

# Crisis? What Crisis?

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A friend told me recently that he is suffering from crisis fatigue. Open an issue of just about any medical journal, he said, and you will find at least one article warning of an impending critical shortage of professionals.

This issue of JOGC is no exception; on page 598, the Maternal Fetal Medicine Committee of the SOGC draws our attention—quite correctly—to the looming MFM shortage in this country.<sup>1</sup> Unfortunately, the MFM subspecialists are not alone in facing potential shortages. Over the past couple of years, we have become increasingly aware of shortages of other sub-specialists (oncologists, urogynaecologists, and REI subspecialists), with no evidence that these shortages will resolve. The SOGC has repeatedly drawn our attention to the now inevitable shortage of maternity care providers and to Canada's decline in standing among OECD countries in rates of infant and maternal mortality. The growing shortage of maternity care providers is not limited to Canada, although in Australia and in the United Kingdom a broader role for midwife care has allowed those countries to focus on providing women with the maternity care they want, rather than on providing maternity care in any form. In Canada, it is likely maternity care providers will soon hit the wall.

But they may hit the wall with a thud that is muffled by the cries from other disciplines within our specialty. The cries to relieve professional shortages have become so raucous that we are in danger of becoming desensitized. We may begin to feel that if we can't fix all of these shortages, then we shouldn't try to fix any of them, and we will simply have to learn to make do with fewer resources. After all, we've been doing that for some time now. But should we?

There is another potential risk of having so many calls for help with shortages. In our frenzied attempts to gain public and political sympathy, we start to pit one segment of the profession against another, and interdisciplinary bitterness develops. Exacerbated by fee schedules that favour first one segment of practice, then another, interdisciplinary

bitterness is heightened by income envy. Departments of obstetrics and gynaecology without overall income parity become houses divided.

These outcomes simply will not do. As I see it, we can do two things in attempting to deal with the fallout from these shortages. First, we can use our joint strengths and make our own plans to deal with future professional challenges. The National Birthing Initiative for Canada is an example of how we professionals can lead politicians, policy-makers, and the public towards practical solutions for health care demands. This is an approach that has been championed by the SOGC, and I applaud the Society for its efforts and accomplishments.

But I think that the second thing we can do may be even more important, and if you bear with me I'll get to it. If we go back to the reasons for our growing professional shortages, we can invoke the unfortunate Barer-Stoddart report<sup>2</sup> with its consequences for physician supply. Most provinces have now accepted the need for increased numbers of medical graduates, and are planning accordingly or have already increased the number of medical school places. We can also invoke the demands from new medical graduates for a better balance of professional and personal life than their predecessors had, with consequences for calculating the needed number of physicians. The effects of these two factors on overall physician loads are known. So we must also explore why it is that recent graduates and specialty trainees are not following in the footsteps of their obstetrics and gynaecology mentors, and expanding the academic side of our practice with sub-specialty training.

In Canadian departments of obstetrics and gynaecology, full-time academic positions are occupied for the most part by sub-specialists. The divide between academia and private practice is much less clearly defined than it used to be, and service contracts for sub-specialists have in most cases provided incomes for academics that are fairly comparable to those of specialists in full-time practice. However, in addition to clinical practice, academic appointees are required to participate in research, teaching, teaching administration, and intellectual leadership. If we accept the claims of the

MFM sub-specialists<sup>1</sup> and of Canadian gynaecologic oncologists<sup>3</sup> that there has indeed been a decline in the number of applicants for sub-specialty training, why would that be? If there is no major difference in anticipated income for a career academic, why are specialty trainees not seeking academic careers?

As with so many questions like this, the answer is multifaceted. The overwhelming desire of most medical graduates is to provide patient care and become a good doctor. Added responsibilities of teaching, research, and academic politics are not seen as primarily important or even desirable. If this is indeed the case, coercion from outside will make no difference. Instead, we have to appeal to the dormant enthusiasm in our embryonic specialists.

So the second thing that must be done, in order to tackle the looming shortages in the sub-specialties and in clinical academia, is for those of us who are sub-specialists and academics to be visibly excited about our careers. We have to show that we're having fun. We must encourage residents

and undergraduates to become aware of the dramatic history of our discipline, and of how advances within it have changed the world. We must show our residents and fellows the passion for scientific advancement that leads to national and international collaborations and friendships. We must show them how accomplishment at the leading edge brings unparalleled professional satisfaction.

There is nothing as infectious to outsiders as an obvious passion for our work. We must show hesitant trainees why they should want to be like us.

## REFERENCES

1. Farine D, Gagnon R, and the SOGC Maternal Fetal Medicine Committee. Are we facing a crisis in maternal fetal medicine in Canada? *J Obstet Gynaecol Can* 2008;30(7):598-9.
2. Barer ML, Stoddart GL. Toward integrated medical resource policies for Canada. Report prepared for the Federal/Provincial/Territorial Conference of Deputy Ministers of Health, 1991.
3. The Society of Gynecologic Oncologists of Canada News. Available at: <http://www.g-o-c.org/en/news.aspx>. Accessed May 11, 2008.

## ERRATUM

Bhatti T, Baibergenova A. A comparison of the cost-effectiveness of in vitro fertilization strategies and stimulated intrauterine insemination in a Canadian health economic model. *J Obstet Gynaecol Can* 2008;30(5):411-420.

The following statement in the Results section of the Abstract, page 411, was incorrectly provided as "The results were sensitive both to the cost of IVF cycles and to the probability of live birth." The sentence should read "The results were insensitive both to the cost of IVF cycles and to the probability of live birth." The authors regret the error and any inconvenience it may have caused.