CFMS/FEMC POSITION PAPER

Physician Supply and Non-Physician Clinicians in a Changing Canadian Health Care System: Adjusting to the New Reality

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BACKGROUND

A decrease in physician supply, coupled with increased demands on the health care system has left many stakeholders scrambling to find a solution for providing seamless medical care in the face of growing gaps. As medical students we must remain accountable to the health care system of the future by continuing to push for long term solutions in place of short-term fixes. We must also recognize that the face of healthcare is changing, and our role in the medical community is shifting from autonomous practitioners to key members of the "interdisciplinary team". Physicians of the future will have to be more responsive to patient demands for alternative health care provision and so must expand our training and skills to embrace a wide range of health care options. Above all, we must strive to ensure the uniform high quality of health care delivery is preserved.

Physician Supply Diminishing

Extensive evidence supports the claim that the physician supply in Canada is diminishing. The physician supply has fluctuated over the past 10 years, with a significant physician shortage rooted in legislation to decrease postgraduate training positions and undergraduate enrollment in the early 1990s. However, the long term effects of these decisions are only now being felt, as the number of physicians begins to decrease while at the same time the demand for healthcare is increasing. Reasons for this are many fold, but the biggest contribution is thought to be the cohort of physicians set to retire by 2011, which may lead to a change in the physician to population ratio from 550:1 in 1998 to 737:1 in 2021 (a 34% increase) (CMA internal data). Furthermore, the demographics of the physician population is changing; the number of MD's aged 55 + will go from 21% in 1998 to 46.8% in 2021. (CMA internal data). As well, there is evidence to suggest that the current physician resources are being taxed more heavily than before: the mean hours/week worked by physicians has increased from 46.9 hours in 1993 to 53.3 hours in 1998 (CMA Physician Resource Questionnaire survey).

The CMA and other partner organizations have been working to determine the extent to which this will effect health care delivery and craft solutions to avoid any interruption in quality health care delivery. There are three avenues for approaching the issue: increasing enrollment at the undergraduate level, increasing licensure of International Medical Graduates, and finally developing redistribution models to shift some of physicians current workload to other health care providers or allowing for reentry and retraining of current MD's. Each of these streams have their own associated challenges, and are being addressed investigated by the CMF and the various Career Flexibility Conferences hosted in the past few years. While all three possibilities have important

effects on medical students, the purpose of this document is to discuss the impact of other health care providers from the perspective of medical trainees.

Non-Physician Clinicians (NPCs)

Dr. Richard Cooper, in his trilogy of submissions to JAMA (September 1998) defined the cohort of non-physician clinicians as 10 disciplines: nurse practitioners, physician assistants, nurse-midwives, chiropractors, acupuncturists, naturopaths, optometrists, podiatrists, nurse anesthetists and clinical nurse specialists. He goes on to group these disciplines into three cohorts; traditional services (nurse practitioners, nurse midwives and physician assistants), alternative disciplines (naturopaths, chiropractors and acupuncturists), and specialty disciplines (optometrists, podiatrists, certified nurse anesthetists and clinical nurse specialists). While largely determined by individual governments, increases in legislation and regulation surrounding these health care roles will likely increase their autonomy and clinical prerogatives, suggesting that these roles will continue to increase in the health care system of the future.

Beyond assuring that the quality and uniformity of health care delivery is never compromised, what is the role for future physicians in shaping this new system?

Medical Students Role

The interest in complementary medicine and its role in the current traditional health care paradigm is reflected in the inclusion of complementary topics in medical school curricula today (CFMS survey, 2003). As well, it is widely held that patients are creating a role for complementary disciplines now, more than ever before. Dealing with this new reality will become a vital aspect of our role in the future.

As future physicians, we should embrace appropriately trained and accountable complementary health care providers as members of the interdisciplinary team, who are able to contribute and augment the current system by bringing complementary treatments and services to the table and provide patients with a truly holistic approach to health care. This should involve the disciplines discussed above, in addition to occupational therapists, respiratory therapists, nutritionists, physical therapists and other augmentative disciplines. Knowledge and understanding of the toolkits that each of these providers hold, if instilled in the medical curricula, will ensure that their participation in health care scenario will serve only to enhance the care process. Cohesive team work will result in a renewed system that is responsive to the changing demands of patients and the communities in which they live.

These augmentative and complementary disciplines, although expanding with new regulation and autonomy, should not be seen as a solution to a physician shortage. As medical students and future physicians, we should seek alternative solutions to the challenge of a diminishing physician supply, in recognition of the unique role of physicians in medical practice. The understanding of a team is that each member brings individual skills and tools to the table - this presupposes that one or many members

cannot replace another, regardless of the external pressures imposed on the system. As physicians, we have a duty to ensure a constant, uniform and adequate supply of physician mediated care, and thus encourage the movement of the CMF and their constituents to develop a new model to fulfill these needs. Our contribution will be to participate in the ongoing discussion of the six solutions set out by the CMF, and to work toward employing solutions to ensure adequate physician supply.

Overlapping Roles

The one final issue to address in the realm of the NPC role in the health care system is that of overlapping roles. The current market pressure and the availability of NPC supply makes some of the more traditional disciplines very attractive to medical administrators in areas where expertise may overlap. In the new model of a rostered, HMO-type system, the temptation is to involve NPC's, especially nurse practitioners (NPs), in primary care where their duties involve mostly well-person, preventative visits. This gives NP's a berth on the primary care team, as well as alleviating some of the demands on the physician. In a fee for service environment, this temptation is even greater, given the tremendous time restraints facing doctors today, and the usually large fee differential between services provided by NPC's and MD's. However, it has been shown that this simple licensed general care encompasses more than 50% of the care provided by primary care physicians (JAMA, Sept 1998), and many experts in the field of preventative medicine will attest to its grave importance in long term reduction of morbidity and mortality of most well patient populations. Physicians cannot turn their backs on this aspect of health care.

In these areas, there will never be clear cut answers, other than to advocate for a communicating, functional interdisciplinary team that is responsive to both the needs of the patients, and the resources and toolkits of the providers that comprise it. On the same token, it is our hope as physicians of the future, that the current strains in the health care system of today never force the hand of decision makers, thus diminishing the role the physician is able to take in patient care, simply because of a lack of physicians to assume that role. We hope that these resource issues do not become the sole determinant of our working environment in the future. Amelioration of the physician shortage we are currently facing will result in an environment that is suitable for such role defining decisions to be made. It is not until after the physician shortage challenge is solved that the entire interdisciplinary team will be able to work out the roles each member must take; decisions taken before that time may not be permanent, as they will fluctuate with the entry of new physicians into the system, and lead to either an over-supply of NCP's or physicians in the future. Division of labour should ideally not become a question of displacement vs. supplementation, as Dr. Cooper succinctly labels it, but rather, as an "abundance theory" would dictate - a synergist process where the strengths of each team member is showcased. This ensures that the defined roles are a product of contributive capacity, and not lack of resources - in fact, it will hopefully ensure that the uniformity and quality of health care delivery in Canada is never compromised, and remains constant.

Conclusions

As medical students and future physicians, we embrace the many members of the interdisciplinary team that will form the health care system of the future. We encourage their training and professional development with the aim to assume roles in patient care. However, we do not see these providers as answers to the problem of a diminishing physician supply. We believe that our challenges in the future will be to create a system where the physician demand is met adequately, and where professional definition of roles for every member of the health care team is constantly evolving and responsive to both patient demands and contributive capacity of each discipline. Ultimately, we strive to ensure that the quality of health care delivery in Canada remains as high as it has always been.

RECOMMENDATIONS

To support medical students in navigating models of interdisciplinary care, the CFMS/ FEMC recommends the following:

- Medical School Curricula continue to reflect the importance of the interdisciplinary team by encouraging education of the various roles that each discipline plays;
- Various stakeholders within the medical communities continue to promote a flexible and accessible medical education system, at the undergraduate and postgraduate level.

First Drafted

2003 Tara Mastracci (University of Ottawa)

Updated

2010 Cait Champion (University of Toronto, 2012) Tyler Johnston (McMaster University, 2010)