

Chan has suggested that a bigger decline in the output of training programs was caused by an increase in the length of training required to meet new certification standards in family medicine and an increase in the number of graduates opting for specialty training. He could have pointed out that the switch to a 2-year family medicine program was needed to increase portability within Canada and to meet international standards in education. The government did not provide any additional postgraduate positions to accommodate the extra year of training and instead used the re-entry positions usually reserved for international medical graduates and specialty training.

It is also worth noting that there was a net loss of 4000 physicians from Canada in a single decade, at a total cost of approximately \$6 billion to the taxpayers who paid for their education. A physician pool that includes a substantial proportion of aging physicians cannot afford to lose any of its young physicians this way.

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#### Reference

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2. Wharry S, Sibbald B. What physician shortage? *CMAJ* 2002;167:64.
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A recent *CMAJ* article<sup>1</sup> does not give Ben Chan's study<sup>2</sup> the emphasis it deserves. This is an important document on physician human resources that will have as much impact as the landmark Barer–Stoddart report of 1991.<sup>3</sup> Chan diplomatically says “one cannot ‘prove’ that any particular policy ‘caused’ a particular trend to occur. The reader is encouraged to draw his or her own conclusion.”<sup>2</sup>

However, most of us in the “business” of health care provision recognize

the poor quality of decisions made a decade ago by departments of health, licensing bodies, medical associations and medical schools. These decisions were made in the absence of national or regional physician resource planning and without allowance for checks along the way to correct any adverse outcomes.

For the 2.4 million people living in Atlantic Canada, the problem is further complicated by the existence of 4 uncoordinated health care plans, one for each province. Economic restraints have not allowed the 2 medical schools in Atlantic Canada to raise their enrolments or adjust postgraduate residency training positions. Physician-to-population ratios for the Atlantic provinces expose the difference in physician resources between this region and the rest of Canada, particularly for specialists (Fig. 1).<sup>4</sup>

Unfortunately, the same players are now making decisions to increase physician supply, again without national or regional physician resource planning. There is an immediate need to review the increasing health care demands of Canadians and the new technologies becoming available within the Canadian health care system, but already there are plans to increase medical school enrolment. These plans do not account for the fact that primary care physicians are not providing comprehensive care,<sup>5</sup> nor do they account for the rising demands for physician ex-

tenders in both primary and acute hospital care. We can easily predict the appearance of another report in the next decade, describing another “crisis” and another perceived surplus.

Atlantic Canada urgently needs regional physician resource planning; in fact, we urgently need regional health care planning.

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4. Statistical information on Canadian physicians [tables online]. Ottawa: Canadian Medical Association; updated 2001 July. Available: <http://www.cma.ca/cma/menu/display.Menu.do?tab=422&skin=125&pMenuId=6&pageId=/staticContent/HTML/N0/12/statinfo/index.htm#intro> (accessed 2002 Oct 3).
5. Chan BTB. The declining comprehensiveness of primary care. *CMAJ* 2002;166:429-34.

#### [Benjamin Chan responds:]

My report on Canada's physician workforce<sup>1</sup> does not trivialize the impact of undergraduate enrolment cuts in the future, but it rejects the notion that such cuts were the driving force behind Canada's declining physi-

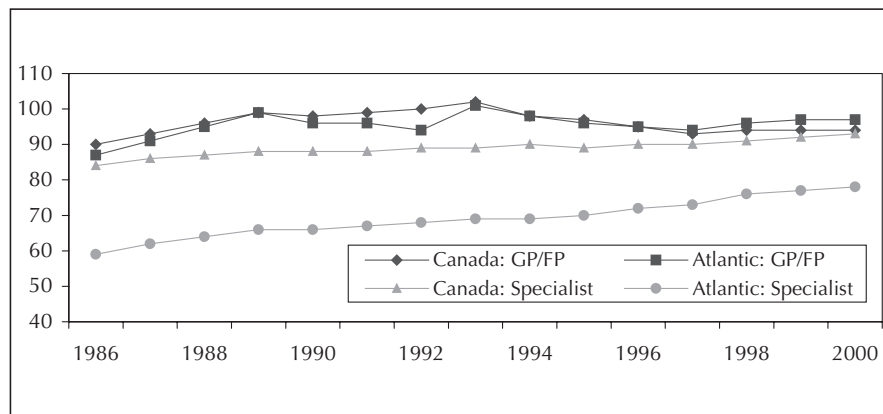


Fig. 1: Physicians per 100 000 population, Atlantic provinces, 1986–2000. Calculated from Statistics Canada population data and physician data from the Canadian Institute of Health Information (available on the CMA web site).<sup>4</sup>