

Family physician shortage in ontario: causes, effect on communities, current meas...

[Business](#), [Strategy](#)



Abstract Family physicians shortage in Ontario remains a grave crisis despite the recent efforts by the Ontario Medical Association. Healthcare system in Ontario is almost on the verge of collapse due to shortages of general physicians, nurse, and health-eroding waiting lists for diagnosis and treatment. This paper discusses the real causes behind family physicians shortage, its effect on communities, what current measures are being taken, and some possible solution to this problem.

Introduction Family physician shortage in Ontario come into public notice when in 1999, the Ontario Medical Association warned that physician human resource shortages represented a “ looming crisis.” (Carlj, 1999) And now the shortage has deepened further to become an issue of major public concern, and is now recognized by other authorities that include the College of Physicians and Surgeons of Ontario (CPSO), the Canadian Medical Association (CMA), and the Health Council of Canada (HCC). (OMA Human Resources Committee, 2003) Most disturbing is the reality that the current crisis has not yet peaked.

While Ontario physicians continue to make extraordinary efforts to meet the service needs of the population, the stability of the health-care system remains at risk due to provider shortages. While the number of Ontarians without a family doctor has fallen to 1 million from 1. 2 million a few years ago, the outlook is grim because many doctors are at retirement age and baby boomers are expected to put a huge strain on the health system in years to come. (OMA Human Resources Committee, 2003) The family physician shortage problem in Ontario affects communities as large as Toronto as well as towns and rural areas across the province. According to The Ontario College of Family Physicians, the situation is only expected to

get worse with 23 per cent of family doctors in Ontario expected to retire over the next five years; 22 per cent seriously thinking of leaving the profession; 16 per cent thinking of leaving the province; and, fewer family doctors coming into the system. (Ontario College of Family Physicians, 2003)“ While physicians in Ontario continue to make exceptional efforts to meet the needs of patients, the province still lags behind the rest of the country in terms of physician resources and our ability to care for patients,” said Dr. Greg Flynn, President of the OMA.

“ Although the province has taken several steps to train more doctors and certify those trained abroad faster, much more remains to be done, before we will see improvements.” (College of Physicians and Surgeons of Ontario, 2004)**The Causes of Shortage**The shortage crisis started when an action taken to control the number of physicians entering practice in Ontario was to completely restrict graduates of foreign medical schools from entering practice in Ontario. This indefensible regulation, entered in 1984, was challenged in court. The Ministry of Health was forced to designate 24 residency positions for international medical graduates. In 1990, the Ministry implemented regulations that prevented any physician who had received all of their training in another province of Canada from obtaining a license in Ontario. In 1991, as part of a national strategy, Ontario reduced the size of medical school classes by between 10 and 15%. (College of Physicians and Surgeons of Ontario, 2004)In 1992, the province began requiring newly graduating physicians to take either the two-year family residency-training

program or a Royal College specialty program and pass the appropriate certification examinations to obtain a license to practice.

In the process of implementing this plan in 1996, 100 extra internships that had maintained the supply of family physicians in Ontario were eliminated. Those steps have reduced the number of family physicians/general practitioners being licensed in the province from more than 1, 000 a year in the early 1980's to 188 in 1997. (College of Physicians and Surgeons of Ontario, 2004)At the same time that the supply of new family physicians was reduced, there was a growing exodus of experienced family doctors to the United States. American recruiters are currently paid a finder's fee for Ontario's so-called " Platinum Physicians". Our physicians are valued in the U. S. for their broad scope of practice preparing them to satisfactorily deal with more than 90% of all presenting medical problems. The usual attrition rate through retirements further decreased the number of family physicians practicing in the province.

The reduction in supply, the increased attrition and the practice of most new graduates of doing locums for the family physicians has caused an erosion of the working conditions for the remaining physicians. The increased workload makes it difficult to provide the broad scope of services and practice according to the four principles of family medicine. The Janus report states that " the average family doctor in Ontario works seventy hours a week and takes call once every five or six days. Recent media reports describe working conditions in which physicians are working four consecutive twenty-four hour emergency shifts. (College of Physicians and Surgeons of Ontario, 2004) It is

estimated that there are three hundred and sixty fewer family physicians than required to provide basic care in the region.

With fewer than two hundred and sixty trained and licensed family physicians entering practice in Ontario each year, and the annual attrition of family physicians exceeding this number, there seems to be no way to address the identified shortages. A shortage of physicians, especially in a smaller community, creates excessive workloads for the physicians who remain behind. Using the example of a community where there are seven physicians, if two leave and are not replaced, the remaining physicians, in the best circumstances, must be on call one night in five. With the additional workload of the departing physicians and holidays or illness increasing the need for on call to one in three, the workload becomes intolerable and the remaining physicians seek relocation.

(OMA Human Resources Committee, 2003)Physicians attracted to a practice in the United States are often not attracted by higher incomes, but are attracted by the promise of reasonable workloads and less requirement for call. Eighty-four percent (84%) of the members of the Ontario College reported that they had increased difficulty in getting replacements when they were absent from their practice. Because of physician shortages, 43% of Toronto physicians and 68% of Ontario physicians reported that there were problems in accessing medical care in their region. The Janus Report includes the finding that half of the physicians in Toronto and 73% in Ontario reported that there were insufficient numbers of family doctors. Our

members also reported (71% in Toronto and 66% in the rest of Ontario) that there were insufficient specialists.

(College of Physicians and Surgeons of Ontario, 2004)Effect on CommunitiesFor most Canadians, the family physician is the first and main point of contact with the health care system. Family physicians must be accountable directly to their patients. They must be responsible for ensuring access to the rest of the system, for quality service, and for continuity of care for their patients. The family physician serves as the link to all other health care providers and institutions within the system and oversees all aspects of their patient's care. The family physician – patient connection remains one of the most vibrant and successful parts of the healthcare system, even while other aspects of the system have begun to fail.

Thus, this relationship must remain at the heart of any analysis of the healthcare system. Each individual health care provider, such as specialists, midwives, social workers, nurses, etc. deals primarily with only one aspect of patient care. On the other hand the family physician is truly the general practitioner who serves to deliver and coordinate much of these areas of care. The family physician who knows and understands the patient as a complete individual, appreciates the impact each one of these components has on the patient as a whole. There is however, no question of the value of an interdisciplinary approach to patient care, and this should be emphasized in any discussion involving health care improvement. (OMA Human Resources Committee, 2003)Family physicians are in the unique position to understand in detail the psychological, social and physical impact of illness

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on their patients' lives. Family physicians care for individuals through the full spectrum of life, from the fetus in the womb to the geriatric patient.

They deal with and must understand a multitude of illnesses, diagnostic tests, treatment options and their outcomes. Family physicians must interact with every other health care provider in the health care system. They are linked to absolutely every facet of health care and especially to their patients.

The family physician is linked hand in hand with their patient. (Dawes R, Willett J, Lofsky S, McNestry G, Gould M, et. al, 2002)The citizens of Ontario rightfully expect our health care system to at least provide them with basic health care. Consider an individual patient who is ill. This patient expects to be able to see or speak to their family physician. They would like to be able to do so the day they are unwell, and after-hours if necessary.

They would like their family doctor to be available and able to offer them quality time. They expect their family doctor to be able to order necessary tests and obtain their results within a reasonable amount of time. They would also like to have timely access to a specialist consultation if necessary. As well, patients want to receive appropriate and timely treatment whether that includes drugs, radiotherapy, surgery, or seeing ancillary health professionals.

If hospitalization is required, then emergency, acute or elective beds are expected to be available with full and complete patient care. If necessary, nursing, homecare, chronic or palliative care should be available as well.

(OMA Human Resources Committee, 2003) Unfortunately, in the past ten years our system's ability to provide the patient with the above has deteriorated.

There is a family physician shortage in Ontario. Family doctors' offices are swamped due to patients' needs and demands. There has been a decrease in after-hours care by family physicians because the government removed the incentive to provide it. It can take 9 months to get a MRI. It can take up to 6 weeks to get a PAP test result. It takes most specialists 3 to 4 months to see patients. Patients are dying in ambulances. Emergency wards are overloaded because there are no beds to admit patients.

There is inadequate home care and chronic care facilities. Lastly, cancer patients in need of radiation therapy, must leave their family and homes and travel to the US, or sign a waiver absolving hospitals of the responsibility for progression of their cancer. (Dawes R, Willett J, Lofsky S, McNestry G, Gould M, et. al, 2002) Current Measures The recently implemented CPSO Registration by Practice Assessment Program (RPA) is a good beginning, but it has a five-year return of service requirement, and for this group of physicians, it requires an unnecessary on-site practice assessment.

Much more can be done to successfully and quickly recruit excellent physicians from this pool. Postgraduate Reform Re-entry: National statistics indicate a 73 per cent drop in re-entry positions from 1989 to 1999 (from 177 positions to 47 positions). In 1992-1993, 12 per cent of all residents were re-entry trainees, contrasted to 2.

5 per cent in 1999-2000. (College of Physicians and Surgeons of Ontario, 2004)The magnitude of this change contrasts with the moderate change in all the other common factors cited for the lack of interest in family practice - negative messaging in medical school, inadequate fee schedules, and lack of prestige and respect were all present pre-1993. For the student considering family practice, but who may have other interests, the personal cost of making the wrong decision is enormous. If they are ultimately unhappy or wishing to follow matured interests, they are faced with restrictive re-entry requirements, required to relocate (perhaps with family) to an under serviced area, or, alternatively, face repayment for salaries earned while providing patient care during residency. (Ontario College of Family Physicians, 2003)The Committee believes that significant barriers have been created for the relatively small number of residents and family doctors who are no longer comfortable with their long-term career choice. These barriers deter a much larger number of medical students with interest in family practice. This, in the Committee's view, is one of the major factors for the avoidance of family practice in the Canadian Residency Matching Service (CaRMS) match. Furthermore, it has affected specialties such as psychiatry, diagnostic medicine, and anesthesia, which traditionally relied on re-entry positions as a major source of human resources.

To rectify this, at least a fourfold increase in re-entry positions, with much reduced restrictions and elimination of return of service, is urgently needed.

(College of Physicians and Surgeons of Ontario, 2004)· Common PGY1In

the mid-1980s, the CMA initiated the reform of the postgraduate system by

recommending a two-year licensure for family practice, while hinging this recommendation on a flexible third stream to allow the undecided more time for choices. Regretfully, this never materialized, with the result that medical students must make choices early in their training, with frequent unhappiness in the choices made. To rectify this, the OMA and CMA have advocated for the return of a common PGY1.

(Ontario College of Family Physicians, 2003) In 2004, CMA Council voted to favor a voluntary common PGY1, and discussions have continued at the Canadian Medical Forum. It is unclear at this time whether this model will move forward. The Royal College of Physicians and Surgeons of Canada (RCPSC) is exploring a core competency model. Regardless of which model is ultimately implemented, the OHRC feels strongly that increased flexibility, more time for decision-making, and giving credit for training already completed in other specialty programs, must be improved.

The Committee still believes this does not yet address family practice issues, and will continue to contribute to premature choices with mismatches in other specialties. (College of Physicians and Surgeons of Ontario, 2004)

Limited Licensure In eight out of 10 Canadian provinces, resident physicians provide care under limited licenses as part of the solution to the health human resource shortage. The OMA, CPSO, and Professional Association of Internees and Residents of Ontario (PAIRO), among others, have recommended implementation of a similar strategy in Ontario. Despite a pilot project approval at the CPSO, residents are currently unable to contribute under the limited licensure model in Ontario due to a lack of

acceptance on the part of Ontario universities. (Ontario College of Family Physicians, 2003) Recommendations Establish a new, independent and permanent “ Office of Physician Workforce Policy and Planning,” which would provide a central and ongoing focus for issues related to physician workforce police and planning in Ontario.

Develop access modeling pilots, as proposed in the McKendry Report, for core services in medical fields where patients have ongoing problems getting timely access to care. Further increase medical school enrolment to address the growing shortage of physician human resources in Ontario. Develop and implement a spectrum of incentives aimed at retaining practicing physicians, such as retention bonuses, long-service leave (sabbaticals), practice overhead support, retirement/pension plans, improved continuing education, locum assistance, and spousal support. Employ the OMA Rurality Index for Ontario (RIO) as a tool for scaling incentive structures. Temporarily increase the number of fully qualified international medical graduates (IMGs).

Eliminate all coercive measures, such as OHIP fee discounts and physician billing thresholds, which impact negatively on the provision of medical services. Eliminate policies and regulations mandating forced retirement of physicians based solely on age. Develop a new repatriation program aimed at recruiting Canadian-trained physicians currently practicing in the United States, Ontario-trained physicians currently practicing in other provinces, and Ontario medical students studying in other provinces, to return to Ontario. Improve the flexibility of choice for medical students when

determining their field of practice, and facilitate the ability to change field of practice during the training period.

Make tuition fees for medical school more affordable to prevent financial barriers to medical training. Increase the flexibility of the Ontario Ministry of Health and Long-Term Care “ Free Tuition Program,” and further enhance the financial aspects of the program. Increase efforts to improve efficiencies and reduce the administrative burden on physicians in the delivery of medical services. Assess the impact of medio-legal issues on physician resources, and the need for tort reform in address the shortage of physicians in Ontario.

Analyze, evaluate, and address the impact of increasing patient knowledge about, and requests for, medical services on the overall problem of physician human resources shortages. Develop public education initiatives emphasizing the appropriate use of medical services. Increase research and evaluation activities regarding the integration of non-physician providers into the health care system. Increasing physician human resources to adequate levels will require increased levels of funding. Re-create a common PGY1 year to allow further flexibility in career choice for new physicians. Incentives should be developed to encourage willing and able physicians near retirement age to consider continuing practice with a scaled-back workweek. Develop a measurement tool for quantifying physician human resources. This would include an analysis of various full-time equivalent measures.

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