

Are We Facing a Crisis in Maternal Fetal Medicine in Canada?

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INTRODUCTION

In November 1996, the Society of Obstetricians and Gynaecologists of Canada published a position statement on the “obstetrical crisis” in Canada.¹ The document outlined the reasons for the looming crisis and suggested solutions. Some of the reasons listed were an aging population of obstetricians (with an average age of 52), litigation, and reimbursement for obstetrical care. Although some of these issues have been addressed, the overall picture has not changed much. In 2006, the President of the SOGC clearly stated that such a crisis is still looming.² A major area of concern in his view was the fact that only 450 obstetricians cover 250 community hospitals. Obstetricians are now delivering a relatively greater proportion of babies than in the past, as fewer family physicians deliver babies,³ and the number of deliveries by midwives does not compensate for this. A recent article written by a resident in Canada suggested that one of the ways to make our specialty more attractive is to increase the size of call groups,⁴ a solution that is impractical for most of rural Canada or for subspecialists in a small centre.

We have little information on the future Canadian requirements for specialists in obstetrics and gynaecology in general, and, more specifically, to meet the needs in the area of maternal fetal medicine.

CANADIAN SURVEYS

Surveys were conducted recently by the Association of Professors of Obstetrics and Gynaecology (APOG)⁵ and by the Maternal Fetal Medicine Committee of the SOGC (MFM-SOGC). The two surveys were performed a few months apart and used slightly different methodology, so the results were similar but not identical. In the APOG survey, the chairs of all university departments of obstetrics and gynaecology in Canada were asked to provide information about their training programs in the different subspecialties and their resource needs in these fields in the next five years. In the MFM-SOGC survey, all MFM subspecialists in Canada were asked about plans for recruitment in their own units over the next five years. The responses were then checked with the head of MFM in that unit and/or the department’s chair or chief. The major difference between the two surveys was that the APOG survey requested information about all subspecialties but was limited to the academic departments of obstetrics and gynaecology, while the MFM-SOGC survey was limited to information about MFM but also included the needs of some non-academic centres.

The APOG survey showed that by 2011, there will be a need for an additional 38 MFM subspecialists to fill currently vacant positions and to meet new needs. The MFM-SOGC survey showed a need for 52 positions (of which 8 were for Level II units). These numbers are impressive in view of the fact that currently there are only 110 MFM subspecialists in Canada. The responses did not suggest that there is a disparity between different parts of the country. The majority of MFM subspecialists (100) work in Level III centres, and only 10 work in Level II centres. The MFM-SOGC survey showed the following distribution of MFM subspecialists needed in five years: Atlantic Canada: 5; Quebec: 10; Ontario: 18; Western Canada: 19.

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Data provided by the Royal College of Physicians and Surgeons of Canada (RCPSC) show that the MFM training programs in Canada had 24 FRCSC graduates between 2001 and 2005. This amounts to about five graduates every year. In addition, there were 13 trainees without FRCSC certification who trained in Canada between 2001 and 2005 (< 3 per year). It is estimated that at least 15% of the MFM graduates who hold FRCSC certification in obstetrics and gynaecology are non-Canadian. Many of the foreign FRCSC certificants who graduate in MFM plan to return to their own countries and will not practise in Canada. In addition, the number of Canadian obstetricians planning careers in MFM is at a nadir. Only two Canadians started subspecialty training in MFM in July 2006. Therefore many of the training programs have unfilled positions. Only two of the nine training programs in Canada had trainees every year during the last 10 years. This indicates that the shortage will likely worsen in the near future.

THE MFM SHORTAGE

The data gathered in these surveys may not reflect the exact needs for Canada, but they provide the best available estimate. The responses may represent planned needs for specific units, a wish list for some, and a combination of both for others. Accurate calculation of the needed number of new subspecialists must take into account the number of expected retirements. In addition, the projected needs do not include many of the Level II units in the country that plan to recruit MFM subspecialists. There is an urgent need for a more objective ongoing assessment of the Canadian demand for MFM specialists that is based on such factors as population size and services provided.⁶ Even if all these issues are considered and the data are accepted as an estimate, it is clear that Canadian needs cannot be met by our current training programs. In planning the future, we have to realize that at present there is still a significant shortage of MFM specialists and that in many parts of the country the system is already stretched to its limit.

The implications of a major shortage of MFM subspecialists are multi-faceted. Access to specific procedures such as chorionic villus sampling and fetal therapy may be compromised. Obstetricians who need a consultation from a subspecialist in MFM may experience delays. Since many consultations are time-sensitive (for diagnosis, therapy, and termination of pregnancies with extremely poor outcome), the referral system may become dysfunctional. Maternal transfers for care that are already sub-optimal in some parts of the country will be further compromised. In a system with not enough care providers, the number of women presenting with acute problems will increase in the tertiary centres, with a domino effect on other centres. The result will

be sub-optimal care for patients and dissatisfaction for care-givers. There will be less time for research and planning, potentially dissuading residents from choosing MFM as a career. Patient care will suffer as a result of decreased accessibility and restrictions in some procedures. Pregnancy outcomes and maternal mortality rates are inversely related to the number of MFM subspecialists,⁶ and outcomes for patients with several obstetrical diagnoses are improved if treatment is provided by MFM subspecialists.⁷

In summary, an acute shortage of MFM subspecialists will result in poor care and a collapse of the hierarchical system of primary, secondary, and tertiary centres; it will fail other obstetrical care providers who need advice and consultation and who need to transfer patients. It will have also a profound effect on teaching of advanced obstetrical skills.

In order to address these issues, all relevant national professional bodies (SOGC, APOG, RCPSC, and CMA) in partnership with provincial governments need to collaborate and coordinate their activities to find solutions. Such solutions may include the following.

- Providing adequate and stable new funding for MFM subspecialty training in Royal College accredited programs without penalizing general obstetrics and gynaecology training
- Promoting MFM training and subspecialty practice, and advising potential candidates about future job opportunities.
- Making policy makers aware that Canada needs to become self-sufficient in training an adequate number of MFM subspecialists to optimize the care of pregnant women with special medical needs.

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APPENDIX

Contributing members of the Maternal Fetal Medicine Committee of the Society of Obstetricians and Gynaecologists of Canada

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