We are not tied to the fee-for-service system -- Develop alternate payment systems.

We practise collaboratively with other health professionals -- Encourage this.

We are increasingly in short supply -- Make more of us.

We practise evidence based care -- Facilitate it.

We value practice standards -- Measure our successes and failures.

We are trained in the latest information technology -- Fund the infrastructure we need.

We value the opportunity to practise on the same terms as established physicians -- Protect this.

We value well-being for our patients and ourselves -- Help us promote it.

Through this submission we hope to begin an ongoing dialogue between new physicians and the Commission.

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I. INTRODUCTION

The Canadian Association of Internes and Residents (CAIR) is the national body of the seven provincial medical resident associations¹ in English-speaking Canada², that collectively represent over 5000 medical residents. We are the new face of medicine.

On behalf of its member associations, CAIR is an active player in every major medical organization in the country³. CAIR has developed widely recognized position papers addressing physician resources, medical education, training, licensure and resident well-being⁴.

Through representation from the seven provincial medical resident associations, CAIR is well grounded in the grassroots concerns and perspectives of medical residents working on the front lines of our health care system. In many cases, individual provincial resident associations have recognized expertise and credibility participating in the development of health care policy and initiatives⁵.

¹Professional Association of Residents of British Columbia, Professional Association of Residents of Alberta, Professional Association of Internes and Residents of Saskatchewan, Professional Association of Internes and Residents of Manitoba, Professional Association of Internes and Residents of Ontario, Professional Association of Residents In the Maritime Provinces, and the Professional Association of Internes and Residents of Newfoundland.

²Medical residents in Quebec are represented by the Fédération des médecins résidents du Québec (FMRQ), which has an ongoing and cooperative working relationship with CAIR.

³This includes the Canadian Medical Forum, the National Coordinating Committee on Postgraduate Medical Training, the Canadian Medical Association, the Royal College of Physicians and Surgeons of Canada, the College of Family Physicians of Canada, the Association of Canadian Medical Colleges, the Medical Council of Canada and the Federation of Medical Licensing Authorities of Canada.

⁴The following CAIR reports and position papers are available at www.cair.ca: *CAIR Position Paper on Return of Service*, June 2001; *CAIR Position Paper on International Medical Graduates*, revised February 2000; *CAIR Position Paper on Resident Well-Being*, June 1998; *CAIR Position Paper on Guidelines for Health Care Reform*, February 1997; *CAIR Position Paper on Physician Resources*, April 1994; *CAIR Statement on National Physician Resources*, September 1993.

⁵For example, the Professional Association of Internes and Residents of Ontario has been very active provincially in physician resources, convening various fora of stakeholders to develop a variety of reports, including: *Return of Service Discussion Paper*, March 2000; *Forum '99: A Summary of Proceedings: Searching for Solutions to Physician Recruitment and Retention in Southwestern Ontario*, February 1999; *From Education to Sustainability: A Blueprint for Addressing Physician Recruitment and Retention in Rural and Remote Ontario*, December 1998; *Toward Solutions: Recruiting and Retaining Physicians in Southwestern Ontario*, March 1998; *Toward a New Vision for Globally Funded Group Practice Agreements*, January 1998; *Forum '97: Progress and Direction, Physician Recruitment and Retention in Rural and Northern Ontario*, May 1997; *Answering the Call: Towards an Effective Recruitment and Retention Program for Communities and Physicians in Ontario's Underserved Areas*, April 1996. These reports are available at www.pairo.org

CAIR is committed to the principles and values underlying our publicly funded Medicare system. Medicare is not only, as the Commissioner has noted, fundamental to Canada's national identity; as new physicians, it is also fundamental to our own individual identities as the children of Medicare. But, we believe that changes - incremental and fundamental, systemic and local - are needed in order to sustain and enhance the ongoing quality and accessibility of Medicare.

CAIR's passion for, and commitment to, the accessibility and sustainability of our health care system is longstanding, dating back to the birth of the Canada Health Act seventeen years ago. At that time, CAIR was an active participant in the parliamentary process, articulating the values and perspectives of Canada's physicians in training. CAIR brings to the current debate over the future of Medicare the same commitment to sustaining and enhancing the principles of Canada's publicly funded health care system. However, as we discuss below, we also have some of the same concerns now, as we did then, over ensuring patient accessibility to new physicians within Medicare. We remain confident that the voices of the physicians who will be practising in Canada's future health care system will be heard.

As new physicians, we also bring to the current reform process an openness to pursue change, combined with a willingness and desire to embrace new models of health care delivery, organization and payment. We want to help create the health care system Canadians deserve, one where physicians deliver the kind of care we know our patients need -- timely, universal, accessible, modern, accountable, efficient and sustainable.

Our submission reflects the perspective of new doctors -- not only on those issues which directly affect us as medical residents, but also on those issues which affect the future of the health care system in which we will be participating and which we will be inheriting. Whatever decisions are made today, we will be living with them throughout our future careers.

Our primary goal in this initial fact-finding phase of the Commission's process is to assist the Commission by identifying those critical issues, challenges and opportunities that we believe any review of the future of our health care system must consider, weigh and assess. We then hope to facilitate an ongoing dialogue between new physicians and the Commission in the subsequent recommendation-making phase of the Commission's work⁶.

⁶In preparing this initial submission, several provincial resident associations conducted focus groups, some among elected resident representatives, and others with both current and past resident leaders. The CAIR Physician Resources Secretariat then reviewed the deliberations of these focus groups, and the CAIR Board of Directors then approved this document for submission to the Commission. CAIR and its provincial housestaff associations would welcome the opportunity to facilitate and organize kitchen table sessions between the Commissioner and medical residents/new physicians, as the Commission enters its second work phase.

II. WHO ARE TODAY'S MEDICAL RESIDENTS AND CANADA'S NEW PHYSICIANS?

1. Our Duties and Responsibilities

Medical residents are physicians who have completed their undergraduate medical school education, and who are now undertaking specialized postgraduate training in such diverse areas as family medicine, surgery, internal medicine, obstetrics, psychiatry, laboratory medicine and radiology. The essence of residency training is the overwhelming medical service and patient care activities which residents provide; our learning is primarily through our service to our patients in teaching hospitals and other institutions, in urban, rural, Northern and remote settings. Residency involves direct, hands-on patient care. Twenty-four hours a day, seven days a week, residents are working on the front lines in all areas of the health care system. In most major hospitals, a resident is the first physician a patient meets when they come seeking care. The medical services we provide are highly skilled and sophisticated.

Over the course of a residency training program, there is a continuous assumption of greater degrees of responsibility, such that by our later years of training, residents may be frequently consulted by staff physicians in other specialties, or by physicians in other hospitals in the community. While residents function most independently in their senior years, the fact is that throughout our training we have considerable individual responsibility. In part, this is because of the on-call system, where even a first year resident may be the most senior physician physically available in the hospital at night and on weekends.

As part of our training, we work with the most up to date technology, practise evidence-based and patient-centred medicine, and provide care in team-based and collaborative models of clinical service delivery. We proudly continue to carry on the classic tradition of providing high quality and empathetic patient care over the course of completing our medical training.

2. Our Training Programs

Medical residents are working towards certification by either the College of Family Physicians of Canada (CFPC), or the Royal College of Physicians and Surgeons of Canada (RCPSC). In most provinces, certification is a requirement for independent or full licensure. Family medicine residency lasts for two years, with options for additional further specialized training (usually a year in length) in areas such as emergency medicine, advanced obstetrics, geriatrics and native health. The length of training in RCPSC program residencies varies, with a minimum of four years and typically five years of training. It is also increasingly common for subspecialty and fellowship pursuits to add at least an additional two or more years of training.

3. Our Changing Demographics

Representing the new face of medicine, over one half of today's medical residents are women. We also reflect more than ever in the physician workforce the ethnic and multicultural diversity of Canadian society. Moreover, as a result of significant alterations to the education, training and licensure pathways over the past decade, medical residents now complete their training with a wider range of previous life and work experiences, and with more varied academic backgrounds.

Today's physicians often enter the workforce later in life, with richer personal and work experiences than many of our established colleagues. Many new physicians are beginning their careers, even during their residency training, with life partners and children. Together with rapidly escalating medical school tuition fees, this leaves an increasing number of new physicians trying to financially support their families, and establish their practices, while carrying and managing significantly higher debt loads.

4. Our Outlook on and Commitment to the Practice of Medicine

Medical residents and new physicians often have a different set of personal and professional values, priorities, and workload expectations, flowing in part from a commitment to a more balanced approach to career, family, and well-being. These new values are increasingly playing a role in career and remuneration decisions. As a result, new physicians tend to be more open to alternative methods of compensation and health care delivery than traditional fee-for-service or solo physician practice.

As medical residents, we play critical roles in the operation of our health care system -- front-line physician employees, teachers, learners, and researchers. The multiplicity of these roles gives us a unique perspective on the strengths and weaknesses of our medical education and the provision of medical services. As the new physician workforce, we are vitally concerned with, and passionate about, the ongoing sustainability of our public health care system.

All of this makes new physicians open to change, and particularly well-suited to becoming the future leaders, managers and administrators of needed alterations to models of health care delivery, organization and payment.

III. THE PROCESS OF REFORMING OUR HEALTH CARE SYSTEM

This Commission will receive many different analyses of the deficiencies and shortfalls in the present health care system. The symptoms and problems are all too easy to identify, and include an aging population; rising expectations and awareness of the general public; advances in medical technology; serious shortages of physicians, nurses, and other health care providers, in both rural and remote communities and larger urban centres; long waiting lists; delisting of medically necessary services; aging infrastructure and equipment; inadequate information technology in all sectors and across institutions and providers; the shift from institutional to home care without needed supports; and the escalating costs of drugs. Even the very concept of health itself has been revised. A health care system which was designed to provide medical care is now asked to meet a newer and more challenging definition of health which embraces the concepts of wellness, global determinants of health, prevention and alternative care.

No doubt, the Commission will also receive many different substantive recommendations for reform, from many different perspectives. However, CAIR believes that it is critical to recognize that the process of change is as important as the changes themselves.

1. Successful Reforms Cannot Be Unilaterally Imposed

The health care system is comprised of many individuals and institutions with varying levels of authority and a wide variety of functions and responsibilities. No one part of the system – including government – should or can successfully impose change on the rest of the system.

2. Incentives Work Better than Coercion

CAIR urges the Commission to avoid top-heavy punitive recommendations that seek to impose disincentives on different players in the health care system. Rather, the focus should be on the need to better align existing and new incentives with the needs of the public and the objectives of the health care system⁷. Change will only be successful with the willing and constructive

⁷ Indeed, as new physicians, we are all too familiar in the context of physician distribution measures with punitive and coercive measures that, in the name of seeking to solve the physician distribution challenge, single us out for discriminatory treatment by limiting where we can practise medicine and requiring that we practise in certain limited geographic areas. These measures succeed only in balkanizing the provision of physician services by restricting mobility, in forcing a mismatch between community needs and physician skills and aspirations, and in driving out our newest physicians. It is far better to develop and implement a comprehensive package of both monetary and non-monetary incentives which respond in a sustainable manner to the underlying problems of physician recruitment and retention in underserved communities.

participation and input of the various providers involved in the delivery of health care; if they are alienated by the imposition of coercive measures, their needed goodwill, expertise, morale and cooperation will be seriously undermined.

3. Stakeholder Participation in Designing and Implementing Change

Government must also meaningfully involve stakeholders in the process of implementing needed reforms to the health care system. Too often, governments have tended to rely on the academic views of health care economists and government policy analysts, rather than the real-life grounded experience and expertise of actual providers and representative members of the public⁸. It is critical to the success of any proposed reforms that they be implemented from the ground up, rather than from the top down. Certainly, resident physicians and the associations that represent them should be involved at each stage. In this respect, CAIR would very much appreciate the opportunity to facilitate a series of kitchen table sessions between the Commission and representative leaders and members of the medical resident community, as the Commission moves forward with the task of making specific recommendations for reform.

4. The Need for Evaluation

As new physicians trained in evidence-based medicine, we also believe that successful reform of and improvements to our health care system will require ongoing evaluation. For this reason, we also support the implementation of reforms on a pilot basis, so that we can all learn from different experiences and structures. These evaluation tools need to be planned and funded from the outset with relevant and meaningful endpoints that are agreed to by all participants.

5. Avoiding Cookie Cutter Solutions

It is also critical that health care reformers avoid the temptation to impose a single cookie-cutter solution, particularly given the diversity of communities, institutions, patient needs, practice settings, practice patterns and physician roles and service delivery models in our health care system. New training, payment, delivery and funding structures must be sensitive and responsive enough to deal with the various constraints and opportunities, and strengths and weaknesses, within our health care system.

⁸ For example, the decision to cut medical school enrolment in the early 1990s, which is now widely recognized as having led to our current physician shortage crisis.

6. Matching Responsibility with Accountability

Reforms to the health care system must include consideration of better matching responsibility with accountability at various levels of our health care system, including funding and taxation structures, service delivery mechanisms, and payment systems.

IV. SUSTAINING AND ENHANCING HEALTH CARE EDUCATION AND TRAINING

1. Introduction and Historical Overview

The training and education of the physicians is of critical importance to the sustainability of the health care system. Any review of the sustainability of our health care system must include within its focus an emphasis on ensuring that new physicians are trained in the skills and in the settings which are consistent with the needs of the Canadian population. Although residency training provides a crucial learning window, physician training does not end at the conclusion of residency. Rather, life long learning is a key tenet of a physician's medical life cycle. If the health needs of the population are to be met, both new and established physicians must have meaningful opportunities – including funding, flexibility, locum and other supports – to maintain and augment their skills during the full course of their careers.

Any consideration of needed changes in education and training requires an understanding of some of the forces that have shaped the current educational and training environment. The training of new physicians has changed substantially over the last decade. The result has been a series of positive and negative incentives whose impacts are still being felt and evaluated.

a) Changes in Medical School Admission

The prerequisites for entering medical school have been enhanced with new academic criteria and higher admission requirements. Within the past decade, the requirement for admission to medical school has in most medical schools increased from two years of undergraduate education to a four-year degree, with many successful medical school candidates having already completed graduate work. There has also been a shift to consider a broader range of academic and non-academic experiences in the selection of candidates. These changes have lengthened the period of study necessary before beginning medical school, while at the same time bringing a more diverse group of individuals into the medical profession. At the same time, more work needs to be done, particularly since certain populations including those from rural and first nation peoples are still underrepresented in the application pool.

b) Changes in Medical School Education

Medical school education has also shifted in focus and structure. This includes an increasing emphasis on multi-disciplinary education, so that physicians are learning and working with other members of the health care team including nurses and nurse practitioners, physiotherapists, occupational therapists, social workers and dentists. Medical schools have also started to broaden the definition of health with a greater emphasis on the determinants of health and recognition of alternate care approaches.

Clinical exposure is being introduced earlier in training with a strong emphasis on patient-centred care, appropriate use of information technology, evidence-based medicine and clinical practice guidelines. These changes are helping to prepare new physicians for the challenges and realities of our evolving health care system.

c) Excessive Medical School Tuition Increases

The last few years have seen an unprecedented rise in medical school tuitions across the country with threats of further increases in the near future⁹. This has significantly changed the climate of medical school education, threatening both accessibility to medical education and the diversity of the future physician pool. The detrimental effect of these increases has been recognized by many national and provincial organizations¹⁰.

One very significant concern is that excessive tuition levels have resulted and will continue to result in a dramatic shift in the economic background of applicants to medical school. This discriminatory effect on low income and rural applicants will, in turn, lead to a lack of economic, cultural and geographic diversity in the practising physician workforce. It will also lead to fewer applicants from rural areas, which will only serve to reinforce the shortage of rural physicians.

Concern has also been expressed that the increasingly high debt loads of medical students will distort career decision-making and practice patterns, with medical students choosing residencies based on perceived earning power, and residents choosing type and location of practice based on their ability to pay off student debts. These perverse incentives will not meet the needs of society, nor are they ones that students wish to be, or should be, responding to when they choose a career as a health care provider.

Federal and provincial loan plans have made almost no adjustments to respond to the changing financial pressures facing medical students. Scholarship or bursary programs at most medical schools remain completely inadequate. Responding to these accessibility and diversity concerns requires strict regulation of tuition levels, significantly increased

⁹ Tuition fees at Canada's 16 medical schools have risen an average of 9.9% for the year 2001-2002 academic year alone, according to Statistics Canada, the highest increase among all programs. Fees have roughly doubled over the past five years. Ontario's five medical schools have the highest average fees (\$11 546). The University of Toronto and University of Western Ontario have the country's highest tuition fees, at more than \$14 000 annually: see the *Canadian Medical Association Journal*, October 2, 2001; 165(7), p. 935.

¹⁰ For example, see the Canadian Medical Association position paper *Tuition Fee Escalation and Deregulation in Undergraduate Programs in Medicine*, 2000, found at www.cma.ca/advocacy/tuition/position_paper.htm, and the Canadian Federation of Medical Students position paper *Double Jeopardy: The CFMS Position Paper on the Threat of Escalating Medical School Tuition Fees Limiting Access to Medical Education in Canada, 2000*, found at www.cfms.org/representation/pospapers/articles. Eight professional associations have formed the National Professional Coalition on Tuition, which presented a paper to the Commons Standing Committee on Finance last year, warning that high fees "create socio-economic barriers" to professional programs, and that "we are rapidly approaching a situation in which we have medical education for only the affluent."

financial grants, and improved loans and other forms of financial assistance to medical students in need. Furthermore, in order to be non-discriminatory, federal, provincial and local financial support must be redesigned in a manner that does not have coercive elements such as tying financial support to access to education, career choice or practice location. Access to education in this country should be needs blind both in letter and in practice.

d) Changes in Residency Training

Residency training has also evolved substantially. One significant change has been the loss of the rotating internship in 1992. The rotating internship was a general and generic entry point to practise, or to further specialty training¹¹. However, today's medical students must effectively decide as early as their second year of medical school on a specific specialty career course, in large measure because of the loss of the flexibility associated with the rotating internship. Through the rotating internship, residents had the opportunity to be exposed to a variety of disciplines such as family medicine, obstetrics, surgery, emergency, and paediatrics, during the first year of their residency training. There has also been a concurrent change in the structure of residency training, with many specialties now having separate and specialized training streams entered directly from medical school.

Taken together, these changes have exerted new pressures on medical students to make major choices about their career path early in training. Coupled with cutbacks in funding and in the number of residency training positions, this has resulted in significantly less opportunity for changing training specialties during the course of residency training, and less opportunity for established physicians to re-enter residency training to pursue a different specialty.

2. Suggestions for Enhancing Medical Education and Training

a) Flexible Training and Licensure Opportunities

CAIR believes that one key element to enhancing the sustainability of our health care system is through providing a greater degree of flexibility in training and specialty choice for future physicians. Improvements in this area would significantly increase the

¹¹ Furthermore, because physicians could obtain a general license to practise medicine after completing a one year rotating internship, they were able to obtain exposure to and provide locum medical services in needed areas outside of their specialty training programs. While some provinces still permit limited licensure for trainees to practise outside of their training programs once they have attained a certain level of competence and expertise, this opportunity has been lost in a number of other provinces, where residents cannot obtain a license to practise outside of their training programs until either CFPC or RCPSC certification.

likelihood that new physicians will meet identified societal needs, while at the same time working in areas consistent with their own skills and interests.

While a return to a general license after a one year rotating internship may not be required, a shift to a common PGY-1 year - recognized on a national basis by both the CFPC and the RCPSC, and by licensing bodies - would allow medical students more flexibility in making later choices about career specialties. At a minimum, common PGY-1 years for surgical and medical specialties should be considered. These changes can and should be made without extending the total length of training. Furthermore, a nationally recognized pathway to licensure after a minimum of two years of acceptable training, particularly for those residents who decide that they no longer wish to pursue their initial choice of specialty training, would serve to enhance the licensure portability of physicians across the country.

Finally, through increased government funding support, there should also be greater opportunity for changing training programs within residency, together with increased flexibility in recognizing previous training and practice when this happens. Re-entry training positions must also be expanded so that established physicians can pursue new specialty training (particularly in specialty areas of physician shortages). As well, if we are to encourage established physicians to undertake re-entry specialty training in order to meet societal needs, there must be appropriate compensation and administration measures in place to allow them to do so.

b) Matching Training to Societal Need

Turning to the actual content of the training of medical residents to become our future physicians, there has been a growing recognition of the need to focus on skills development in present and anticipated areas of need -- both geographic and specialty based. This has been most pronounced in the area of rural medicine, where several initiatives across the country have led to increased and appropriate exposure and training in rural settings and in rural medicine, at both the medical student and residency levels. This includes the current discussion of new rural and Northern medical schools and/or satellite campuses in both Ontario and British Columbia.

We believe that there is a need to continue and intensify these efforts, particularly in the area of RCPSC specialties, and in urban underserved domains of practice. There is also a need for further expansion of comprehensive rural training at both the undergraduate and postgraduate levels of medical schools, with a particular emphasis on the development of community based training centres, increased recognition of rural preceptors, and increased rural teaching by tertiary specialists. Similarly, the needs of urban or inner city populations are increasingly being recognized as needing specific skills training in areas such as mental health, addiction, new immigrant and HIV/Hepatitis.

However, there are a number of constraints on shifting the nature and location of residency training. There must be funding and staff made available to replace or cover the clinical service now provided by medical residents in urban teaching hospitals. Furthermore, medical residents should not be expected to undertake training outside of the traditional urban teaching hospitals if they are to be financially penalized for so doing. There should be dedicated funding in order to reimburse residents for accommodation, travel and living expenses, as well as guaranteed application of the negotiated provincial collective agreements regardless of training location. The shift in training type and location must also be accomplished without compromising educational quality. Any shift to more decentralized training must also contend with the increasing centralization of many key technologies in large centres, and by the trend to amalgamate and/or eliminate community medical resources. As a result, there is a need to ensure that sufficient resources are provided, and appropriate infrastructure is in place, to fund and sustain meaningful learning opportunities, as well as an appropriately recognized teaching faculty, in smaller teaching centres whether in a rural hospital or an inner-city clinic.

c) Funding and Preserving Academic Health Science Centres

At a broader system level, the Academic Health Science Centres (AHSCs), in which medical students, medical residents and other health care providers are primarily trained, are facing chronic underfunding as they seek to pursue their mission of providing tertiary and quaternary care, education and training, and research. This stems in large measure from significant cuts in funding from both government education and health budgets, and in part from the inability of the predominant fee-for-service payment mechanism to provide appropriate incentives consistent with the mission and objectives of AHSCs. We believe that it is critical that adequate funding amounts be provided, and that alternative payment mechanisms be developed and implemented to ensure appropriate incentives are in place in order to adequately compensate the multiple clinical, education and research roles of AHSCs and to redress the serious issues of staff morale and balance. AHSCs physicians simply cannot be expected to do more and more, with sicker and sicker patients, and lower and lower levels of support.

V. SUSTAINING AND ENHANCING HEALTH CARE DELIVERY

1. The Physician and Health Human Resources Crisis

As residents met across the country to discuss the issues raised by the work of this Commission, the theme of health human resources was repeatedly raised. In particular, the sense of a crisis already in progress - which has pervaded the reports of various health care and community organizations, professional associations, and even governments - was once again heard in the discussion of 'who' is going to be available to deliver health care in any system regardless of how our funding and delivery model may evolve.

As a first step there is a documented need to increase the overall supply of physicians¹² and various other health care providers including nurses. At the same time, we must work towards answering the linked questions of how many health care workers are required, their roles and scope of practices, where they will work, and in what model of care delivery they will practise.

Developing answers to these questions is a source of excitement and opportunity for new doctors. We are particularly open to exploring options and working in partnership to develop new and needed systems. Medical residents, working on the front lines, are also well positioned to see the need for change and to offer concrete support in the design and implementation of alternate models.

2. The Need for Positive and Constructive Incentive Measures

While generally open and accepting of needed changes, new physicians are wary of some potential directions for change. We believe that it is a fundamental principle of Medicare that patients should be able to access new physicians on the same terms as they can access the services of established physicians. Positive measures and incentives are needed to develop sustainable models of health care delivery and encourage an appropriate distribution of physician services. Apart from their dubious effectiveness and doubtful constitutional validity, coercive approaches which single out new physicians for punitive financial measures impose barriers which undermine both new and established physician's moral, drive needed physicians outside of the region and limit public access to new physician services. These discriminatory measures also

¹² Most recently, the CFPC has documented the serious shortfall of family physicians across Canada: see The College of Family Physicians of Canada *Initial Data Release of the 2001 National Family Physician Workforce Survey, October, 2001* found at www.cfpc.ca/communications/newsreleases.

risk alienating the very group of physicians whose skills, training and attitudes make them ideally suited for implementation of needed health reforms. This is particularly the case at a time of growing recognition of physician shortages across the country, in both rural and urban centres. Indeed, virtually every study of the physician distribution issue has concluded that coercive and discriminatory measures aimed at singling out new physicians are ineffective and has recommended against imposing these measures on new physicians¹³.

3. Enhancing Patient Access to New Physicians Under the Canada Health Act

During the parliamentary debates over enactment of the Canada Health Act in 1984, Canada's new doctors - through CAIR - expressed our support for Medicare and for the principles of the then proposed Canada Health Act. But, we pointed out that a practical consequence of the ban on extra-billing under Medicare, which we supported, is that, in order to practise as a doctor, one must practise within the publicly funded system.

CAIR emphasized that denial to new doctors of the equal opportunity for access to Medicare - for example, coercive physician resource restrictions - would interfere with the right of patients to select their own physician. Clearly, it would be inconsistent with the principles of fundamental fairness as well as the basic tenets of Medicare to deprive patients of access to new physicians within Medicare, given that patients are, as a practical matter, precluded from access to new physicians outside of Medicare.

CAIR was concerned then, and remains concerned now, that if new doctors are singled out for discriminatory treatment in comparison with established physicians - and effectively locked out of the opportunity to provide their services within our Medicare system - they and their

¹³ For example, the Ontario Government's 1995 multi-stakeholder Provincial Coordinating Committee on Community Academic Health Science Centre Relations (PCCCAR) Underserved Areas Needs Committee Report concluded that "providers should continue to be encouraged and supported - rather than compelled - to choose to practice in underserved areas". This perspective was most recently reconfirmed by the Ontario Government's January, 2001 Expert Panel on Health Professional Human Resources Report, which included as one of its core principles that "strategies to improve the distribution of health care professionals should be designed to attract and encourage them to practice in areas of need rather than penalizing them for not doing so." Similar sentiments were expressed in the September, 1995 Report of the National Ad Hoc Working Group on Physician Resources, comprised of a variety of non-governmental health care bodies, which concluded that "mechanisms and programs to promote objectives in distribution should not be designed in such a manner that the onus of achieving the objectives falls disproportionately on one segment of the medical professions (e.g. new graduates)."

potential patients will become less accepting of the restrictions on billing outside of publicly funded health insurance plans, thereby undermining an essential component of Medicare¹⁴. We also stressed then that our physician distribution challenges will only be resolved through a comprehensive package of incentive measures which is responsive to the actual barriers to sustainable physician recruitment and retention.

We continue to believe that any physician resource, payment or health care delivery reform initiative should apply equally to new and established physicians, and be equally accessible and applicable to the profession as a whole. For this reason, CAIR believes that it is important to affirm, as an underlying principle of Medicare and the Canada Health Act, that as a matter of patient access and fundamental fairness, new physicians must have an equal opportunity to participate in Medicare without discrimination and on the same terms as established physicians.

4. Meeting the Physician Distribution Challenge

In terms of the implementation of positive and constructive measures to meet the needs of rural and remote communities, new physicians support and have identified a variety of measures, which, if implemented, would lead to effective and sustainable physician recruitment and retention in these areas¹⁵.

Many of these measures could also be applied to specific urban underserved populations. Certainly the transient nature, medical complexity, multitude of social concerns and need for differently skilled health professionals means that the conventional models of service delivery are inappropriate.

a) Alternate Payment and Group Practice Funding and Delivery

Alternate payment mechanisms are needed in order to recognize the unique skills and demands of rural and Northern practice. These include the higher burden of care that must be delivered in communities isolated from the support of a large number of specialists, and often in the absence of tools for investigations available to physicians in larger urban centres. Many physicians in rural and remote communities have concluded that the current fee-for-service system is not necessarily the most appropriate for meeting the unique skills and demands of their medical practices.

¹⁴ One of the effects of CAIR's efforts in 1984 was that the Canada Health Act was amended to provide that, in order to meet the criterion of accessibility, provincial health insurance plans must provide for "reasonable compensation for **all** insured health services rendered by medical practitioners..."[emphasis added]. However, as we propose later in this submission, we believe that the time has now come, as we collectively work together to renew our commitment to Medicare, to strengthen this protection to more explicitly ensure that, within Medicare, patients are guaranteed equal access to new physicians, and new physicians equal access to patients.

¹⁵ See, for example, the 1992 CAIR position paper on "Recruitment and Retention of Physicians to Non-Urban Practice Areas, and the various reports prepared by PAIRO referred to above in footnote 5.

Funding should be provided to encourage physicians in rural and remote communities to work in group practice models within appropriate clinic infrastructures and with shared facilities. This includes funding to encourage established physicians to shift to a group practice model. Group practice allows physicians to pool administrative and management responsibilities, and concentrate on providing comprehensive medical care. It also facilitates shared call responsibilities.

Funding models must also ensure the opportunity and support to receive appropriate training, including maintenance and acquisition of unique rural skill sets like GP anesthesia or GP surgery.

Alternative payment and group practice models in underserved communities must also recognize the requirement for a critical mass of physicians in rural and remote communities, so as to ensure sufficient mutual support, particularly in the provision of evening and weekend on-call services, as well as sustainable physician recruitment and retention.

New physicians are more likely to be attracted to communities where, regardless of payment mechanism, there is a group clinic facility with shared staffing, information systems and administrative support in place. This would also provide increased opportunities and space needed to integrate allied health professionals.

Finally, funding amounts and programs might vary depending on the degree of rurality or remoteness. Such a sliding scale of incentive measures would ensure that the most rural and remote communities attract and retain physicians.

b) Specialist Support

There is also a need to develop and fund improved laboratory and specialty referral networks to enhance clinical support and decrease stress and potential 'burnout'. Another approach involves encouraging the physicians in various provincial specialty pools to become responsible for providing province wide care through such initiatives as expanded locum tenens programs and rotational duty/visiting specialist initiatives. Professional and academic support for physicians once in a rural area is an essential retention measure.

More attention must also be devoted to alternate payment plans and/or sessional payments for specialists, including block fee call remuneration for core specialties. Hospitals should also be encouraged and funded to provide office and clinical support for specialists.

c) Information Technology

Information technology such as tele-video or digital radiology can also prove particularly critical in rural areas and can help bring the resources and skills of larger centres into

smaller centres, decreasing the sense of collegial isolation and improving patient care. By the same token, technology can never replace the need for a critical mass of doctors to handle acute and chronic care duties.

d) Encouraging Locum Physicians

Locum physicians (i.e. physicians who replace permanent physicians to allow them to take needed professional and personal time off) have always been a critical retention tool for rural physicians. Locums allow established physicians to avoid burn out, take maternity/paternity or illness leave, or pursue important continuing medical education (CME). At the same time, the opportunity to serve as a locum physician is also a useful recruitment tool as it gives the locuming physicians exposure to new practice settings. Unfortunately, licensure restrictions (reviewed above), together with limited coordination and inflexible and inadequate funding, have significantly limited the traditional pool of locum physicians, an effect that has been deeply felt in both rural communities and urban settings.

Fortunately, many new physicians are increasingly interested in spending their early stages of practice providing locum tenens (or replacement physician) services, for two main reasons. First, there is a traditional desire to test out different settings and areas of practice before deciding on a permanent location or position. Second, new physicians increasingly cannot afford the capital and other expenses of setting up practice because of their high debt loads upon completing their residency training.

We believe that the willingness of new physicians to serve as locums, coupled with the need for locums in underserved areas, suggests that the development of improved locum delivery and funding programs should be a priority. This includes implementation of interprovincial locum licenses to allow both new and established physicians to cross provincial boundaries to provide locum services, guaranteed minimum income and travel expense reimbursement, more flexible conditions of service, exploring regional and local administration and delivery of locum services, and increased utilization of clinical faculty and their trainees.

e) Spousal and Family Supports

One of the critical constraints on recruiting and retaining physicians in underserved areas is the difficulties faced by physicians' spouses and families, particularly in terms of employment, educational and social opportunities. This is often reinforced by the inordinate demands on physicians, including on-call requirements and hospital and administrative responsibilities, which limit family time and increase spousal and family isolation.

While there are no easy solutions to this dilemma, we believe that coordinated efforts to assist and support spouses and family members is another important aspect of improving

physician recruitment and retention in underserved areas. This could include communities taking a more active role in recruiting residents, new physicians and their families, and in establishing regional rural family support networks. It is also critical that communities recognize that when they are recruiting a physician, they are also recruiting the physician's spouse or partner and family.

5. Primary Care Reform

Alternate funding plans, group practice, information technology, and allied health care professionals -- these are all woven into the concept of primary care reform. In fact, these features of primary care reform initiatives reflect the training, skills and values of new physicians. For this reason, it is critical that primary care reform be planned and implemented with the input of new physicians and in a manner which facilitates and encourages their participation.

Primary care models need to be flexible, with separate templates reflecting different geographic, patient and physician needs. They also need to be flexible enough to allow varying patterns of practice, including shared and part-time practice, which are particularly suited to some new physicians.

It is also particularly important that patients have the mobility within and between primary care models so that they can access the physician of their choice, including access to new doctors. The underlying philosophy of primary care should be to improve health care delivery, not reducing needed patient care expenditures or protecting established physicians. For example, rostering or patient registration can enhance the quality of health care, but it should not be used as a vehicle to limit patient choice or new physician access to the system.

Looking beyond the needs of primary care delivery, specialists also need to see system reform that allows access to alternative models of payment and practice. Rapidly changing technology, shifting societal expectations regarding health care and increasing demand from an aging population will put large strains on the services specialists provide. As discussed, many specialists working in the Academic Health Science Centres also have the additional roles of teaching and research, which must be appropriately encouraged and adequately compensated.

6. Information Technology

There is a critical need to fully fund and implement improved information technology. Not only is this critical to the success of any primary care reform initiative, but more generally, we currently suffer from a lack of effective and integrated information technology across and between all sectors, institutions and providers throughout the health care system. The technology exists, but there is no dedicated or committed funding from governments to implement it.

Without doing so, we will be unable to enhance the quality of patient care, and there will continue to be unnecessary and duplicative paperwork and patient visits. The health care system requires a substantial initial investment, one well-suited to be supported on a national basis through federal funding.

7. Working with other Health Professionals

In all areas of practice, urban and rural, primary care and specialization, there is clearly an important and growing role for physicians working together with non-physician health care providers in a supportive and collaborative model. These individuals may include midwives, nurse practitioners, physician assistants, psychologists, social workers, clinical study coordinators, counsellors and surgical assistants. Appropriately defining their scope of practice and providing payment structures which prevent competition and duplication of services is critical, as is determining the legal and clinical responsibility of the physicians in relation to these partners. We must allow various service providers in the system to do what they are best trained for, without providing services more appropriately preformed by someone else. It must be remembered that allied health care professionals share many of the concerns and issues of physicians, including a need for appropriate and ongoing training for their practice setting and a desire for a more appropriate balance between their professional and personal priorities.

8. Patient and Physician Education

New physicians are also committed to increasing efforts at public education in such areas as appropriate utilization of the health care system, the costs of various types of clinical care, realistic expectations, and illness and accident prevention. At the physician level, we support the development and distribution of practice guidelines with an increased focus on efficiency and effectiveness, linked to health outcomes. Combined with public and patient education, the goal is to reduce unwarranted tests, unnecessary referrals and redundant services.

9. Health Human Resource Planning

Health human resource planning must not only take into account the role of non-physician health providers, but also the changing demographics of the new physicians. As discussed above, there are significant demographic changes in the composition of the new physician workforce. This leads to a greater desire to balance work with family priorities and with concerns about personal well-being. The changing practice patterns of new physicians means that traditional models of physician working-hours and workload must be altered in the context of physician resource planning. Coupled with the reality that many established physicians are reaching retirement age,

this also means that concerns with physician shortages today will likely become even more serious over the next decade.

10. Committing to our Public Health Care System

Finally, it is critical that we collectively develop processes and structures through which society can democratically debate, and then make, informed decisions regarding the limits of our publicly funded system. At the present time, the system permits arbitrary decisions and hidden rationing, much of it forced by undirected budget cuts and constraints imposed at governmental, institutional and individual levels. If we are to retain our commitment to public funding of medically necessary services (with the possible expansion of this commitment to embrace the home care and pharmacare) then we must also recognize that no amount of reform to the efficiencies of our existing health care system will avoid the need for substantial infusion of additional funding. As new physicians, we continue to believe that sustaining and enhancing our public Medicare system is both the fairest and most efficient way to meet our future challenges.

VI. CONCLUSION: NEW DOCTORS HELPING TO MEET THE CHALLENGE

There are many challenges that we must face collectively in order to preserve and enhance the sustainability of our public health care system.

New doctors are up to facing those challenges. We are committed to contributing our skills, passion and energy to ensuring that Medicare not only survives, but thrives.

We value the principles of the Canada Health Act -- Enhance them.

We want to develop skills that are needed -- Establish training models that permit this.

We are being discouraged from becoming physicians -- Regulate tuition and provide financial aid.

We need access to varied training opportunities -- Allow for career change and re-entry.

We want to work where we are needed -- Create necessary incentives and supports.

We are not tied to the fee-for-service system -- Develop alternate payment systems.

We practise collaboratively with other health professionals -- Encourage this.

We are increasingly in short supply -- Make more of us.

We practise evidence based care -- Facilitate it.

We value practice standards -- Measure our successes and failures.

We are trained in the latest information technology -- Fund the infrastructure we need.

We value the opportunity to practise on the same terms as established physicians -- Protect this.

We value well-being for our patients and ourselves -- Help us promote it.