Training

The Conversation on Health frequently focused on the education of British Columbia’s current and future workforce. Tuition costs, space and demand for educational seats, and models of education were commonly discussed. Participants addressed Multi-disciplinary training and the continuing education of health professionals. Here is a selection of what British Columbians had to say on the subject of the training of health professionals.

Tuition Costs and Training Fees

The Conversation on Health received a considerable amount of feedback about the cost of medical education in British Columbia. Some are concerned about large student debt-loads driving health professionals out of the province in search of higher pay. Others believe that high tuition fees are deterring lower-income students from entering medical studies. Several discussions suggest fully subsidizing health professionals’ education in return for spending a number of mandatory years practicing within the Province, similar to the education pay-back model that exists in the military. Some participants extend the requirement for service specifically to rural and remote locations, while others suggest compulsory practice solely in the public sector. Participants believe that critically understaffed health care disciplines could be filled by targeting subsidies to those training programs.

Space and Demand within Educational Institutions

Numerous participants describe the number of medical students currently being accepted into universities and colleges as insufficient. They think that this number would not meet the current or projected demand for trained staff and call for an expansion in the available post-secondary medical, technical, and health science seats.

Much of the discussion also focuses on access to the seats currently available in post-secondary institutions. Some participants believe that professional colleges and associations are overly-protective of the spaces for medical education, which, they argue, prevents many qualified students from beginning study for several years and possibly discourages them from entering a medical profession. Many also voice concerns about the accessibility of educational institutions for residents in northern and rural areas of the province. Some participants recommend the expansion of
private education to create more available space for prospective medical students in British Columbia.

*We have an increasing tendency to ramp up entry-to-practice credentials...it is denying working class kids an entry into many professions, and it's exacerbating the shortages.*

- Focused Workshop on Health Delivery, Vancouver

### Models of Education and Training

Many agree that British Columbia’s health practitioner training models require changes to produce the graduates needed to meet current workforce demands. Participants cite restructuring mental health training to increase its accessibility to all professionals and expanding clinical training opportunities to address a deficit in practical, hands-on training as examples of necessary change. Many participants also call for an increase in the number of internships and mentoring positions for students. Others recommend that senior professionals should be retained past the retirement age to mentor the new students.

Some participants emphasize that, although these reforms are necessary, they will place more stress on the already thinly-stretched health human resource pool. To overcome this difficulty, they suggest laddering or bridging programs, which would allow Licensed Practical Nurses or care aides to practice while upgrading their educations. Other suggestions include: reducing the four year registered nursing degree to a three year to expedite registered nurses into the workforce; and, in First Nations communities, integrating traditional healing and cultural sensitivity into current training regimes.

### Multi-disciplinary Education

Many participants suggest that various levels of the education system must reform in order to implement a multi-disciplinary approach to health care. Opening up lines of communication between the colleges, they argue, is necessary to allow for the sharing of practices and information, and reduce uncoordinated training and education. Others recommend more frequent co-ordination between educational institutions and the practicing workforce. Some suggest integrating a range of medical studies into common classes, which would create more respect across professions. Many participants believe that some level of alternative and complementary education should be taught to all students in the medical profession to encourage its integration into mainstream medicine.
Continuing Education for Health Professionals

The majority of participants understand that health professionals require increased support for continuing education. Many participants viewed additional training in alternative and complementary medicine as key to creating a more holistic practitioner. Training to better educate all practitioners on caring for those with mental health issues is also a priority. Others recommend leadership and management training for administrative and front-line personnel to create a more efficient and personable working environment.

*Further education that allows health practitioners to broaden their education and enhance their skills can be critical in retaining professional staff, particularly in a world where the competition for skilled talent is increasing.*

- The University Presidents’ Council of British Columbia, mail

Conclusion

Participants in the Conversation on Health believe that the education system has an opportunity to help address British Columbia’s health human resources shortage. Fully subsidizing tuition fees and costs relating to ongoing education in return for mandatory practice within the province, they argue, would bolster recruitment and retention. To create more training opportunities, some participants believe the professional colleges and universities must increase the amount of post-secondary seats currently available to medical students. Participants also suggested that, while in training, students should be taught the values of multi-disciplinary care to stimulate a better understanding and higher level of cooperation between professions. The scope of education for medical students should be more concise to increase the number of trained professionals while also removing any unnecessary credentialing and extending practical training to within the hospital. Participants see education as an ever-changing and ongoing process that must be encouraged and supported throughout a health professional’s career.

*I would like our health care to be the best in the world and would like the top students to want to go into medicine.*

- Email, Coquitlam
Training

This chapter includes the following topics:

- **Education and Health Human Resources**
- **Multi-Disciplinary Education**
- **Education and Training Models**
- **Continuing Education**
- **Tuition Costs and Training Fees**
- **Credentials and Licensing**

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Submission to the Conversation on Health
Submitted by the British Columbia Nurses’ Union

2020, The Future Without Breast Cancer
Submitted by the Canadian Breast Cancer Foundation

Related Chapters

Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: Health Human Resources; Scope of Practice; Morale and Collaboration in the System.

Education and Health Human Resources

Comments and Concerns

Health Professional Recruitment
Access to Education
Post-Secondary Funding and Staffing

• Comments on health professional recruitment:
  • British Columbia may possess an insufficient number of citizens interested in an occupation in the health care field.
  • Negative imagery and poor public perception of the health care field is driving away prospective students at the high school level.
  • The current education system is turning out only half the amount of trained professionals needed to properly address the Province’s health human resource issues.
  • The student limits that the professional colleges enforce do not help in addressing the health labour shortage issues in British Columbia today.
  • There are long wait lists for First Nations band-subsidized education.
  • Physiotherapy education consists of only 60 seats in British Columbia – too little to affect the labour shortage issue in the province.
• The wait to enter into a nursing program is too long.
• A re-assessment of medical school recruiting criteria is long overdue.
• The colleges and universities of British Columbia require an investigation of their admittance practices.
• Health service volunteers are becoming a rarity; the increased amount of training required to work with patients is becoming overwhelming and is driving people away.

• **Comments on access to education:**
  • Paediatric therapist training programs are only available in the lower mainland.
  • All teaching institutions are in the coastal, lower-mainland region; the northern and interior regions are left with little choice for their education.
  • Mental health training is lacking in northern British Columbia.
  • Residents in Fort St. John and Dawson Creek have limited access to the University of Northern British Columbia’s Bachelor of Nursing program.
  • Athabasca University is the only distance education option in western Canada due to restrictive legislation.
  • The Thompson Rivers University does not have a Licensed Practical Nursing program.
  • Those who apply on-line to various universities and colleges do not receive an immediate response regarding the status of their application.

• **Comments on post-secondary funding and staffing:**
  • Colleges and universities lack the funding necessary for an increase in dietician training.
  • Funding for first responder training is extremely poor.
  • Care aides and Registered Care Aides lack the funding necessary to any increase in training and certification.
  • There is a concern that the British Columbia Institute of Technology (BCIT) is losing many teachers, professors and instructors.
  • The Vancouver General Hospital may lack staff trained in the role of teaching technician.
  • Schools have lost the ability to network and set up clinical placements for their graduating students.
Ideas and Suggestions

Health Professional Recruitment
Access to Education
Post-Secondary Funding and Staffing

• Ideas about health professional recruitment:

  • Allow for more medical education seats at the University of British Columbia and
    the University of Northern British Columbia.
  
  • The provincial government must double the number of students and interns to
    address the shortage of trained doctors and nurses.
  
  • Expand the number of residency spaces available to doctors in training.
  
  • The protectionist tendencies harboured by the professional colleges must be
    addressed; the Province lacks trained health professionals and the low-supply,
    high demand rationale practiced by these colleges must end.
  
  • More universities, colleges and institutes are needed in Canada to address current
    labour shortages.
  
  • Provide paid work experience for professionals still in training.
  
  • Attract more professors and teachers to medical schools by increasing salaries.
  
  • Create incentives such as flexible scheduling and lower admission fees to
    encourage enrolment in the Licensed Care Attendant and Licensed Practical
    Nursing programs.
  
  • Reinstate nurse’s aides during the summer, to recruit new people into the health
    field.
  
  • The proposed expansion of the University of British Columbia’s School of
    Pharmacy would provide the province with a greater number of pharmacists; they
    would also understand their role in a sustainable health care system by working
    with patients, physicians, and nurses to ensure effective and appropriate drug use.
  
  • Add incentives to increase enrolment in family physician training.
  
  • Outsource education to accredited foreign educational systems such as the
    United States of America.
  
  • Offer incentives for Canadian citizens to train outside Canada and return to a local
    practice upon graduation.
  
  • Establish a government-mandated standard for entrance into medical schools.
Conduct interviews prior to acceptance into medical colleges to identify those interested in long term dedication to the health care field.

Expand and privatize medical education institutions.

Increase interest in an occupation in health career at the high school level.

An effort must be made to encourage Aboriginal youth into occupations in the healthcare field.

Eliminate restrictive legislation on open learning.

Establish career and aptitude testing in high schools to discover and recruit those ideal for the health professions.

Those with computer and math skills can be recruited for occupations in human resource management or general administration sector.

Eight hundred students will be accommodated in the new Faculty of Health Sciences at Simon Fraser University.

Ideas about access to education:

Create new schools in the smaller rural centres.

Expand undergraduate programs.

Increasing the human resource pool can be achieved by increasing the capacity of training programs such as:

a. Midwifery;

b. Para-medicine;

c. Registered nursing;

d. Licensed practical nursing;

e. Physiotherapy;

f. Recreation aides;

g. Diagnostic services;

h. Rehabilitation services;

i. Clerical and administrative services;

j. A wide array of health sciences;

k. General Practice;

l. Audiology; and,

m. Speech therapy.

Encourage more First Nations representation in the health professions by increasing the amount of northern training programs.
• Create college programs in northern British Columbia that offer the first two years of an undergraduate degree.

• Educating professionals in the community will likely result in their practice within that community. Create more community education programs to facilitate this.

• Create internet-based courses for care aides and support staff.

• Create elderly peer leadership training at local colleges.

• Establish more training for Physiotherapists at the University of Northern British Columbia to address staff shortages in the north.

• Universities have brought $77 million to British Columbia from the Canadian Institutes for Health Research to support health-related research activities.

• There is a need for counsellors trained in family dynamics.

• Offer training within First Nations’ communities.

• **Ideas about post-secondary funding and staffing:**
  
  • Increase the number of health care instructors by hiring retired professionals.
  
  • Address shortages of instructors while maintaining the qualifications they require.
  
  • Northern British Columbia’s educational institutions require the resources to train and produce a wider array of health professionals.
  
  • Create a mobile teaching unit that provides basic education services directly to rural communities and reserves.
  
  • Although the recent expansion of the number of training positions in the UBC Medical School is a positive step, but the time involved in training physicians means the effect will not be felt for some time.
  
  • Target provincial training monies to increase the number of Aboriginal Registered Nurses and Medical Doctors.
  
  • The provincial government needs to allocate additional funds to train more midwives.
  
  • Provide more capital investment in Fort St. John to create new labs and more space for medical programs.
  
  • Programs aimed at upgrading and credentialing foreign-educated professionals require an increase in their capacity and thus an increase in the resources allocated to them.
  
  • Initiate greater collaboration between home and community care managers regarding the allocation of education monies and resources.
Multi-disciplinary Education

Comments and Concerns

Collaboration between Colleges and Universities
Training Health Professionals

• Comments on collaboration between colleges and universities:
  • The academic system is extremely slow in adopting new processes which
    challenge established orthodoxy.
  • There is no impetus in the education system to work collaboratively for the
    benefit of patients.
  • Educational institutions train in silos, thinking and planning only for the individual
    profession.
  • The colleges and associations do not communicate among themselves.
  • The individual colleges do not have any interest in sharing or opening their
    curricula to a more collaborative approach.
  • Various colleges and associations have a different scope of practice for the same
    position.
  • Health Canada has offered twenty million dollars, or only two years worth of
    funding to initiate grass-roots collaborative efforts across the country.
  • High level legislation aimed at increasing teamwork and collaboration could
    prove harmful if not done after consultation with a number of differing parties.
  • There is a split between the operating Medical Association and physicians as a
    whole because the association tends to be run by older people. New physicians
    need to take the place of the executive in the medical associations because they
    have had more exposure to these cooperative models.

• Comments on training health professionals:
  • Healthcare professionals lack transferable skills and knowledge.
  • Doctors are so specialized that they cannot practice in other fields.
  • Physicians have ingrained patterns of autonomous behaviour which is an
    education factor.
  • New doctors may be interested in multidisciplinary teams but do not know much
    about them.
• There is no effective training on teamwork in pre-licensure education.

• Alberta and British Columbia are behind other provinces with regard to successorship and mentoring.

• Some educators with only one year of out-of-school experience are teaching the next generation of professionals.

• Apprenticeship programs are non-existent.

• There is concern over the scaling back of mentorship programs.

• The remuneration offered mentors is inadequate.

• There is too much pressure being put on student mentors.

• Drug companies should not be the ones providing pharmaceutical education for physicians.

Ideas and Suggestions

Collaboration between Colleges and Universities
Training Health Professionals

• Ideas about collaboration between colleges and universities:

  • Building a multi-disciplinary approach within the educational system will allow for a new generation of health care providers who are able to communicate effectively and work with each other.

  • Increasing inter-disciplinary training would improve efficiency in the educational system.

  • I think there needs to be more done about working collaboratively during their medical and nursing and physical education.

  • Change the education strategies in universities, colleges, institutes, and professions to better integrate collaborative studies.

  • Increase multi-disciplinary learning by utilizing the same educator for nurses, Nurse Practitioners, medical students and the midwifery and pharmacology programs.

  • British Columbia is becoming the home to a new model for medical education. The expansion of the University of British Columbia's medical education program includes partnership with the University of Northern British Columbia and University of Victoria. The distributed model provides students with the same curriculum to all three sites, delivered through a combination of cutting edge
videoconference and internet technology, face-to-face instruction, and learning from local doctors in various health care settings.

• The medical deans of Australia and New Zealand have signed up to Canada’s national curricular framework for Indigenous health and medical education is now linked to the accreditation of medical schools in Australia.

• **Ideas about training health professionals:**

  • Universities should offer courses that encompass all fields of medical study. This would force the practice streams into one venue, if at least for a short period of time. This would be a critical step to ending the individualist attitudes of practitioners.

  • Having common courses, such as public health, in the curriculum of nurses and doctors would aid in the communication and collaboration of these professionals.

  • Establish one year in a medical students’ education as their multi-disciplinary training year.

  • Implement collaborative training with the Ministry of Forests and Range and the Ministry for Employment and Income Assistance to gain greater knowledge about the social determinants to health.

  • Team behaviour requires team training.

  • Health teams should be trained along the same lines as airline crew. Although they operate together for a short period of time, they are efficient and understand each other’s roles.

  • Pharmacy and medical students should be taking some of the same courses together.

  • Create a unified college of professionals for those willing to learn in an environment immersed in multi-disciplinary content.

  • Create a better system for communication and collaboration between educational institutions and real world workplaces.

  • Facilitate better dialogue between the workforce and educational institutions to increase the training capacity of those fields in high demand.

  • Provide more opportunity for professionals from different cultures to understand each other and to train among themselves.

  • Have more collaboration between health professionals and school administrators and teachers to improve the education on health in our schools.
• Increase mentoring with apprenticeships for medical assistants and Nurse Practitioners.
• Employ more staff trained to take on more mentorship and preceptor roles.
• Offer incentives for mentors taking the time to train new staff.
• Decrease the amount of mentors in the healthcare system.
• Encourage mentors to scale back their practice and pass those practices on to the student.
• Allow retiring or retired professionals to continue or return to practice to mentor new professionals without impact to their pensions.
• Host career fairs for health professionals.
• Attach professional schools to hospitals.
• Create a forum for health professionals to discuss how they may compliment each other.
• Health professionals requiring long-term disability leave should be retained to train and mentor new staff.
• Pharmacological and medical students are participating together in some courses in some regions.
• The Inter-professional Rural Placement Program is a promising model.
• There is data indicating that those professionals who go out and get re-invigorated with new collaborative information come back to the team a very enthusiastic learner.
• Current mentorship programs are working well.
• The University of British Columbia program partnership with Cowichan Tribes Ts'ewulhtun Health Centre is a step in the right direction.
• Those doctors trained alongside Nurse Practitioners tend to be more open to delegation of their duties.
• Require a level of collaborative and quality improvement education in all professions.
• Community centres will require a specific type of health care team. Data containing the needs of the aging demographic would be necessary, and from that point, one could sort out timelines required to train personnel.
British Columbia must look at inter-education, and at the notion of why a team does or does not work. We also have to look at how we retain people in the system.

The Deans and Directors must meet more than twice per year.

Education and Training Models

Comments and Concerns

- **Administration and Management**
- **Credentials and Program Length**
- **Training and Curriculum Content**
- **Practical Experience**

- Comments on administration and management:
  - Advanced education has become too de-personalized.
  - Universities, colleges and institutions are at the cutting edge of orthodoxy and, once they are in place, it is very hard to change those established conventions and practices.
  - Canada has been very slow to exploit the potential of people to learn new skills beyond the age of 24. This would solve a lot of competency and capacity problems by just taking a very modular, logical approach to how people learn.
  - Content taught in university ten years ago is now taught in high school; medical education outdates itself extremely fast.
  - Many students are choosing to take specialized training in order to increase their potential earning power or obtain more flexible working hours rather than taking a generalized medical degree.
  - The information doctors use to treat hepatitis is outdated or obsolete.
  - The cultural discrimination in educational institutions is unacceptable.

- Comments on credentials and program length:
  - The four year program required for Registered Nurses is too long.
  - The British Columbia Nurses Union is instigating political opposition to shorter nursing programs.
  - After four years of training, students realize that they do not enjoy the practice of nursing.
• Comments on training and curriculum content:
  • Training around cultural sensitivity is either lacking or non-existent.
  • Colleges and universities lack training in practitioner-patient communication.
  • The Medical Diagnostic Services (MDS Metro) chain of laboratory employees are lacking in job-specific training.
  • With the exception of injection education, there is no operating room content in a nurse’s curriculum.
  • Many Canadian Diabetes Association volunteers lack adequate training.
  • Medical training is focusing on the prescription of drugs and treating symptoms instead of addressing the root causes of disease.
  • Family physicians do not receive adequate training to recognize that dementia is not a normal part of aging, and that early, and proper diagnosis is critical to ensure positive health care outcomes.
  • The four year physician program focuses primarily on acute care, yet most do not need this level of training.
  • Current curricular scope does not meet today’s work force scope and lacks in:
    a. Prevention;
    b. Management of aggressive behaviour;
    c. Medical training;
    d. Safe client handling, and;
    e. Gerontology.
  • The current training model for students surrounding mental health issues is extremely poor.

• Comments on practical experience:
  • Nurses in British Columbia are entering their fields after graduation with little to no practical experience.
  • At present graduating nurses are not sufficiently trained to start working without some degree of supervision and on-the-job training due to high acuity and an over-generalized education.
  • Recent nursing graduates may be showing hesitation when administering morphine due to poor training.
• Practicum students are seen as a liability and too risky to take into practice by hospital staff.
• The heavy workloads borne by hospital staff are not conducive to the addition of training a practicum student.

Idea and Suggestions

Administrations and Management
Education Delivery Models
Credentials and Program Length
Training and Curriculum Content
Practical Experience

• Ideas about administration and management:
  • Regularly test education models to ensure the efficacy of practitioner training.
  • Hold educators accountable for their role in the effective training of British Columbia’s health professionals.
  • Accompanying any change in the education culture must be change in the culture of professionals. The two must co-relate any goals in order for them to be effective.
  • Create a flexible education system that dictates how personnel can be better utilized across a wider scope of practice, instead of a narrow and orthodox training regime.
  • Incorporate observations from medical best practices into the education system.
  • Make tapping into the Vancouver Island Health Authority’s training programs easier for First Nations peoples.
  • Create a network of social accountability for medical schools.
  • British Columbia possesses a great college infrastructure.
  • The control over learning competencies by professional colleges is positive.
  • Direct the development of education programs based on population needs. For example, a marked population increase in chronic disease or issues surrounding aging should be followed by corresponding curricular changes to include more education on chronic disease management and gerontology.
• **Ideas about education delivery models:**
  
  • Allow for more on-line and part-time training of professionals.
  
  • Pair on-line training with companion aide duty in order to gain bedside experience.
  
  • More in-home training for midwifery students.
  
  • Reduce the number of universities, colleges and other teaching institutions to enable a unified focus on the training needed for real-world practice.
  
  • Modify the nursing program to fit into smaller week-long or month-long modules to accommodate those living in remote communities.
  
  • Nurses should spend two years training in the classroom, followed by two or three years working in an applied hospital setting.
  
  • Run medical schools for-profit and without taxation support or provincial government subsidy.
  
  • There is a need for more privately operated medical schools.
  
  • Students possessing an undergraduate degree could work within a practice in a restricted manner while finishing their medical studies at night.
  
  • Accredit alternative and complementary medical approaches.
  
  • Create educational sessions for police, primary care givers and emergency workers surrounding proper care for those with mental health issues.
  
  • First Nations peoples must become engaged in the educational-policy making process.
  
  • The University of Northern British Columbia’s Medical Doctors’ program is a model program.
  
  • Other institutions could follow the curricular model for Aboriginal health set by the University of British Columbia.
  
  • The Northern Rural Project is achieving success in co-ordinating health education with healthcare.
  
  • Create two streams of professional degree programs for nurses: an active nursing program and a residency program with a stipulation for required practice in rural settings before moving on to cities.
  
  • Have nursing students choose a specialty by the end of their second year or the beginning of their third year so that the fourth year or during the last half of the fourth year, they could focus on the specialty training of their choice.
• Include a rural year of practice in a medical student’s training.

• **Ideas about credentials and program length:**
  
  • Introduce a laddering of education strategy that includes cross training and mentoring and allows students to work earlier such as:
    
    a. Six months training for a Registered Care Aide;
    b. One and half years training for a Licensed Practical Nurse;
    c. Two and a half to three years for a Registered Nurse;
    d. Four years for a bachelor of science in nursing; and,
    e. Five to six years to achieve a Nurse Practitioner’s level.

  • Introduce a three year hospital training program for Registered Nurses.
  
  • Restore the 28 month Registered Nurses diploma program.

  • Establish a Licensed Practical Nursing program that can be completed in two years.

  • Canada should emulate Britain’s model of a five year medical degree.

  • Do not sacrifice the quality of one’s education for faster degree programs.

  • Implement national standardized exams for graduating practitioners.

• **Ideas about training and curriculum content:**

  • Better training creates better staff, which takes the pressure off hospitals.

  • Ensure that general practitioners, especially those who practice in isolated rural communities, are trained in all birthing methods.

  • Implement flexible education policies to support culturally specific educational requirements within Aboriginal communities.

  • Simon Fraser University has a new undergraduate programme and graduate programmes training specialists in public and population health, global health and infectious disease control, and mental health.

  • Nursing schools must go back to training generalist nurses competent in surgery and obstetrics.

  • Western medicine requires the integration of traditional Aboriginal healing ceremonies.

  • General practitioners require more education around cancer treatment.

  • Implement more mental health education programs surrounding topics such as diagnosis, support and treatment options.
• Train family physicians in the more complex and specialized treatment methods required for senior care.

• Students need more content delivery in their training; for example, there is a lot of information taught to students on treating asthma, though very little on how to effectively communicate with the patient the reason for their treatment methods.

• Expand education on herbal medicines in allopathic training institutions.

• Home care support workers require a more comprehensive training curriculum.

• Provide specialized training for 24 hour, seven day a week triage and clinician roles.

• Establish a more appropriate training regime for palliative care workers.

• Allow for more preventative training for soon-to-be primary care physicians.

• Increase the amount of education on the role of health technology in modern care techniques.

• Create additional education for care aides, nurses and doctors around end-of-life care.

• Create a course on operating room practice similar to that which exists in Alberta.

• Include non-violent, crisis intervention training in the educational curriculum of medical students.

• A Medical Doctor’s training must include education surrounding proper nutrition and the benefit of organic foods.

• It is critical that the medical school curriculum include sufficient attention to health issues affecting the frail elderly.

• Skills such as critical thinking, problem solving, and ethics are important to producing a well-rounded, practical health professional.

• Mandate comprehensive education surrounding addiction and mental health.

• Universities must create more content focused on the social determinants of health in school curriculum.

• Primary health care providers require specific training in women’s physiology and its unique response to illness.

• Implement basic medical training classes within high schools.

• Standards for Registered Nurses and Care Aides working in geriatric and palliative nursing must be raised by including training around dementia.

• Triage nurses practicing in emergency rooms are well educated.
· Health care providers educated in Canada possess a high quality of medical training.
· Highly trained generalists are doing a great job in British Columbia.
· Integrate conflict resolution skills into the medical student’s curriculum.
· Allow for more compassionate care education when training palliative care workers.
· Train those planning on permanent practice in northern and rural British Columbia with multiple fields of practice.
· Medical students require an increased exposure to detoxification programs to better their knowledge about addiction and rehabilitation.
· Universities or medical schools should be offering content surrounding the health authority’s management structure.
· Make bedside experience part of a professional’s training.
· There is no single form of culturally appropriate care; therefore, physicians must be taught to adapt to the diverse needs of their patients.
· Professionals need generalist training to cope with an ever changing variety of health care demands.
· Include units similar to a Registered Nurse’s training on staff supervision in a Licensed Practical Nurse’s training.
· Include comprehensive emergency room training in the medical student’s education.
· Resources such as libraries are available to some health professionals.

- **Ideas about practical experience:**
  · There are teaching hospitals in British Columbia that are performing at an excellent level.
  · Medical professionals in training should spend a number of years working within a busy urban hospital.
  · Develop an apprenticeship system that rewards education and experience.
  · The unique strengths of University of Northern British Columbia and University of Victoria, and their related communities, enhance the learning experiences of the students. Students in both the Island Medical Program and the Northern Medical Program have the opportunity to spend time in small, rural and coastal communities such as Ladysmith, Port McNeill, Hazelton and Dawson Creek. These
hands-on experiences in rural practice will help to build the pool of physicians needed to deliver health care in all parts of British Columbia.

- Offer university or college credit to those who engage in community training programs.
- Increase the use of internships in British Columbia.
- To some extent, every hospital should be a teaching hospital.
- Re-invigorate the staff working in teaching hospitals.
- Qualify on-the-job training as university credit.
- Use primary care centres as platforms to educate a new generation of professionals.
- Create more opportunity for students to learn and train within the hospitals rather than within the classroom.
- Medical students should be required to volunteer their services in community care facilities.

**Continuing Education**

**Comments and Concerns**

- There is a lack of human resource development funding at both the federal and provincial level.
- The healthcare sector provides little training in administrative change management.
- Health professionals do not have the time to engage in ongoing education.
- A large number of nurses are required to seek out specialized education after graduation in order to continue practice.
- Some nurses who wish to upgrade their education are excluded from accessing public funds due to family income regulations.

**Ideas and Suggestions**

- Incorporate a culture of change that requires practitioners to undertake ongoing education which could also include an ongoing review of their capabilities.
- Encourage current nurses to upgrade to Nurse Practitioners and allow their existing practical experience be applied toward their degree.
• University courses for existing professionals should include education on more holistic treatment.
• Subsidize the expenses incurred by those who must travel to receive their education.
• Support ongoing education for caregivers, professionals and volunteers.
• Offer seniors’ care courses to all health professionals.
• Increase First Nations cultural awareness training, developed in conjunction with Elder and Youth councils, for health professionals.
• Develop consistent training programs for nurses that focus on mental health issues.
• Make leadership training available to any front-line health professionals.
• Further education that allows health practitioners to broaden their education and enhance their skills can be critical in retaining professional staff, particularly in a world where the competition for skilled talent is increasing.
• Ensure management is continually trained and up to date on health information and techniques.
• Continue to educate healthcare providers concerning healthy living initiatives, social determinants of health and preventative health strategies.
• Nurses need to engage in sensitivity training before treating patients diagnosed with chronic diseases.
• All practicing professionals need access to advanced, chronic disease education.
• Continuous education should be compulsory with strong incentives to study new methods of treatment.
• Offer cultural education delivered by First Nations teachers.
• Provide the opportunity for practicing health professionals to change fields.
• Ensure that mental health workers employed within First Nations communities are trained in traditional and spiritual methodology.
• Addictions counsellors need ongoing, updated training.
• Award bursaries or grants to paramedics wishing to further their education.
• Health professionals should adhere to a four day work week with one day reserved for training and education.
• To increase the overall efficiency of the system, health professionals should receive the necessary training to become experts within their scope of practice.
• Surgeons need enough guaranteed operating time to maintain and further develop their skills.
• Offer Licensed Practical Nurses a specialty course on operating room practices.
• Provide training opportunities for clinical office staff on new procedures and techniques.
• Our best health care research must be available to decision makers and front-line practitioners who deliver patient care.
• The most efficient practice conditions prevail when nurses are in the workplace providing care for 80 percent of their working hours, while spending the other 20 percent on professional development and mentoring.

**Tuition Costs and Training Fees**

**Comments and Concerns**

• The high cost of university tuition is eliminating many working class students from a prospective career in health care.
• Students are being driven into poverty by increasing educational costs.
• The high cost of education and the resulting debt cause many graduating students to leave the healthcare field entirely.
• In order to attend training to become a paramedic or ambulance attendant, people must take unpaid leave from work, placing them in a financially compromising situation, sometimes deterring them altogether from entering into study.
• Too many subsidized and publicly trained professionals are leaving to find employment in other provinces and countries.
• The provincial government must investigate the discrepancies in training costs across British Columbia.
• The British Columbia loan forgiveness program should include students in specialty areas and facilities rather than to just those who work in geographic locations that qualify as under-served. A recent graduate may have $21,000 in student loan debt and the operating room in their town seriously may be understaffed, but since that area is not classified as under-served no forgiveness of the student’s loan will occur.
• The high cost of education is forcing some health professionals to become very financially driven and aggressive regarding remuneration for their services.
Ideas and Suggestions

- Fully subsidize a medical student’s education.
- Those professionals who choose to leave British Columbia upon graduation should repay the subsidized portion of their education.
- Increase medical study tuition.
- Other countries fund post-secondary education based on the belief that graduates go on to become positive, supportive and contributing members of society.
- Reduce tuition and training fees for those enrolled in medical studies.
- The health authorities should be directly responsible for providing financial and other assistance for students.
- The high public cost of educating health professionals demands that British Columbia develop better strategies for keeping those professionals within the health care system.
- Forgive the student loans of those students who finish their medical school residency.
- Doctors who have received subsidized training should have to work a term of between one and fifteen years in the public system or face repayment of all subsidized monies.
- The provincial government should subsidize seats in private colleges for students.
- Create a student loan forgiveness program that is reliant upon graduates spending a number of years working in rural communities.
- Their must be more financial assistance available to Aboriginal medical students.
- Guarantee funding for new graduate Registered Nurses and undergraduate nursing programs.
- Student loan forgiveness should be offered to those in specific fields and practices that are in need of additional human resources.
- Offer a reduced salary to practitioners if they choose to receive fully subsidized education.
- The cost to train more nurses would pay for itself in the long-term.
- Offer subsidy or bursaries to those interested in gerontology training.
- The on-line application process for medical studies should include a receipt of application along with follow-up by recruitment personnel.
Credentials and Licensing

Comments and Concerns

- The over-credentialing of health professionals is becoming more prevalent, forcing health professionals into lengthy but unnecessary graduate studies.

- Ramping up the credential requirements for practice in British Columbia will not address health human resource issues; rather they will only continue to exacerbate them.

- There is a lack of inter-provincial recognition and standardization of professional licensing requirements.

- Health care practitioners are over-educated and under-skilled; for example, nurse managers require a master's degree, but this does not guarantee they have good leadership skills.

- The British Columbia Medical Association is restricting the level of education that physicians may receive.

- There is no requirement for re-assessment once a practitioner has left university.

- A two year and a four year program for Licensed Practical Nursing both contain the same content; however, one requires a greater amount of dedicated time and money.

- The training required for home care workers is of low quality.

- The Registered Nurses Association of British Columbia needs to change its requirement regarding the Bachelor of Science in Nursing for registered nurses.

- Make it mandatory for nursing program instructors to have a Master of Science in nursing degree.

- Physiotherapists require a master’s degree to practice.

- Registered Care Aides lack a dedicated regulatory body, which is leading to an inadequate level of training.

- Fewer physicians are emerging from residency programs following the Federation of Medical Licensing College’s decision to extend physician training and abolish rotating internships. This decision will force many students into sub-specialty areas rather than assuming a wider scope of training.

- The British Columbia College of Family Physicians should not hold the authority to audit their members; an independent body free from internal interests should accomplish this.
• The College of Registered Nurses and the British Columbia Medical Association are holding up nurse’s licensing.

**Ideas and Suggestions**

• Increase professional education across all fields and broaden credentials.

• Nationally standardize the credentials necessary for a medical doctorate; health could use the Red Seal program that governs trades-people as a national model.

• Implement an international accreditation standard for health licensing.

• Review the College of Nurse’s guidelines and professional standards.

• Implement realistic degree and certification requirements.

• Look to other jurisdictions for ways to improve the licensing process.

• The College of Physicians and Surgeons of British Columbia should not be responsible for the accreditation of doctors.

• Each province needs an impartial Board, made up of representatives from all professions, which adjudicates the credentials of all professionals.

• Merge the three colleges of nursing into one single, self-regulating, professional body.

• Create a provincial government office that would be responsible for evaluating the qualifications of practicing family physicians. This body would also be responsible for providing malpractice insurance to practitioners.

• Eliminate the need for credential and allow those who successfully complete their education to practice freely within their field.

• Accredit proficient foreign educational institutions instead of having to accredit individual persons upon arrival in Canada.

• Mandate a pilot project that regularly assesses the capabilities of health care practitioners; it would operate independent of the various regulatory bodies of colleges.

• Implement regular evaluation methods for doctors, dentists and nurses sent to remote communities for practice.

• Health care administrators need more health oriented training.

• Investigate the waiving of certain credentials or certificates for some professions.

• Offer community health representatives credit in the Prior Learning and Assessment Recognition Plan (PLAR) for their time spent working in the field.
• Offer restricted licenses to practice in some fields, such as family practice, where obstetrics certification and certain other qualifications may not be required.

• Care aides and support workers in rural areas can easily upgrade to Licensed Practical Nurses.

• The provincial government should subsidize nurses’ licensing fees.

• Should a candidate fail the initial adjudication process, he or she should be informed of their deficits and sent to a competent counsellor who would assist in addressing these deficits for success with future testing.