Growing our own

A number of years ago I wrote an editorial about the early indicators of physician shortages in this country, the additional specter of a graying/unhappy physician demographic, and the seeming lack of attention both of these red flags seemed to be generating in our legislators and educational institutions.

This was not a prescient revelation on my part, as most of us graying physicians were acutely aware of our shrinking professional resources with the progressively longer wait times for just about everything and the accelerated exit strategies that many of our close colleagues were excitedly describing during our very brief (and getting briefer) hospital interactions.

Since that time the situation has not only become more professionally problematic, it has finally become a politically important item—at least here in BC where the current government has increased the size of the medical school and very appropriately agreed to fund three satellite faculties in addition to the Point Grey Campus facility. The combined UBC medical school will eventually graduate two-thirds of the doctors this province requires yearly just to keep up with our replacement needs as our top-heavy physician demographic retires, moves into nonclinical work, or dies.

So, where will the rest of our docs come from? Historically, the rest of the country has supplied BC with large numbers of physicians who would rather carry an umbrella than wield a snow shovel. However, the rest of the country suffers from exactly the same problem as BC and these climate-challenged regions are already drying up as rich sources of Canadian-trained physicians. In fact, virtually all of these venues are suffering through the extensive damage caused by the feds recommending to all of Canada's training institutions to reduce their training positions in response to the Barrer, Stoddart report released in December 1991 *(Toward Integrated Medical Resource Policies for Canada)* and the accompanying endorsement of BC's very own medical economist, Robert Evans. The rest of the Western world also finds itself doctor-deficient, and Irish doctors, British doctors, and South African doctors are no longer arriving in droves to fill the vacancies in the more rural areas because they are needed in their own countries and are being given lots of inducements to stay at home. There are a few non-licensed, internationally trained physicians out there who could be added to our numbers fairly quickly, but they represent a mere drop in the bucket when we look at Canada's current and long-term physician supply needs.

The obvious answer—and one that we physicians have been suggesting for years—is that Canada must become self-sufficient and as quickly as possible develop the political will to commit substantial resources to the training of adequate numbers of physicians to meet our needs.

This is a huge undertaking and not something for the faint of heart, but it is absolutely necessary that it gets done quickly. A political project of this size will cost an enormous amount of tax dollars and will require many years of planning and even more years of intelligent implementation. As we all know, "politically fast" is generally the antithesis of political velocity in Ottawa, but this problem is too big and

too immediate to allow it to languish on some committee table or wait for yet another Royal Commission. This problem needs to be addressed now.

Dr Brian Day has begun this process with a plea for all of us to get behind the CMA's lobbying group in Ottawa in their efforts to convince our federal legislators to see the political necessity for this project to be moved forward and become a national program with an all-party endorsement. I would like to encourage all of you to send the postcards that Dr Day sent your way, call your MP, write a letter to your local newspaper—get involved, let people know how bad it really is.

I find myself worrying that at a time when I need a family doctor, unless something changes quickly, she will have already been happily retired for many years. Instead, the MSP Helpline will be directing me to the nearest pharmacist who will be pleased to prescribe something for me.

—JAW

Flying lessons

Flying used to be such an adventure, and people actually got dressed up if they were traveling by air. There was a mutual understanding among passengers and cabin crew that we were a favored few and warranted special attention, which in turn engendered proper behavior from all parties. Being addressed as "sir" by flight attendants ("ma'am" disappeared a while ago) is the only thing that remains from the golden days of flying; the accompanying smile was seen as redundant long ago.

But while the excitement and glamour of air travel sadly has disappeared, we must be grateful that safety (and efficiency, to a lesser extent) seems to have steadily improved. I hate it when others quote US rather than Canadian statistics, but I'm going to do it anyway because the numbers are really very impressive: in 2006, according

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to the US National Transportation Safety Board, there were 11 200 000 airline departures in the United States and a measly two fatal accidents with a loss of 49 lives. It was the highest number of airline departures ever recorded, but the relative fatality rate remained at the same level it had been for 12 years (except for 2002, when they actually had no fatalities at all).

I also hate it when uninvolved people become armchair critics, but here goes anyway. The airline industry has done a terrific job of providing safe and efficient transportation for increasing numbers of passengers. Sitting in a passenger aircraft that belongs to an established airline and that is flying on a scheduled route is a ridiculously safe place to be. If airlines can make such a safe environment, why can't hospitals? You probably remember the article published in *CMAJ* in 2004 (Baker RG, Norton PG, Flintoft V, et al. CMAJ 2004;170:1678-86) that estimated that about 185 000 Canadians annually experience an adverse event while in hospital, and that close to 70 000 of these events are preventable. The authors estimated that between 9000 and 24 000 of the deaths associated with these adverse events (medical or surgical) were potentially preventable. Granted, hospitals and aircraft are very different environments; by and large, hospitals are filled with sick people, and passenger aircraft are full of (generally) healthy people. Nevertheless, the number of people who die in Canadian hospitals as a result of error is inexcusable, no matter how the statistics are presented. Medical error is arguably the next great medical frontier.

So many factors can contribute to medical error that concentrating on a single factor is unlikely to have a significant effect on hospital safety. However, comparing hospital procedures and conventions with airline procedures gives some useful contrasts. For example, aircrew have strict rules to follow regarding how many hours they may fly without rest, and professional pilots acknowledge far more readily than medical professionals that if they are tired they don't perform effectively during critical times. Medical and surgical hierarchies are becoming flatter, but it still takes nerve for a nurse or junior resident to question the judgment of a senior consultant, and in many cases it simply does not happen. Cockpit procedures, on the other hand, are becoming increasingly non-hierarchical. If a flight attendant smells smoke, the captain lands the aircraft and then asks questions.

However, not all medical error occurs in the operating room or in the ICU at 3:00 a.m. Errors can involve mistakes in medication doses, lapses in sterilization protocols—the list is almost endless. The problem is that error is often difficult to discuss in medicine. We are all perfectionists whose overriding goal is to make our patients better and send them home, and to accept personal responsibility for error is difficult for all of us and impossible for some. Aircrew are trained to deal with errors proactively and non-punitively, and the results speak for themselves. We could learn from their procedures.

But, for physicians, flying is not always safe. Some years ago I was on a red-eye flight when an anxious call for a doctor came over the PA system. I waited for the second call (you see, I'm a gynecologist, not a real doctor) and then offered my services to the flight attendants. As I got up to attend to the afflicted passenger, the man sitting across the aisle from me tweaked my arm.

"I'm a lawyer" he said. "I'll be here if you need me."

—TCR