

Planning for the Future

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I thank the Society of Obstetricians and Gynaecologists of Canada (SOGC) for placing their confidence in me as the incoming President of the Society. I accept this appointment on behalf of my father, Matthew Davis, who was a specialist obstetrician-gynaecologist in a small community in Western Canada. I remember seeing him go off to work in the mornings and hearing him say “I *get* to work today.” It took me some time to understand what he meant by that. I also could not have undertaken this task without the support of my wife, Judy. She has an uncanny ability to inspire me while, at the same time, keeping me grounded.

The SOGC was founded in 1944, some 62 years ago, and it has grown to a point where our membership is nearly 3000. This includes specialist obstetrician-gynaecologists, family doctors, nurse practitioners, and midwives. In November of 2005, the SOGC undertook its fourth strategic planning workshop. At that meeting, our Executive Vice-President, Dr Lalonde, reminded us of the activities of the SOGC that can sometimes be overlooked because of the quiet efficiency of the organization. They include the regional educational meetings and the annual clinical meeting. Clinical practice guidelines are developed by more than 20 committees with over 400 volunteers. Our “sexualityandu.ca” website, which has over 200 000 hits per month, provides patients, parents, and teachers with up-to-date, accurate health information. This website reaches 20 countries, and in 2005, it won a United Nations World Summit Award for Excellence in Multi-Media Projects.

A major undertaking, the Managing Obstetrical Risk Efficiently (MORE^{OB}) Program, is on the cutting edge of managing obstetric care in North America. It is conducted in approximately 125 hospitals in Canada and engages more than 6000 health professionals nationwide. As an Albertan, I am proud that the Alberta government is the first Canadian provincial government to fund the MORE^{OB} Program for all hospitals providing obstetric care. This program will have far-reaching benefits because of the current

and looming human resource crisis in obstetric care. It has distilled the basic clinical sciences pertaining to obstetrics and developed a program for cultural change in obstetric care. The MORE^{OB} Program can teach the science of obstetric care, but the art of obstetrics and gynaecology is not an essence that is easily contained or bottled.

The medical education system is the focal point in addressing Canada’s health care needs. Funding for medical education comes from provincial departments of education, but key decisions regarding sufficient supply are in the hands of provincial departments of health. Because of a lack of intragovernmental coordination, medical schools find it difficult to coordinate their activities with government priorities.¹ Medical schools need to produce a workforce able to serve all of Canada’s regions: urban, rural, and remote. Canada’s medical schools have rebounded from a low enrolment of 1577 students in 1997 to 2096 in 2003–2004. Postgraduate residency positions, however, have not increased in sufficient numbers. There is an increasing problem with a lack of “general specialists.” A growing trend towards subspecialization has led to a large number of specialists and sub-specialists in tertiary hospitals in large cities but a lack of specialty services in medium-sized cities and community hospitals.

Dramatic changes have occurred in our specialty over the past 30 years, and the SOGC has been well-positioned to provide continuing professional development (CPD). We will need to do better in light of the mandatory maintenance of certification being demanded by governments, licensing bodies, and our patients. Half of the members of our Society work outside the larger urban centres. These individuals have unique education needs. Interactions between medical students, residents, nurses, and colleagues in tertiary level institutions provide almost automatic CPD. Community specialists do not need to be spoon-fed, but they could benefit from direction with respect to new trends, important changes in standards of care, and highlighted CPD topics.

Change is inevitable, and the SOGC must continue to facilitate change for its members.

Deploying health professionals into groups so that specialists work with family practitioners, registered nurses, nursing practitioners, and midwives, will relieve some of the human resource shortages. As this happens, the specialist obstetrician-gynaecologist will then likely be asked to assume a more prominent role as team leader and work coordinator. He, or more likely she, will need new administrative skills. She will be increasingly called on to juggle the requirements of her profession and the need for a healthy personal life. The SOGC is involved in the multidisciplinary collaborative primary maternity care project. This is a major step in the coordination of maternity care in Canada.

But more than this is needed. Last year, 330 000 babies were born in Canada. There are about 1500 obstetrician-gynaecologists in active practice in Canada. Only 1040 of them actually practise obstetrics, and they attend nearly 80% of all deliveries in more than 300 hospitals across the country. More than 600 obstetrician-gynaecologists work in large urban university centres, teaching, conducting research, and practising in 50 or so hospitals, leaving only 450 obstetricians to cover more than 250 community hospitals: this can be considered a crisis. We must ask how our government plans to address this huge human resource deficit.

It's no surprise to any of us that obstetrician-gynaecologists are more likely than most specialists to be called in during the night and have their sleep disturbed. Sixty-five percent of babies are born between 6:00 p.m. and 6:00 a.m. Understandably, obstetricians nearing retirement want to reduce night work and on-call. Seventy-five percent of residents are female. They and, increasingly, their male colleagues are emphasizing work and personal life balance, which results in fewer full-time equivalents per graduating class. Residents continue to subspecialize, and residency numbers overestimate those available to undertake maternity care. A cascading problem occurs: fewer obstetricians are available to do call, fewer family doctors are doing obstetrics, and the number of midwives is not increasing as quickly as anticipated. Small and mid-sized communities are disproportionately affected as new specialists settle in larger centres. This results in a trend away from community-based obstetrics.

The SOGC's strategic plan is attempting to address the problem, with some success. Of 600 000 maternal deaths in the world last year, only four occurred in Canada. No country has ever achieved a lower maternal mortality rate, and only Sweden and Denmark have ever equalled it. Birth remains an empowering and transformative experience for families and their caregivers.² We must continue to work at giving maternity care the respect and resources needed to keep it safe and available. The time is now for federal, provincial, and territorial governments to address the looming

shortage in human resources. It is no measure of health to be well-adjusted to an ailing medical system.

Aboriginal health is high on the list of strategic directions for the SOGC. The challenge recognized in our planning sessions was to advance culturally appropriate health and healing for Aboriginal women. Insightful guidelines were developed in 2000 and 2001 by the Aboriginal Health Committee of the SOGC. Five documents were released and are as valid today as they were then. This means the Aboriginal Health Committee was prescient in its deliberations, but it also means we may not have made the progress in the past five years that we had envisioned. Nevertheless, we must continue to try. That more work needs to be done is evident in the statistics. Aboriginal infant mortality is two to three times higher than the Canadian average. Fertility rates in Aboriginal women are twice as high as in other Canadian women. There is a strong belief among First Nations, Inuit, and Metis people that a crisis must occur before any action is taken. That action is then an over-reaction, and a long-term solution remains elusive. The SOGC was asked to participate in the "Many Hands, One Dream" conference under the auspices of the Canadian Paediatric Society in December of 2005. I believe this conference will prove to be a milestone in the evolution of Aboriginal health care.

The Canadian health care system is difficult to navigate, even for members of the "dominant culture": it is inconsistently accessible and involves much waiting. Aboriginal people find the system more intimidating than other groups.³ Moffat and Cook found that it was not the remote rural areas that had the highest rates of perinatal mortality due to prematurity and the lowest rates of specialist referral, but the Aboriginal population in one of Canada's largest cities. These patients just could not access the system. Moffat and Cook also described cultural competency. Health care providers need to have the skill and expertise to understand when there are cultural and language issues interfering with a common understanding and agreement of the patient's condition and the course of action to be taken. The Winnipeg Regional Health Authority has an Aboriginal strategy. Even with large efforts, Aboriginal people account for only 1% to 2% of the workforce in the region, although 12% of the population is of Aboriginal heritage. The wheels move slowly. Dr Noni MacDonald has noted that when Native concerns are addressed from a Native perspective with emphasis on collaboration and partnership, more appropriate health care can be provided with more success. Partnerships can work. New techniques are needed for finding solutions. Our traditional ways have not worked.

The goals of the SOGC with respect to Aboriginal health care include improving outcomes in maternity and child care, increasing the number of Aboriginal health care

providers, identifying and disseminating models and pathways for innovative health care, and closing the gap between underprivileged women and the average Canadian woman.

I would be remiss if I did not mention the tremendous efforts of Dr Lalonde, Dr Senikas, and Dr Milne who, along with the exceptional staff at the SOGC, have made an outstanding contribution to women's health, not only in Canada but also around the world. The SOGC has not always chosen the smoothest road, but it has always taken the high road. It is not only helping in developing countries but also in developed nations, where our activities are used as templates.

We will continue to ask the tough questions and continue to inspire the next generation of obstetrician-gynaecologists to get up in the morning and say "I *get* to go to work."

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