Thank you for the opportunity to contribute to the dialogue.

The following comments are a response to and supplement to the document prepared for the HHR Focused Workshop of June, 2007.

The Current Realities

Family physicians are the backbone of the health care system, along with nurses, and are far and away the most used medical resource for the entire population. As with other disciplines, we have a number of important changes in the family physician workforce.

- It is aging
- The younger workforce
  - Do not establish new practices as historically has been the case
  - Prefers other payment approaches than the traditional and currently predominant FFS payment system
  - Is moving to be predominately female rather than male
  - Sees fewer patients daily, especially so for women
- Mid career family physicians are leaving practice
- Medical students are not choosing Family Medicine as their postgraduate (PG) choice
- Many family physicians are moving into more limited practice fields. This is important as family physicians might be considered the ‘stem cells’ of the medical system – with a broad clinical education, they can respond to needs for skilled service in many important areas: Emergency Medicine, GP Anesthesia, GP Obstetrics, Hospitalists, Sports Medicine, regional cancer care, Palliative Care, GP Geriatrics/ Residential Care, etc. While adding additional services, this also reduces the capacity for comprehensive generalist care.

With limited new graduates, all of these reduce the numbers available to serve the primary health care needs of British Columbians. Other important considerations are:

- Recognition that increasing family physicians in a society extends the populations longevity and reduces overall health costs and improves the equity of healthcare
- Recognition of the need to increase the focus on Chronic Disease Management (CDM)
- Recognition of the need to address preventive health issues more comprehensively
- Recognition that today, many British Columbians do not have a family physician (estimated at ~15% or more)
- Recognition of the aging population, which has an established need for more primary care

Some suggestions to respond to these realities and some responses to the comments/ recommendations in the HHR Workshop document follow.
Recruitment and Retention

- Rural recruitment to Medicine is less than from urban areas. The education system needs to respond to provide greater emphasis on completion of high school, a focus on science-based education, an orientation to University education, and the capabilities of local students to achieve professional levels of education. A component of this could be greater mentoring from local professionals and visitations from former residents of rural communities who have achieved such educational and professional goals
- Evidence has long confirmed that rurally raised students are more likely to return to serve rural communities; they are also more likely to choose a generalist discipline such as Family Medicine
- Evidence is accumulating that the high tuitions in professional faculties are reducing the participation of children from middle and lower income families; students from high income families are less likely to choose generalist disciplines
- The significantly reduced lifetime income of family physicians in comparison to most specialty disciplines contributes to reduced choice of Family Medicine as the preferred postgraduate program
- The recommendation for an educational program with built in funding and elements of ‘return of service’ is not new. Experience with such programs can be reviewed to identify successful features and guide planning
- Emphasizing other remuneration systems will align with the preferences of new FP graduates
- Progressive alignment of family practice incomes with that of other specialists will provide recognition that the discipline is valued by society and redress the current significant economic disincentive to choosing a career in Family Medicine
- Specific support for the development of group practices, incorporating a range of other professionals within well organized collaborative, integrated systems of primary health care will meet many objectives. In this context it is the sort of setting young professionals are keen to join. It is also the ‘right way’ to deliver effective care, a not inconsiderable consideration for young graduates, though is also supports flexibility in practice for young families – male and female physicians, and career and lifestyle flexibility

Education and Continuing Professional Development

Medicine is a knowledge-based discipline, now more than ever in history, and knowledge is expanding rapidly, along with the potential tools and resources to bring that knowledge to bear on supporting the healthcare of British Columbians. Education and professional development, formal and informal, never ends. Earlier we noted some of the ways in which family physicians extend their skills, knowledge and service in specific domains.

- The need to acknowledge, and to act accordingly, that education is a continuum from at least high school, through university and on into professional programs was noted above
The barriers and distortions of financial considerations when students plan for their education was also noted – in choosing a university education, in deciding whether they can afford a postgraduate program, and which one, and in selecting which specialty to enter.

A barrier to the choice of specialty for some graduates is the limitation on the ability to train further in another specialty. Many Royal College specialists regret that, unlike in the past, family physicians have very limited opportunity to return to train in a Royal College discipline. Many senior physicians have expressed the value to the system of experienced family physician bring to their new disciplines. Younger physicians who are uncertain at their ability to cope with the complexity of Family Medicine practice opt for the safety of a more defined field.

Forty years of expert reports have supported the value of collaborative, interprofessional delivery of primary care services, with recent reports including Romanow, Kirby and Fyke. Recent research and practice innovation with a focus on quality outcomes have reconfirmed this in practice, and emphasise a new set of skills in organisation and communication required to develop and sustain a focus on quality outcomes across the broad range of primary care components. While BC is beginning to recognise this evolution, there are very few opportunities for trainees in the various disciplines to learn, or join together in learning these new skills.

Good progress is being made in developing Undergraduate (UG) and Postgraduate educational opportunities in Medicine and Family Medicine across the province. Unfortunately while education is valued, teaching in healthcare is not. The growth of these programs and the requisite clinical education is funded at a most meager level and, for example, for Nurse Practitioners, not at all! This needs to be addressed.

Despite the immense development in knowledge of biology, physiology, pathology, pharmacology, etc, as well as the operational needs and skills for effective delivery, the province betrays minimal ‘value’ in professional continuing development. The choice to and the cost of continuing education is predominately left to individual discretion – with consequent wide variation; focused support is needed.

**Regulation and Scope of Practice**

Flexner’s report of 1910 led to the development of a highly and much more consistently educated profession, with a basis in science (i.e. evidence). Some of the suggestions in the working paper would take us away from this legacy, the root of the development of today’s dramatic capabilities.

- The issue of International Medical Graduates (IMG’s) needs review. It begins with national immigration approaches – what is being ‘sold’/ told to potential immigrants? Those specifically selected for their potential contribution should be offered appropriate assessment opportunities, leading to additional educational experiences appropriate to individual needs, leading to comparable examinations and licensing to Canadian graduates. The current program, which has seen some modest expansion, should be further developed.

- As with Canadian UG and PG programs, IMG’s should (and do) learn in teaching practices, under supervision appropriate to their level of expertise. As noted before, this is time intensive work and the preceptors need to be remunerated as professional educators.
• As noted above, the goal for Primary Care should be group, collaborative, interprofessional services. The capabilities and education of the professional groups inevitably and appropriately overlap. Efficiency warrants that each should practice at the upper band of their skills and knowledge, which itself should be constantly developed. Effective teams will review the nature of their population, assess the capacities and experiences of the disciplines on their team and plan an efficient and flexible response that meets the health and service needs. Licensing and legislation, as well as legal approaches should support such an approach.

• Non-evidence based practitioners should be encouraged to demonstrate with comparable rigor the additional value of their services. In a time of great pressure on the health care system, hope and assertions cannot warrant a claim on the limited provincial budget. Similarly, prescription and referral from those not trained in an evidence-based and scientific manner would increase inefficiency and waste.

**Health Human Resources Planning**

Most of the suggestions in the document are quite relevant.

• ‘Certificate’ programs suggest themselves as routes to evaluable skill development and acknowledgement, whether it be for RN’s developing skills for Diabetes care or COPD care, or Home Care or family members developing skills to support patients with Dementia or physical disabilities.

• Just as we now provide funding support for ‘Independent Living’ and for Home Care services, with suitable assessment, and perhaps training (as preceding), family members or even neighbours might be ‘paid’ for care services.

• Programs for ‘stress’ etc need to be appropriately assessed for actual value. Better attention to adequate staffing, adequate resources and scope of control over work, appropriate recognition, including pay all suggest themselves as more fundamental and evidence-based supports for workers.

• Increasing engagement of the population in supporting their own health, using supportive, non-punitive approaches should be a focus. In this domain, newer information technologies provide very interesting opportunities, with the potential to require less staff for some tasks. Evidence is showing:
  
  o Patients will welcome and use a practice internet portal to make appointments, to access their health record, to contribute to their health record and to access health information tailored to their health conditions.
  
  o Patients can complete pre-visit assessments, identifying areas not commonly assessed (for example, functional deficits), and focusing the visit.
  
  o Patients welcome the opportunity to address many health issues over the phone, a very efficient and more traditional approach, but one not often funded, and eagerly adopt Email correspondence. As with much office-based care, much of this can be provided with other health professionals, such as nurses. The Nurse Healthline is a good, but
underutilized example. Unfortunately, it is not linked to the patients main record which would deepen its capabilities and improve its safety and potential effectiveness.

- Tele-health is being explored and offers the potential for efficiency and even improved effectiveness in some examples
- Self-management is being explored and showing some strong evidence of effectiveness in some areas. Early examples are in Mental Health such as Depression and Anxiety
- The BC College of Family Physicians Self-Management program is helping family physicians learn how to engage patients in beginning the difficult process of making changes in core living choices in support of improved health

Conclusions

The BC College of Family Physicians welcomes the opportunity to review some of the suggestions made to the Conversation on Health and to contribute our own views. In the preceding, not all observations have been made as direct suggestions; rather, the direction for action is implied in the commentary and is intended as such.

Our health system has and does serve us well. Nonetheless, as knowledge expands (including management approaches) and society evolves (particularly the development of Information Technologies) there is a need for healthcare and healthcare disciplines to move from a gradual evolution to major transformations to align with these changes. It is not a time to be timid; a strong commitment to meaningful and effective change is required.

The BC College of Family Physicians looks forward to being a partner with the Ministry, Health Authorities, educational and licensing bodies and other professional disciplines in further developing a robust, efficient, effective, equitable, engaged health system.

Thank you.