NEWS

Task Force Two calls for pan-Canadian approach to physician resources

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Harmonized, national standards for assessing and licensing aim to increase physician mobility.

A comprehensive "pan-Canadian" strategy for educating, recruiting, licensing and equipping doctors should be implemented to ensure that Canada has enough physicians to meet evolving needs, states Task Force Two, a blue-ribbon panel struck to resolve means of alleviating the shortage of physicians in Canada.

Such a strategy should include harmonized national standards for assessing and licensing both Canadian-trained and international medical graduates (IMGs) so as to ultimately allow more mobility for doctors, the panel says in its report, *A Physician Human Resource Strategy for Canada: Final Report* (www.physicianhr.ca).

Skeptics say such harmonization would only exacerbate doctor poaching by wealthier provinces but the panel argues that harmonization of licensing, in tandem with creating a national repository of physician credentials and implementing other elements of their pan-Canadian strategy, would create "a more level playing field" across the country and making issues like poaching moot.

The panel urges wholesale reforms in 5 areas related to physician supply: education and training; interprofessionalism; recruitment and retention; licensure, regulatory issues and liability; and, infrastructure and technology.

Change must be "comprehensive" and incorporate reforms in all 5 areas, says Dr. Hugh Scully, a past president of the CMA, who along with Royal College of Physicians and Surgeons of Canada (RCPSC) ex-CEO Dr. Michel Brazeau and College of Family Physicians of Canada ex-president Dr. Nick Busing co-chaired the steering committee of Task Force Two, the $4.8-million, 5-year initiative that produced the report.

"It needs to be integrated," Scully added in an interview. "It needs to be tied with what's happening with other health professionals, so that we make the best use of everybody that we have. It doesn't make any sense to me that we're going to be continuing to have silos of education between nursing and medicine and pharmacy and some other disciplines."

Along with standardization of the licensing, regulation and liability protection of physicians, Task Force Two urges concomitant modifications to physician education and training, including more direct links between medical school enrolments and national physician demand, as well as pedagogic changes to improve instruction on team-based medicine. Among recommendations to promote recruitment and retention of physicians is a call to develop programs to attract health care workers to serve Aboriginal peoples and isolated communities. Team approaches to health care delivery could be encouraged by new remuneration models for collaborative practice, while the entire system would be served by ensuring better access, by all, to information technologies and medical equipment.

Oversight of the broad strategy should be vested with a national agency, the report says, arguing that sweeping reform is the only way to ensure "the right kind of physicians, trained to offer the right kind of care, are working in the right parts of the country at the right time."

Although the cost, structure and authority of such an agency haven't been determined, Scully argues the impetus for its creation is evident in the "consensus" reached in the report after years of consultation with various levels of government and national health groups.

There's no doubt a uniform, pan-Canadian approach to health resource planning would yield a more accurate picture of physician need, says Dr. Dale Mercer, president of the College of Physicians and Surgeons of Ontario. "The benefit of a national approach is that you see fluctuations in resource utilization and requirements, probably by region within Canada. Immediate fixes in one area are not likely to be effective nationally."

A national approach to mandatory continuing medical education (CME) as a condition of licence revalidation, as well as to the assessment and credentialing of IMGs, would serve to ensure that Canadians receive quality care right across the country, Mercer adds.

Standardization of CME and licensing, as well as curriculum reforms

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related to team-based medicine and "cultural competency" in the provision of health care to groups like the Aboriginal community are vital to eliminating regional variations in quality of care, adds Danielle Frechette, lead author on the report and RCPSC senior advisor, governance and policy development. "Why is it right that Canadians would have a different level of care in Ontario, than they might in say, Newfoundland?"

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Scully argues that harmonized licensure of new graduates, as well as standardized revalidation of existing and international physicians, and a national repository, would also vastly improve physician mobility, making it easier for doctors to jump jurisdictions to serve underserviced areas, or fill spikes in regional demand caused by emergencies.

Meanwhile, poaching by both wealthier provinces and urban centres, the report contends, could be allayed by modification of compensation models. Standardization would also curb the trend toward issuing restricted licences, which has become so widespread that it has "gone beyond the original intent of it being a mechanism used only in exceptional crisis circumstances," the report states.

But College of Physicians and Surgeons of New Brunswick Registrar Dr. Ed Schollenberg argues the barriers posed by mobility do not necessitate change that would undermine the ability of smaller provinces to recruit doctors to underutilized regions, particularly by using conditional licences to attract IMGs.

"That's all that we're arguing about really, at any particular time, 20%–30% of all physicians. I think the experience is it would be a pretty big problem for some locations if we had exactly one simple standard. Already, we lose physicians constantly to the centre of the universe [Ontario] and it would, in the long run, from a recruiting point of view, from a health delivery point of view, probably make things worse."

"From a health delivery point of view, it's hard to see an upside," Schollenberg adds.

Although Scully says Task Force Two isn't advocating the creation of a national body responsible for all licensing, it's not that great a leap once harmonized standards and a national repository are in place.

College of Physicians and Surgeons of Alberta Registrar Dr. Trevor Theman says such a notion shouldn't be rejected entirely out-of-hand. "From a public policy perspective, there's some appeal to that. But at the present time, it would be very challenging. ...[W]e've got the national and federal stuff and the provincial and territorial stuff, and we've got shared responsibility and shared roles. And really what you're asking is somebody to give up their responsibility and authority. Good luck." — Wayne Kondro, *CMAJ*

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Chronic malnutrition grips western Nepal

The combined effects of conflict and large-scale drought have led to a high rate of chronic malnutrition in western parts of Nepal, reports Action Contre la Faim (ACF), a France-based international, non-profit devoted to hunger relief.

ACF, which has 220 volunteers including doctors and nurses in 19 countries, came to this conclusion following a month of nutritional assessment in the north-western part of Nepal. It found that less than 15% of the population of some north-western regions had food stocks. The rate of severe malnutrition was 3.3% and overall malnutrition rate of the areas is 12.3%.

The worst affected are children. Benoit Miribel, director general of the ACF described the condition of children as "alarming."

"Malnutrition rates of children younger than 5 is 5 times higher than those in Darfur," he said at a media briefing in Paris.

In the north-western region, 60% of children have basic nutritional problems, there is a 40% rate of anemia and 40% iodine deficiency.

Nepal has been witnessing armed conflict since the beginning of Maoists' led "People's war" in 1996. The conflict has claimed 14 000 lives, destroyed infrastructures and severely affected the economy of poor rural communities. Compounding the problem is the fact that the north-western region experienced its worst drought in 40 years from February to March this year.

- 47% of the farmers have not been able to harvest and the remaining ones have only collected 25%-50% of their usual harvest
- 42% of Nepalese live below the poverty line and more than a third consume fewer than 2250 Kcal per day
- 60% of households of mountainous areas are not self sufficient, while agricultural production only covers food requirement for 3–8 months per year.

It will be even more difficult for them in the coming months as the next harvest is not expected until September, said Jean-Pierre de Margerie, acting country director of World Food Programme (WFP) Nepal.

In the 19 days of recent protest against King Gyanendra, road travel was severely curtailed and curfews were imposed in major cities making it very difficult for aid agencies to continue food distribution. The protests ended after the King restored multiparty democracy on Apr. 24 by reinstating the dissolved parliament and handing over sovereignty to the people. After the restoration of democracy both the government and Maoists announced a ceasefire.