PROFESSIONAL ASSOCIATION OF RESIDENTS OF BRITISH COLUMBIA

the future face of medicine

Submission for Health Care Sustainability to the Standing Committee on Health

Prepared by the Professional Association of Residents of British Columbia

Summary of Recommendations

Question 1: Rural health care services

- Increasing efforts to recruit medical students with rural backgrounds and strengthening training and support for rural community medical preceptors to ensure learners have positive learning experiences in these settings;
- Increasing the number of rural residency positions and increasing rural residency experiences for specialist physicians;
- Continuing to provide financial incentives such as hardship allowances, housing grants and paid vacations to physicians working in rural areas;
- Maintaining rural health infrastructure: for example, supporting electronic medical record technology and maintaining rural hospitals.

Question 2: Inter-disciplinary teams in primary and community care

- Developing of a streamlined primary care infrastructure, in the form of community group practices which include general practitioners, nurses, social workers, dieticians, physiotherapists, pharmacists and other allied health care workers;
- Expanding inter-disciplinary clinics specifically designed to treat common chronic conditions, such as diabetes, COPD and asthma;

Question 3: Improving end-of-life care

- Ongoing and expanding access to training in palliative care for physicians caring for patients with palliative disease;
- Supporting research in palliative care in the British Columbian medical landscape;
- Emphasising continuity of care and resources as patients with chronic diseases near end-of-life;
- Supporting family and specialist physicians that engage in advanced care planning in non-crisis situations and care for patients with palliative disease.

Question 4: Enhancing addiction recovery programs

- Encouraging the growth and development of addictions research capacity and in turn making efforts to implement evidence-based policies to improve addictions treatment (including, but not limited to, an emphasis on harm reduction);
- Promoting education in addictions medicine through mechanisms such as trainee scholarships and research grants and supporting the development of advanced training opportunities such as the St. Paul's Hospital Goldcorp Addiction Medicine Fellowship;
- Supporting public education and promoting awareness campaigns aimed at the de-stigmatization of addictions.

Recommendations

Question 1: How can we improve health and health care services in rural British Columbia? In particular, what long-term solutions can address the challenges of recruitment and retention of health care professionals in rural British Columbia?

What do a 58 year old diabetic, 21 year old healthy female and 12 month old infant have in common? They exemplify patients who routinely present to rural emergency departments with medical issues that could be addressed in a family physician's office. These patients live in rural British Columbia and because of the shortages of rural family physicians, their only option to have medications refilled or immunizations administered is to be seen at a local emergency department (ED). After they leave, there are often few options for follow-up, which can incur repeat visits to the ED.

Although the above scenario is fictional, it is representative of some of the problems that arise in rural settings as a result of physician shortages. The Canadian rural physician shortage and the inequity of distribution of family and specialist physicians has been well documented (6, 12). While more than 18% of the population resides in rural areas, only 8.5% of Canadian physicians practice rurally (6). Appropriate access to family and specialist physicians is an ongoing challenge for people in rural communities (12).

A large Ontario study found that patients with chronic illnesses who did not have a family physician were significantly more likely to visit an ED, translating into an estimated 17,741 excess visits over a two year period. They were also significantly more likely to be admitted to hospital (7). Unnecessary visits to the ED result in increased costs to the health care system and on average cost five times more than a visit to a family doctor (5). Improving health and health care services in rural communities would allow for more effective health care delivery for rural British Columbians as well as cost savings that could strengthen other health programs.

The most effective way of increasing the number of rural physicians is to recruit and train medical students from rural backgrounds (17). Research has consistently shown that growing up in a rural area, planning to practice rurally and planning to practice family medicine at the start of medical school are strong predictors of later practice in rural communities (2, 13). The Province of British Columbia and the University of British Columbia have taken a number of steps to improve the rural physician supply: increasing the number of individuals admitted to medical school from rural backgrounds, establishing distributed training programs around the Province in Prince George and Kelowna, and making it mandatory for medical students and residents to do rotations in rural areas (3). In addition to shaping the future physician supply throughout medical school and residency training, there are financial incentives available to physicians who practice in isolated communities (4, 1).

In addressing the challenges of recruitment and retention of physicians to rural and underserviced areas of the Province the following should serve as long-term goals:

- Increasing efforts to recruit medical students with rural backgrounds and strengthening training and support for rural community medical preceptors to ensure learners have positive learning experiences in these settings;
- Increasing the number of rural residency positions and increasing rural residency experiences for specialist physicians;
- Continuing to provide financial incentives such as hardship allowances, housing grants and paid vacations to physicians working in rural areas;
- Maintaining rural health infrastructure: for example, supporting electronic medical record technology and maintaining rural hospitals.

Question 2: How can we create a cost-effective system of primary and community care built around inter-disciplinary teams?

A significant proportion of health care expenditure in Canada is directed towards management of chronic disease. Provision of appropriate, timely and accessible care continues to be a challenge. Management of patients with complex medical problems in tertiary care centres as opposed to primary and community care settings presents an undue financial burden to the health care system. Evidence demonstrates that developing inter-disciplinary community based teams and programs to support patients with chronic diseases in caring for their health leads to improved health outcomes (10).

Incorporation of inter-disciplinary teams in primary and community care is not only effective but also essential for successful preventative care. The Ministry of Health in Ontario found that "people with diabetes who attended an inter-disciplinary, community-based self-care clinic experienced an average 14% drop in blood glucose levels within one year" (10). Investing in patient education led to better control of chronic disease and reduced both the financial impact on the health care system and the risk of complications of diabetes for the patients involved in the self-care clinic.

The comprehensive scope of inter-disciplinary teams in caring for patients with chronic disease helps to ensure a holistic approach to health care. Geriatric patients and patients with chronic pain are among the many populations where the effectiveness and benefit of this approach has been validated (9, 11).

Long term goals in creating a cost-effective system of primary and community care utilizing inter-disciplinary teams should include:

- Developing of a streamlined primary care infrastructure, in the form of community group practices which include general practitioners, nurses, social workers, dieticians, physiotherapists, pharmacists and other allied health care workers;
- Expanding inter-disciplinary clinics specifically designed to treat common chronic conditions, such as diabetes, COPD and asthma;

Question 3: What best practices can be implemented to improve end-of-life care?

A 87 year old gentleman is admitted to hospital with end stage lung disease so profound that he is unable to move himself in bed without becoming exhausted. After many discussions with regards to his limited treatment options and very high likelihood of mortality as well as the increasingly important need to address his severe symptoms, a decision with the patient, his supportive family and his medical team was made to transition to palliative care. Throughout this process the patient and his family were supported by the medical team in making an informed decision about palliative and end-of-life care and the many therapeutic interventions that can be provided to prevent suffering and ensure a good quality of life. Following the decision to move to palliative care the patient's symptoms were effectively controlled and he passed away peacefully with a natural death surrounded by his family on the palliative care ward.

Although the patient described is fictional, his story highlights the importance of end-of-life care as patients and their families prepare for and experience a death. Caring for critically ill patients who require end-of-life care is an extremely humbling and deeply moving experience for physicians. Resident physicians are often the doctors who care for patients and their families when they come to hospital in crisis at all hours of the day and night. The ability to help guide patients and their loved ones through the end-of-life process requires the coordinated work of an inter-disciplinary team and compassionate physicians with strong leadership and communication skills.

Emerging research in palliative care has demonstrated the effectiveness of home based programs for patients with cancer and several other end stage diseases in supporting patients to die at home without a negative impact on caregiver grief (14). Understanding the intricacies of how to provide the best cost-effective palliative care for British Columbians will require more research. Best practices will need to address the patient, their family, their medical team and the infrastructure of allied health care in the cultural, spiritual, socioeconomic and geographic context of the patient at the center of care.

A foundation for a robust set of best practices in end-of-life care should include:

- Ongoing and expanding access to training in palliative care for physicians caring for patients with palliative disease;
- Supporting research in palliative care in the British Columbian medical landscape;
- Emphasising continuity of care and resources as patients with chronic diseases near end-of-life;
- Supporting family and specialist physicians that engage in advanced care planning in non-crisis situations and care for patients with palliative disease.

Question 4: How can we enhance the effectiveness of addiction recovery programs?

It is estimated that over two million Canadians are affected by substance abuse problems, resulting in significant morbidity, mortality and an enormous cost to society as a whole (16). In 2002 alcohol alone was estimated to cost the Canadian system approximately 14.6 billion dollars per year via direct health care expenditures, enforcement costs and lost productivity secondary to alcohol abuse (14). Addictions cut across all demographics, but prevalence is disproportionately high among the mentally ill and those of lower socioeconomic status (15). In the worst case scenarios, this contributes to the evolution of environments such as the Downtown Eastside of Vancouver, where high densities of mental illness and polysubstance abuse compound and allow the growth of complications such as increased crime, homelessness, and transmission of diseases like HIV and hepatitis C.

The treatment of addictions is a difficult undertaking and demands a multidisciplinary approach to address a complex interplay of medical, psychological, cultural and social issues. Despite advances in medical science, treating addiction remains a challenge and one that is compounded by lack of funds, infrastructure, trained practitioners and evidence-based therapies. The Province possess an invaluable resource in this ongoing battle in the form of the University of British Columbia, an institution recognized as a world leader in addictions research and one whose training capacity in addictions is growing at an accelerating rate. As resident physicians, we feel that through promoting this work we will improve our ability to address the incredible burden of disease presented by substance abuse.

In enhancing the effectiveness of addiction recovery programs in British Columbia the following should serve as guidelines:

- Encouraging the growth and development of addictions research capacity and in turn making efforts to implement evidence-based policies to improve addictions treatment (including, but not limited to, an emphasis on harm reduction);
- Promoting education in addictions medicine through mechanisms such as trainee scholarships and research grants and supporting the development of advanced training opportunities such as the St. Paul's Hospital Goldcorp Addiction Medicine Fellowship;
- Supporting public education and promoting awareness campaigns aimed at the de-stigmatization of addictions.

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