Specialty Medical Workforce in Canada: What are the problems and what are the solutions?

November 14, 2008 Consultation with National Specialty Societies

Presentations Booklet

Office of Health Policy and Governance Support January 2009
Preface

This Presentation Booklet accompanies the Meeting Report of the November 14, 2008 Royal College of Physicians and Surgeons consultation with National Specialty Societies (NSS) concerning workforce challenges facing specialty medicine in Canada. Over 50 participants from NSS, the Canadian Medical Association (CMA), the College of Family Physicians Canada (CFPC), and the Federation of National Specialty Societies of Canada (FNSSC) met in Toronto to identify the problem-set and achieve consensus on the key HHR issues facing medical specialties as well as possible pathways to solutions.

This Booklet contains all presentations and handouts that participants received during the consultation. Presentations made during the consultation were as follows:

- “NSS Feedback concerning HHR challenges”, Aileen Leo, Royal College of Physicians and Surgeons of Canada
- “SOGC Health Human Resource Study”, Dr. Don Davis, Society of Obstetricians and Gynaecologists of Canada.
- Dr. Edward Stidworthy Johnson, Canadian Association of Neuropathologists
- Dr. Christopher Feindel, Canadian Society of Cardiac Surgeons
- Dr. Michael Milosevic, Canadian Society of Radiation Oncology
- Dr. Lorne Bellan, Canadian Ophthalmological Society
- In addition, Dr. Ivy Fettes of the Canadian Society of Endocrinology and Metabolism provided a 1-page handout on HHR developments within her specialty.
Presentation 1:

NSS Feedback concerning HHR challenges

Aileen Leo
Royal College of Physicians and Surgeons of Canada

NSS Feedback concerning HHR challenges

Specialty Medical Workforce in Canada: What are the problems and what are the solutions?
Consultation with National Specialty Societies
November 14, 2008

 NSS Feedback concerning HHR challenges

Aileen Leo
Royal College of Physicians and Surgeons of Canada

• In order to facilitate dialogue and exchange concerning relevant HHR challenges faced by NSS, in preparation for the November 14 NSS meeting, a brief questionnaire was sent to 49 NSS on August 28.
• 20 NSS responded to the questionnaire, for a response rate of 40.82%.

NSS were asked the following:

1. Please identify the top three HHR challenges faced by your discipline.
2. What supply issues exist within your discipline?
3. Given the public policy interest surrounding international medical graduates (IMGs), have there been any developments in your specialty with regard to integrating IMGs into practice or are there issues of note that warrant discussion? If so, please describe.

NSS questions (continued):

4. Has your specialty society done any workforce projections and if so are there any particular approaches that you could highlight?
5. Are there any promising new care delivery models within your specialty that may help alleviate HHR challenges?
6. What are the data/research gaps that exist with respect to HHR planning in your specialty?
7. Are there any other critical health policy issues that you would like to address that are impacting your specialty? Please describe.

Four themes emerged across responses to these questions:

• Issues concerning supply.
• Issues concerning delivery.
• Issues concerning gaps in data and research.
• Issues concerning new technologies.

1. Issues concerning supply.
• Shortages of practicing specialists, trainees, and training positions and related issues, including:
  - Inability of new recruitment to meet current demand as well as future demand for services in the face of impending and significant retirements.
  - Lack of new leadership with specialties as retirements increase.
  - Lack of teaching staff and faculty positions.
  - Lack of physicians to do research as well as public policy activity.
  - Lack of funding, impact of high fees on access to training, impact of differences in fee schedules, lack of alternatives to fee-for-service.
• Note: most respondents noted current shortages; one respondent noted a current oversupply of trainees but expected shortages within 6-10 years.
NSS Feedback concerning HHR challenges (Continued)

Aileen Leo
Royal College of Physicians and Surgeons of Canada

Other issues concerning supply noted included:
- Maldistribution of specialists across provinces and territories, urban and suburban, rural and remote areas.
- Increasing demand for services due to an aging population and other factors, higher acuity of patients, etc.
- Demographic changes that impact physician productivity, e.g., newer providers working fewer hours.
- Ability to find work in Canada by new graduates due to financial constraints that their specialty imposes on hospitals.

Issues concerning delivery included:
- Overlapping scopes of practice within team-based care and lack of clarity of who is doing what, changes in scopes of practice yet training in silos and impediments to HHR planning.
- Lack of access to and funding for providers who provide care for the delivery of care, e.g., OR nurses, lab technicians, physiotherapists, social workers, etc.
- Lack of uniform and prompt access and funding for therapeutic pharmaceuticals.

Other issues concerning gaps in data and research included:
- Forms of specialty/subspecialty care provided by province.
- Impact of wait times on patients and patient care.
- Impact of lifestyle issues on HHR planning.
- Workload issues.
- Medico-legal issues.
- Effects of aging population on demand for services.
- Lack of information linked to diagnostics, case mix, and outcomes.
- Need for national disease-specific strategies and guidelines.
- Need for national planning of POME spot allocations.

Other issues concerning gaps in data and research included (continued):
- Issues/questions posed private versus private health care, e.g., should some procedures be done in private surgicentres?; draw of private system means few physicians providing insured services; lack of standards for non-hospital based care, etc.
- How many MDs are providing specialty/subspecialty care for which they are not trained.
- How many MDs work in multiple sites.
- Policy options to encourage choice of specialties, e.g., forgiveness of debt.
NSS Feedback concerning HHR challenges (Continued)

Aileen Leo
Royal College of Physicians and Surgeons of Canada

4. Issues concerning new technologies included:
   - Lack of access to appropriate technologies, time to do these procedures and technological supplies to support these procedures.
   - Changes imposed by technology to clinical approaches/touchy, e.g., minimally invasive surgery, demands imposed by labour-intensive technologies.
   - Increasingly technological approach to some specialties and resulting underestimation of workforce involved for diagnoses and increased fiscal implications.

Next steps:
1. Discuss and reach consensus on HHR challenges.
2. Discuss possible pathways to solutions to HHR challenges

Questions concerning NSS feedback?

Thank you!
Presentation 2:  

SOGC Health Human Resource Study – Key Findings  
Dr. Don Davis

SOGC HHR Survey

- SOGC surveyed three elements:
  - Consumer survey
  - Obstetrician and resident surveys, resulting in HHR projections 2008 – 2021
  - University/Health Centre Education

SOGC HHR Survey: Consumers

- Women expect
  - Reliable ongoing care by the same caregiver of choice during pregnancy & child birth
    e.g. family physician, midwife, ob/gyn, nurse practitioner
  - Timely information about their pregnancy
  - Role in decision-making
  - Birth plans respected

Best case scenario

- expectations can be met in an urban setting
- highly unlikely – if not impossible – in rural setting

Canadians believe that health care system should be able to provide maternity care to them, how they want it, where they live.

SOGC HHR Survey: Obstetricians

Currently approx. 1300 ob/gyns in Canada
Survey revealed high level of satisfaction with their work …

BUT overwhelming frustration & stress related to workload, which is leading to burn-out, early retirement or dr.s leaving ob practice:

“I think that working 24 hour shifts is dangerous and compromises patient care. I think 12 hours is more reasonable and more sane. It is absolutely ridiculous that we work 24 hours and perform surgery at hour 23 and expect our patients to believe this is safe… It should actually be illegal for doctors to work those hours.”

SOGC HHR Survey: Obstetricians

Total on-call hours

- Responses varied considerably
  - Over 25% (29%) work on average 40-100 on-call hours/month
  - However, 3.9% work 101-300 on-call hours/month
  - 6% worked over 300 on-call hours/month
  - 3% worked over 400 on-call hours/month

On-call load

- Both have spent continuous 24-hour periods of on-call time in direct patient care
  - Of these, 6% have been required to provide direct patient care immediately after these 24-hour periods
SOGC Health Human Resource Study – Key Findings (Continued)

Dr. Don Davis

Practice profile: number of births

SOGC HHR Survey: Obstetricians

Using survey data SOGC ran projections estimating future requirements for ob/gyns who do obstetrics. Projections based on population growth, birth rate, current # ob/gyns, residents, caseload scenarios.

In 2009 Canada will be short
- 856 ob/gyns based on 150 births/yr/dr.
- 481 ob/gyns based on 180 births/yr/dr.

Shortages will continue to be severe for next 5 years

SOGC HHR Survey: Residents

Residents surveyed uncovered the looming crisis:
413 ob/gyn residents in Canada
81% responded

What they said showed that that “one-in/one-out” replacement scenario won’t work. Why?

SOGC HHR Survey: Education

- Currently 17 educational/medical centres for the teaching of ob/gyns.
- Funding more residents into the ‘pipeline’ is required **BUT** not enough
- Schools require
  - faculty, classroom space, equipment, e-learning

SOGC HHR Survey: Summary of Key Findings

- Incoming physicians plan to play a significant role in raising their families which will affect the supply of intrapartum care.
- Current Residents of both sexes expect to work less than the current practising workforce.
- ‘Old School’ model of on-call 24/7, year round is not an option for incoming ob/gyns.
SOGC Health Human Resource Study – Key Findings (Continued)
Dr. Don Davis

SOGC HHR Survey: Summary of Key Findings

• One third of Canada’s ob/gyns are unhappy with the balance between their work and family commitments.
  » On-call is cited as most stressful element
  » Residents have made it clear that they are not going to pick up the slack – health administrators are going to have to figure it out

SOGC HHR Survey: Summary of Key Findings

• Collaborative care models that bring midwives, family physicians, nurses, ob/gyns together to provide care will be essential to make sure that women have safe and healthy pregnancies

SOGC HHR Survey: Recommendations

SOGC recommends

• Fed/Prov/Terr Ministers of Health and Ministers of Education need to meet to review obstetrical HHR immediately

• Federal Govt needs to invest in future of maternity care by funding National Birthing Initiative and Aboriginal Birthing Initiative

SOGC HHR Survey: Recommendations

SOGC recommends

• that CIHI & Statistics Canada work with SOGC and other maternity care providers to upgrade information on intrapartum care and disseminate this info in more timely ways.

SOGC HHR Survey: Recommendations

SOGC recommends

• that the number of teachers, researchers and ob/gyn resident positions be increased by 30% annually for the next 3 years and 10% per year thereafter

• that residents be rotated into smaller cities and towns to introduce them to practice outside larger centres & encourage this as a long-term option
### Estimating future requirements for OBGYN specialists who do obstetrics (at 150 births per doctor per year)

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*Source: Statistics Canada Birth Rate Projections, provided October 3rd, 2008*
Estimating future requirements for OBGYN specialists who do obstetrics (at 180 births per doctor per year)

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*Source: Statistics Canada Birth Rate Projections, provided October 3rd, 2008
### Estimating future requirements for OBGYN specialists who do obstetrics (at 200 births per doctor per year)

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*Source: Statistics Canada Birth Rate Projections, provided October 3rd, 2008*
Presentation 3:

Presentation by Canadian Association of Neuropathologists
Dr. Edward Johnson, President

Royal College of Physicians and Surgeons of Canada – National Specialty Societies
Health Human Resources (HHR) Consultation

The Neuropathology workforce in Canada has always been marginal to meet the societal needs, and nowhere will it be as severe than in future years due to age-related attrition unless three measures are undertaken. These measures are: increased recruitment into training programs; funding of resident positions in Neuropathology Programs independent of those for Anatomical Pathology and other laboratory medicine programs; employment opportunities in Canada for graduates of Canadian training programs.

In the aftermath of the Committee of Specialties review and demotion of Neuropathology from a Specialty to subspecialty in 2003, and the restoration of Specialty status upon recommendation by a Royal College Appeal Panel in 2007, one salient fact emerged. Although there was much opinion on Neuropathology, there was little objective information: who does Neuropathology in Canada; what is their training background; what are their practice profiles; what is the anticipated attrition; is the workforce adequate and, if not, how many neuropathologists are needed? To answer these questions and to gain a measure of the status of health human resources of Neuropathology in Canada, the Canadian Association of Neuropathologists has engaged in a two pronged process. The first process, completed in 2008 under the aegis of Dr. Marc Del Bigio at the University of Manitoba, is a demographic survey of laboratory physicians who are either involved in the practice of Neuropathology in Canada and/or have undertaken training in Neuropathology in Canada. The other process, in its germinative stage, is the establishment of national guidelines for workforce measurement in Neuropathology to gauge and predict workforce needs.

The outcome of the demographic survey has been to define the current position of Neuropathology and predict trends with regard to background and training, routes of entry, practice profiles, attrition due to retirement and workforce needs. Dr. Del Bigio has willingly allowed me to share with you some of this information. This survey was conducted as a questionnaire distributed to Canadian members of the Canadian Association of Neuropathologists as well as individuals who had completed Neuropathology training in Canada but have practiced outside the country. The survey was distributed by e-mail with follow-up telephone calls; the response rate was 100%.

Comments will be restricted to those neuropathologists and pathologists currently engaged in the practice of Neuropathology in Canada, who total 51. Of these practitioners, 38 (75%) are certified in Neuropathology by either the Royal College or through the American Boards. The remaining 13 practitioners are certified in Anatomical Pathology with varying amounts of
Specialty Medical Workforce in Canada: What are the problems and what are the solutions? Royal College of Physicians and Surgeons Consultation with National Specialty Societies, November 14, 2008 – Presentations Booklet

neuropathology training. For 65% training was exclusively in Canada, and approximately 15%, each, had either combined Canadian/American training or entirely American training. For all practitioners, 70% had a practice that is restricted to Neuropathology and, of the remainder, 12 have a practice that is a combination of Neuropathology and Anatomical Pathology, two are engaged in a mixed practice of Neuropathology and Neurology, and one practitioner is restricted to Ophthalmic Pathology. Some variations in practice profiles are observed, with approximately 43% of respondents having little in the way of a service load in Pediatric Neuropathology, and approximately 35% having little involvement in Forensic Neuropathology, whereas other practitioners have a selective focus in Pediatric Neuropathology, Neurodegenerative Disease, and Nerve/Muscle Pathology. Distribution of neuropathologists varies across Canada, with the largest number being in Ontario (20) and the fewest being in Manitoba/Saskatchewan (3), and the Atlantic provinces (3). Although the large majority of neuropathologists are in tertiary medical centres, Neuropathology is beginning to be practiced in secondary centres and a limited spectrum of neuropathology services, for the most part tumor diagnosis, is offered in at least seven small sites. With regard to route of entry into Royal College accredited Neuropathology Training Programs, from 1970 to 2008, there is an observed recent trend toward direct entry from medical school. For the period from 1970 to 1993 (27 trainees), 33%, each, were direct entry from medical school, from Anatomical Pathology, or from the Clinical Neurosciences. However, for the period 1993 to 2008 (27 trainees), 52% were direct entry from medical school whereas 33% entered from Anatomical Pathology and 15% from the Clinical Neurosciences. Overall 66% of trainees, mainly direct entry, had prior training in neuroscience research with either a M.Sc. or Ph.D., and were more likely to pursue an academic career. Of concern is the impact on the Neuropathology workforce due to the pending retirement of 19 practitioners (38%) within ten years, and of these, seven in five years.

From the results of this survey, the following observations can be made.

1. Notwithstanding some heterogeneity in background, the large majority of practitioners in Neuropathology in Canada are certified in the discipline and/or have Canadian training.
2. In that 30% of practitioners have a shared service commitment with a discipline other than Neuropathology, the full workforce is not effectively utilized with regard to addressing the Neuropathology workload.
3. Trends are appearing with a shift into community hospitals and the development of subspecialty areas in response to clinical need.
4. Direct entry is emerging as the preferred route to training, and many of these recent trainees have a background in neuroscience that predisposes them to make Neuropathology an early career choice in medical school.
5. Recruitment into Neuropathology training programs is crucial.

**Recruitment:**

Notwithstanding the surge towards a core competency model, Specialty status for Neuropathology has served it well in recruiting trainees via multiple routes of entry, notably the
direct route. At the moment, there are five active training programs with five Canadian trainees in entirety and two IMGs, with prior background in Anatomical Pathology, as fellows. For the first time since 2004, one of these trainees is a PGY-1 level, the hiatus being attributable, from personal knowledge, to the unresolved Specialty/ subspecialty status of Neuropathology and the disincentive of a prolonged and seemingly irrelevant training in Anatomical Pathology as the sole entry route.

**Funded Training Positions:**

Except for the UBC program, the funding of a position in the other Neuropathology Training Programs is based upon on a competition with the other laboratory medicine programs. Thus, the best overall candidate is funded and the losing applicants are obliged to seek training in another discipline and often are lost forever – their life moves on. This system, therefore, creates an artificial but significant barrier to Neuropathology recruitment that need not be if there is dedicated independent funding of these programs.

**Employment Opportunities:**

There is a dearth of employment opportunities in this country to the point that some training program directors are unwilling to accept a candidate if there is no prospect of a job at the completion of training. On the other hand, in a period of fiscal restraint, laboratory directors and hospital administrators are hesitant to fund positions without an indicator of need. Through the establishment of a set of national guidelines for workload measurement, analogous to that being implemented for Anatomical Pathology, the Canadian Association of Neuropathologists hopes to provide this indicator: the number of full-time equivalent neuropathologists required to provide reliably competent, quality assured diagnostic service for a given volume and case complexity of clinical material integrated with commitments for teaching and research in accord with the practice profile of each neuropathologist.

Similar problems in health human resources in Neuropathology are encountered in other countries. However, in Canada, in tribute to the Royal College’s scrupulous monitoring of programs and proactive approach in conjunction with the Specialty status of Neuropathology, we are in the international leadership position where we should be, and we are where others want to be.
Presentation 4:

Cardiac Surgery Workforce Model: What does the future hold?¹

Dr. Christopher Feindel, Canadian Society of Cardiac Surgeons

Motivation

CURRENT SITUATION:
Excess Capacity of Cardiac Surgeons
Declining resident enrollment

THE FUTURE:
Aging Canadian population
+ Aging surgical workforce
+ Six year delay between entry and licensure

Will there be enough Cardiac Surgeons in 10 – 20 years?
Plan now for the future

Future Surgeons: Student Population

- Profile of trainees (excluding visa students)

- New Enrollees: 7

Current State: Clinical Productivity

- 150 Cardiac Surgeons

¹ This study is preliminary and is in the process of being refined.
Cardiac Surgery Workforce Model: What does the future hold? (Continued)

Dr. Christopher Feindel, Canadian Society of Cardiac Surgeons

Aging Canadian Population

Model Inputs

Model Assumptions

Scenarios

Base Case

Conclusions

- Demand per capita based on Ontario, remain constant
- Surgeon age does not affect productivity
- Retirement rates:
  - 10% of age 55-59
  - 63% of age 60-64
  - 100% of age 65-69
- Graduation rate:
  - 80% after R-6
  - 100% after R-7
- Cases completed (CABG vs. Other) proportional to demand
- Productivity increases in proportion to change in Demand-Supply Gap
  - If gap increases 15%, productivity increases 15%
  - Productivity does not exceed a maximum average # of cases

- R-1 Enrollment
  - Increase to 8/year
  - Decrease to 6/year
- Change Average Case limit
  - Increase 20/surgeon/year to 230
  - Decrease 20/surgeon/year to 190
- Population projections
  - Statistics Canada Low projections
  - Statistics Canada High projections

- Model suggests surgeon shortage starting in 20xx, and continuously increasing UNLESS number of trainees increases
Cardiac Surgery Workforce Model: What does the future hold? (Continued)

Dr. Christopher Feindel, Canadian Society of Cardiac Surgeons

**Future Refinements**

- Influence of Demand-Supply gap on enrollment
- Refine annual case load by surgeon age cohort
- National cardiac surgery demand statistics
- Inclusion of other factors affecting the system

**Thank-you!**

Questions? Comments?
Presentation 5:

Radiation Oncology in Canada: Annual CARO Workload and Staffing Survey

Dr. Michael Milosevic

Radiation Oncology in Canada
Annual CARO Workload and Staffing Survey
Michael Milosevic MD

Radiotherapy in Canada

Environmental Forces

- Increasing cancer incidence
  - Aging population
- New indications for RT
- Complex treatment techniques
- Interdisciplinary care
- Increasing public awareness
  - Wait times, new treatments
- Resident anxiety
  - Balanced job availability

Radiotherapy Quality Metrics

- Appropriate access
  - Radiation utilization rates
- Timely access
  - Wait times
- Workload
  - Patient volume and plan complexity
- Radiotherapy quality
  - Treatment guidelines, specialized techniques, outcomes

CARO Workload Survey

- Annually since 1999
- Defined target population
- Department heads: 38 radiation treatment centers across Canada
- Trends in radiation oncology practice
- National staffing and workload levels
- Resident supply and demand
- Equipment

Radiation Oncology
Projected Staffing Levels

Radiation Oncology
Workload

NP Consultations per FTE
Radiation Oncology in Canada: Annual CARO Workload and Staffing Survey (Continued)

Dr. Michael Milosevic

**Radiation Oncology Residents and Fellows**

![Graph showing Radiation Oncology Residents and Fellows](image)

**CARO Workforce Long-Term Planning**

![Graph showing CARO Workforce Long-Term Planning](image)

**Radiotherapy Oncology Short Term Supply-Demand**

- Cumulative annual calculation of supply and demand based on:
  - Predicted new jobs
  - Predicted retirements
  - Residents and fellows completing training
- Does not include:
  - Employment deferral for fellowship
  - Generic vs. sub-specialty jobs
  - Workload preferences (Full vs. part time)
  - Preferred work location
  - Recruitment from outside Canada

**Radiation Oncology Predicted Unfilled Demand**

![Graph showing Radiation Oncology Predicted Unfilled Demand](image)

**Existing radiation treatment centers only**

**Radiation Oncology Predicted Unfilled Demand**

![Graph showing Radiation Oncology Predicted Unfilled Demand](image)

**Existing + projected radiation treatment centers**
Radiation Oncology in Canada: Annual CARO Workload and Staffing Survey (Continued)

Dr. Michael Milosevic

What are we doing?
• Build human capacity
• Build treatment capacity
• Link training to short and long-term demand
  – Training programs, IMG’s
• Education
  – Government, public, patients, trainees
• Federal funding to reduce wait times
• National strategy for workforce planning
  – Radiation oncology, physics, radiation therapy
Presentation 6:

**Ophthalmology Health Human Resources**

*Where are we headed?*

Dr. Lorne Bellan

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**Previous Studies**

- Valberg 1989 - 1:28,000
  - Appropriate
  - Consistent with other countries
- Pratt 2000 - 1:29,229
  - Projected 1:42,296 BY 2016
  - Decline due to fewer residency slots

---

**Increased Training Positions**

- 33 spots matched by CARMS this year

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**Projected Ophthalmologist Numbers**

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Eye MD</th>
<th>% Female Eye MD</th>
<th>% 55+ years</th>
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<tbody>
<tr>
<td>2006</td>
<td>1,100</td>
<td>18.40%</td>
<td>38.30%</td>
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<tr>
<td>2007</td>
<td>1,099</td>
<td>18.90%</td>
<td>38.60%</td>
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<tr>
<td>2012</td>
<td>1,093</td>
<td>22.10%</td>
<td>44.90%</td>
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<td>2017</td>
<td>1,113</td>
<td>25.80%</td>
<td>45.60%</td>
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<tr>
<td>2021</td>
<td>1,122</td>
<td>28.90%</td>
<td>46.30%</td>
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</tbody>
</table>

---

**Physician Resource Evaluation Model**

- postgrad exits
- returns
- recruited IMGs

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**Changes in Ophthalmologist Pool**

- emigration
- retirement
- death

---

**Changes in Ophthalmologist Pool**

- MDs per 100,000 pop
- FTEs per 100,000 pop
Ophthalmology Health Human Resources
Where are we headed? (Continued)

Dr. Lorne Bellan

Ophth:Pop Ratio by Province

<table>
<thead>
<tr>
<th>Province</th>
<th>1987</th>
<th>2003</th>
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<tbody>
<tr>
<td>Newfoundland</td>
<td>1:56000</td>
<td>1:42,241</td>
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<tr>
<td>Prince Edward Island</td>
<td>1:43000</td>
<td>1:34,274</td>
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<td>Nova Scotia</td>
<td>1:29000</td>
<td>1:19,793</td>
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<tr>
<td>New Brunswick</td>
<td>1:53000</td>
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<td>Quebec</td>
<td>1:27000</td>
<td>1:29,452</td>
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<tr>
<td>Ontario</td>
<td>1:27000</td>
<td>1:29,792</td>
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<tr>
<td>Manitoba</td>
<td>1:38000</td>
<td>1:45,287</td>
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<td>Saskatchewan</td>
<td>1:75000</td>
<td>1:27,474</td>
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<tr>
<td>Alberta</td>
<td>1:35000</td>
<td>1:37,847</td>
</tr>
<tr>
<td>British Columbia</td>
<td>1:19000</td>
<td>1:29,159</td>
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</table>

FTE to Population >65

<table>
<thead>
<tr>
<th>Year</th>
<th>Pop. over 65</th>
<th>FTE</th>
<th>FTE:P &gt;65</th>
<th>FTE:P &gt;65</th>
<th>FTE:P &gt;65</th>
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<tbody>
<tr>
<td>1991</td>
<td>317000</td>
<td>1066.33</td>
<td>1.2872</td>
<td>1.2872</td>
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<td>2001</td>
<td>1107.76</td>
<td>1.3003</td>
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<tr>
<td>2006</td>
<td>980.4</td>
<td>1.4301</td>
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<tr>
<td>2011</td>
<td>933.9</td>
<td>1.5150</td>
<td>1.5150</td>
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<tr>
<td>2021</td>
<td>903.7</td>
<td>1.7121</td>
<td>1.7121</td>
<td>1.7121</td>
<td></td>
</tr>
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</table>

Can We Cope?

• Yes we can!
  - Increased efficiency in surgery
  - Technicians in the office

Can We Cope?

• No We Can’t
  - Limit to surgical efficiency
  - Increased demand from telemedicine
  - Increased demand from therapeutic advances

What are our options?

• Careful surveillance
  - Monitor surgical and office wait lists
  - Monitor ophthalmologist to population ratio
• Lobby for increased residency slots
• Explore alternative models for delivery of care
Handout 1:

Developments in Endocrinology and Metabolism

Dr. Ivy Fettes

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CSEM report for NSS-2008

Dr. Ivy Fettes

Supply Issues in Endocrinology

- Aging Endos: about 1/3 CSEM over age 60
- Recruitment Challenge for Endos and Endo trainees (poorer subspeciality)
- Need for Academic Endos (teachers, educators, researchers) Many trainees going into community to do ambulatory 9 to 5 clinical care

Supply issues continued

- Huge Burden of DM2 for adult and pediatric Endos - takes most of time
- Obesity epidemic requires resources that most places do not have
- Ambulatory care of chronic disease undervalued (GIMs more interested in lucrative hospital work)

IMGs

- Large spectrum of competencies
- Their training is time consuming
- In Quebec language sometimes an issue in Francophone patient care
- One suggestion to offer training in specific areas eg in DM for providing more culture sensitive care

Delivery of Care

- Waiting lists 4-6 months for many Endos
- Would like more NPs and to have them do night call
- Many patients without drug plans and can not afford medications
- Aging patients require more time and more support

Delivery of Care continued

- Endocrinologists open to teamwork, case managers, networks, telehealth and new models of care
- Endocrinologists would like more support and recognition for teaching patient care
- Endocrinologists would like public health initiatives for disease (eg DM) prevention