

The Canadian Perspective

How can generalism and practice flexibility be supported and encouraged?

For many years discussion about access to health care in Canada has focused on the belief that increasing the number of generalist physicians will improve access. While it is clear that the shortage of family physicians is a significant issue (in 2004, more than 4 million Canadians did not have a family doctor) which has an impact on wait times for medical care and satisfaction with the health care system, a broader discussion of the challenges in this area is hampered by the lack of consensus of what in fact is meant by generalism in medicine. This in turn hinders human resource planning, and leaves medical education systems and teachers free to define and teach generalism as they see fit. Not every family doctor is a generalist, nor is every specialist lacking in generalism. In psychiatry, the term general psychiatry is used for everything that is not a recognized subspecialty, and yet many general psychiatrists have very narrow practice profiles and expertise.

In 2012 the Canadian Institute of Health Research funded a project to develop a consensus on the nature and role of generalism in medicine and report on the implications. The report is in preparation for publication at this time but the task force recommended that generalism be defined as “a philosophy of care that is distinguished by a commitment to the breadth of practice within each discipline and collaboration with the larger health care team in order to respond to patient and community needs...generalists are a specific set of physicians and surgeons with core abilities characterized by a broad-based practice. Generalists diagnose and manage clinical problems that are diverse, undifferentiated, and often complex. Generalists also have an essential role in coordinating patient care and advocating for patients.” This then has implications in residency training where the need to teach and model the values of generalism are important for all physicians and surgeons, while planning for the correct mix of generalists and specialists involves not only planning but ensuring access within medical education to generalist role models and training settings that are consistent with generalist care. Using the example again of psychiatry, the “general psychiatry” experience needs then to occur in a setting that best reflects generalist psychiatry practice, not necessarily a general psychiatry unit in a tertiary academic hospital.

In Canada, from 1992 to 2003 there was a significant decline in medical students choosing family medicine as their first choice of specialty for residency – declining from a high of 44% in 1992 to a low of 25% in 2003. As a result medical schools and governments, aided by work by the Canadian College of Family Physicians embarked on a variety of strategies to enhance recruitment and interest in family medicine, looking at factors including exposure to family physicians in medical school, educating medical students about family medicine, and improving the profile of family medicine in public and in academic medicine, financial incentives for practice, and expanding the proportion of residencies in family medicine. In 2012, the percentage of medical students selecting family medicine as first choice had risen to 35%. At the same time the percentage of residency positions filled in the national match in family medicine rose from 37% in 2007 to 43% in 2012, with unfilled positions in family medicine dropping from 11.4% of positions in 2007 to less than 3% in 2012. At the same time within family medicine training programs there has been a long standing focus on the philosophy of generalism and comprehensive care within family medicine.

Specialty medicine in Canada has also struggled with finding the right mix and attracting people to generalist specialties. Within Internal Medicine there is a widely reported shortage of General Internists, but here too planning has been a challenge as it is difficult to know who truly is practicing

GIM – most of the stats have traditionally looked at who doesn't have another subspecialty and assumed those are the ones practicing GIM. Using these planning assumptions, flawed as they may be, there has been a definite decline in number of General Internists versus "other" subspecialties in IM up to at least 2005. In 2005 when Canadian Society of Internal Medicine reported this decline and noted that the number of General Internists over 55 was 43.3 %. In 2010 however, after years of work and debate, the Royal College recognized General Internal Medicine as a subspecialty of medicine, which has resulted in renewed interest in the field some programs now unable to take in the number of residents that desired to do General Internal medicine for the upcoming (2014) year. Of interest given the discussion of what is generalism, the Objectives of Training in GIM for the Royal College note that "GIM is a subspecialty of Internal Medicine which embraces the values of generalism, is aligned with population needs, and promote's the practitioner's ability to adapt their practice profile when population needs change...General Internists provide comprehensive care of the adult patient in an integrated fashion as opposed to an organ-centred or disease-centred approach." One wonders how much this greater clarity in defining the role of the generalist has helped raise the profile of this field.

In Pediatrics, issues of definition also plague planning, as the amount of general pediatrics practiced by subspecialists in pediatrics is not clear. Experts in the field note though that there is a trend away from pediatricians providing general office pediatrics as a part of their practice in general, raising concern about the increased demand on family physicians to provide primary pediatric care. A recent survey of residents who completed their core pediatric training in Canada between 2004-2010 showed that 37% were working as general pediatricians, of whom about 2/3 were community based. The Chairs of Pediatrics in Canada have recently circulated to residents results of a survey on vacancies in academic pediatric positions and compared that to residents in training to identify mismatches between need and current training.

In the surgical specialties, there has been an expanding trend for residents to seek out fellowships after their residency, with about 85% of general surgical residents doing additional training after residency in Ontario in recent years. This is driven by many issues including a desire to further develop skills that may not be fully developed in residency, but also is being driven by the current job market for surgeons where competition for jobs has become a significant issue, requiring more and more things on the resume to be attractive to potential hospital employers, which often translates into more specialized skills, rather than the generalist competencies that may be needed.

What patterns, policies, and initiatives are being experienced by each country to promote higher quality and specialized care while balancing the need to meet the range of services required by their populations when and where they need them?

Initiatives in Canada to promote higher quality care and to meet the need for the population can be divided into 4 areas: (1) expansion of the physician supply, (2) expansion of the number of family physicians relative to specialists, (3) addressing issues related to physician distribution, and (4) clarifying the need for specialization when it has an impact on outcome.

In the mid 1990's Canada followed a policy of shrinking medical school sizes and restricting entry of internationally trained physicians with a view towards controlling health care costs. The result of this was that the physician work force aged and shortages became more obvious. Since 2000, Canada has increased the undergraduate class size of medical schools in Canada by 60% and added a new school. With this expansion though there has also been attention to issues related to the distribution of physicians in Canada, which has traditionally experienced significant shortages in rural, small urban and

northern parts of the country, and the mix of specialists and family physicians that are produced by Canadian medical schools. Thus the new school is the Northern Ontario School of Medicine, based in several communities in northern Ontario with a clear mission and curriculum supporting northern and rural medicine. In addition, 11 new regional campuses have been developed, with 4 of those serving northern underserved areas. Students graduating from these programs so far preferentially select family medicine training programs over specialty programs, often in regional or rural programs. As noted above, other policies to attract students into family medicine have recently seen an expanded interest in this field.

Along with the expansion of medical school size there has been the development of programs in many provinces to facilitate entry into postgraduate training for graduates of non-Canadian schools, with programs to support transition, assess training and facilitate entry into appropriate levels of training.

The general expansion of physicians in training has had variable impact on regions of short supply. Physicians who depend on expensive hospital facilities to work, such as surgeons and other procedural disciplines, anesthesiologists, and radiologists, have found an increasingly competitive job environment, and so regions that have had trouble recruiting in these areas, find it easier. Other specialties that do not require the same level of hospital based services have been less affected. Psychiatry has traditionally struggled with distribution issues, based on the ability with a one party government funded system to work very independently of hospitals or health organizations. A recent study in the health authority where I work found that over the last 20 years, less than 3% of the graduates of the provincial university's psychiatry program came to the Interior Health Authority to work, even though we have 17% of the provincial population and very desirable communities. It is clear that addressing distribution is specialty dependent with some requiring not only expansion of training, but careful review of where and how that training is provided.

Canada's geography means that the population outside of the large urban centres is quite distributed with smaller urban areas often quite a distance from large urban tertiary care centres. The balance between generalist skills for specialists and sub-specialization thus requires careful review to determine when the balance between the benefits of providing care as close to the patient as possible are outweighed by the benefits from high volume sub-specialized providers. Thus the degree to which a hub and spoke model of care vs. a distributed model of care is under examination in different specialties and will have an impact on training.

Why and where is greater specialization of the health workforce needed? What factors impede needed specialization?

This is alluded to above and the answer is not clear at this time. The Royal College has been careful about pressures to expand the number of sub-specialties in Canada out of concern for the impact on fragmentation of the workforce. Recently it has developed a program that recognizes areas of special competence where there may be a need to acknowledge unique skills but where the need for full sub-specialty status is not established. In any review of new sub-specialties or these new areas of special competence, the process involves a stakeholder review including medical schools, specialty associations, government, and medical licensing bodies.

The Royal College has recently recognized sub-specialties in psychiatry in the area of Child and Adolescent Psychiatry, Geriatric Psychiatry, and Forensic Psychiatry where previously specialization was determined by use of qualifications from other countries, or Academies of the national specialty

association that set standards through membership. This is in response to a clear recognition of need in these areas for specialized skills. In the surgical specialties concern has been raised about ever-lengthening training and whether sub-specialty training should start sooner, cutting out on generalist specialty skills, but that raises concerns about early career choice for students and a loss of generalist skills that may be necessary in smaller centres.

A barrier at this time to further expansion of sub-specialty training is funding for residency positions which is generally capped at the university level, so any expansion of training length that arises as a result of specialization can result in a loss of positions as previously informally funded fellowships must now be provided through residency which requires the block funding provided by government. At this point we are predicting a serious contraction in training in geriatric psychiatry and child and adolescent psychiatry in Canada as a result of the shift in funding mechanisms and loss of training positions.

Canada has benefitted for years from a highly regulated system of graduate medical education that ensures a consistency of standard across the country, but at the same time relies on full time, entry training (residency or fellowship) for sub-specialization and development of added competencies. Other fields have recognized that skill development can be required across the life span of a person, and thus distance based, part time education for further professional development is the norm in many fields. In medicine though, outside of medical education, we have not developed a part time, distance based approach to developing sub-specialized or advance skills, restricting the ability of the physician work force, especially outside of academic centres, to respond to new population needs or skills development.

What are the incentives to produce health care providers that deliver a wide range of services and/or provide services across multiple settings?

The centralized, university based system of graduate medical education in Canada allows for planning with government to respond to health care needs, and has enabled some of the changes discussed above. The Association of Faculties of Medicine of Canada has recently produced a report "The Future of Medical Education in Canada" that identifies several key themes that the medical schools in Canada will be addressing in the next decade. These include a desire to ensure the right mix, distribution, and number of physicians, and cultivate social accountability through experience in diverse learning and work environments. The Royal College in turn is about to publish a series of white papers on the topics in this report that will add further recommendations.

The challenge that persists is to ensure that physicians who begin practice with such accountabilities continue to be able to provide a wide range of services within their scope of practice which also requires attention to payment systems. While the predominant funding system for physicians in Canada is a fee for service system that funds unique acts by physicians, alternate payment plans and systems are being developed to better pay for the care of people with chronic illness and complex conditions.