INTRODUCTION:

In April, 1998, the British Columbia Ministry of Health requested the consulting services of Lucy Dobbin in a matter regarding physician services in rural areas of the province.

Subsequent to preliminary discussions with the British Columbia Ministry of Health officials, Mrs. Dobbin was contracted under the following terms of reference:

Within the context of the Medicare Protection Act and other legislation, and current circumstances in the Province of British Columbia;

To identify factors leading to the withdrawal of physician out of hours coverage by some doctors in some northern and rural communities; and specifically,

To examine the problems of providing 24 hour emergency coverage to northern and rural British Columbia communities, including issues such as relief; compensation including on call; specialist support; and recruitment;

To review in particular the Northern Isolation Allowance (NIA) program, which provides special compensation to physicians in northern and rural communities, to determine whether this program should be modified or expanded;

To clarify appropriate levels of coverage and levels of service provision for rural and remote communities;

To seek input from the various stakeholders;

To examine approaches to resolving northern and rural medical issues in other provinces;

To recommend means to resolve the current problems and ensure that in future an appropriate range of medical and other health care services are available to northern and rural communities;

To provide a report of the findings and recommendations, in a format suitable for immediate implementation, to the Minister of Health, no later than May 31, 1998.

CONSULTANT'S PROCESS:

The process included meetings, telephone conferences, review of written material including submissions by groups and individuals.

Meetings were held with physicians in Vanderhoof, Fort St. James, Fraser Lake,
Burns Lake, Prince George, Quesnel, Golden, Fernie, Sparwood and Elkford.

Telephone consultations were held with physicians from William's Lake, 100 Mile
House, Nakusp & New Denver, the NIA Committee and Dr. Peter Newbury.

In addition to physicians, meetings were held with municipal representatives in the
north through representatives on the Bulkley Valley Regional District Board, a
conference call with many of the mayors and individual meetings with some.

Representatives of the Northern Interior Regional Health Board and the Community
Health Councils (CHCs) of Smithers, Houston, Golden, and Sparwood were
interviewed either individually or in groups.

Meetings were held with representatives of the British Columbia Medical
Association (BCMA), the College of Physicians & Surgeons, the British Columbia
Medical School, the Registered Nurses Association of British Columbia (RNABC),
the British Columbia Nurses Union (BCNU) and the Health Employers Association of
British Columbia (HEABC).

Meetings were held with MLAs who represent some of the areas where the job
action is taking place.

Discussions were held with the Minister of Health and the officials of the Ministry
on several occasions.

Several groups and a few individuals made written submissions and there was a
wealth of written material reviewed including summaries of actions taken in other
provinces, previously prepared but related documents in British Columbia, including
the Northern & Rural Task Force Report of 1995, documents on NIA and articles in
professional magazines.

Because of the very limited time available, it was impossible to visit all the
communities affected or to hold meetings with the public. But it is believed that
those consultations mentioned above reflected quite well the underlying concerns
related to the present impasse and provided thoughtful advice which could apply to
most of the rural and remote areas of the province.

PROVISO this report and its recommendations are reflective of the needs of the

rural and remote communities known as NIA communities and while some recommendations may have wider ramifications, the restriction remains.

THE CURRENT IMPASSE:

In January of 1998 a significant number of physicians in some northern, rural communities of the province began to withdraw their "on call" services at the local hospitals. These initial actions were joined at later dates by physicians in other rural areas of the province. Most actions resulted in physicians being available in clinics during the day and on call for the community during the off hours but resigning their hospital privileges and being on call for hospital emergencies only of a "life or limb threatening" nature.

Attempts have been made to settle this dispute through meetings between the doctors and the Minister of Health and Ministry officials as well as through the efforts of Mr. J. Monroe. Each effort has failed and the job action has spread to many communities and may have more serious and far-reaching consequences if it is not resolved soon.

Unfortunately, because of real or perceived issues during the dispute, there now exist strong feelings of anger, distrust and cynicism toward the Ministry of Health on the part of the doctors. Many of the physicians hold to the notion that Government does not wish this dispute to end.

While communities have supported the physicians for the most part, there are some resentments growing among the people because they are deprived of the care they have come to expect and because some of them have felt the real hardship of long drives while ill, separation from loved ones and increased costs. This resentment is towards both the government and the doctors.

BACKGROUND:

The difficulties of remote and rural physician practice are not new; neither are they peculiar to British Columbia. Rural medical practitioners, nationally, have long identified the issues which set them apart from urban service provision.

Some of the obvious differences are:

- Long working hours - In rural communities the numbers of physicians are smaller proportionately than in urban areas but care must be available to the

people 24 hours a day. Consequently, it is usually not possible for the doctor to close his/her office at 1700 hr. and be free until 0800 the next day. The issue is a matter of the critical mass of physician numbers as well as the absence of specialist back-up and the absence of modern technology. Whether the responsibility is greater if one is also on call for a hospital or if one is alone and solely responsible is not the issue. The issue is the value attached to having the expertise of the physician available to the community.

Rural physicians are generally faced with a more frequent, often unrewarding on call system than are urban doctors.

Rural physicians have greater difficulty in obtaining locums.

There is a general lack of a coordinated recruitment strategy for remote and rural areas.

The opportunities for continuing medical education and professional support are much greater for urban physicians than for remote or rural practitioners, principally, but not totally, because of distances and costs associated with the location of most Continuing Medical Education (CME) occasions.

The remuneration potential for urban physicians is generally greater than for physicians in remote or rural locales. The population of most rural areas is sufficient to support only so many practitioners and life style issues, such as time off, which would require additional numbers of physicians, cannot be supported by the population base.

Family life style issues such as employment opportunities for spouses and educational opportunities for children are more compelling in rural and remote areas.

Nine other Canadian Provinces have addressed the issues of rural and remote physician services and have brokered solutions which have been more or less successful. In this context, it was only reasonable to expect that the physicians involved in rural practice in British Columbia should expect similar treatment to address similar problems.

Prior to the January withdrawal of "on call" services, rural physicians had, as early

as October 1997, discussed their concerns with local Regional Health Boards (RHB)
and with the lack of response to their concerns, the eventual withdrawal should
not have come as a surprise to anyone.

ISSUES CENTRAL TO PRESENT DISPUTE:

While there are many concerns arising from this present impasse, the central themes are:

a. Being on call for hospitals without payment for same,

b. The frequency of on call (I day in 2, 1 in 3, or even every day),

c. The difficulty in recruiting locums if on call is frequent and unpaid,

d. Difficulties around CME.

A. ON CALL TIME FOR HOSPITAL EMERGENCIES AND LACK OF REMUNERATION FOR SUCH CALL:

In communities where there is a hospital, physicians who apply for privileges are
generally expected to take call as a responsibility attached to those privileges.

In smaller hospitals such call is for 24 hours. Even if the doctor is in a busy clinic
during the day, if he is on call and if there is an emergency in the hospital, he must
respond. As a result, his clinic backs up, his day is extended, patients become
frustrated and the physician is more tired.

At the present time there is no remuneration attached to this call unless the physician visits the hospital and sees a patient. For example, he may discuss
conditions of a patient or patients with the nurse in the emergency room on several
occasions during the night with consequent loss of sleep, but receive no remuneration. Nevertheless, he/she must be on duty in the morning.

Just as we discuss staffing for hospitals in terms of "full time equivalents" (FTEs),
we should realize that the same definitions should apply to physicians. While there
may be 5 doctors in a community, there may be only 3 FTEs and 2 who work part time. Even if there are 5 full time equivalents, unless locums are available on a
continuous basis, there will usually be only 4 physicians available because of
vacation time, CME, maternity leave, etc.

Seemingly forgotten within this present impasse is the notion that there is an inherent value in having a physician available should the need arise. While this has become more readily acknowledged during this dispute, more tangible evidence of this value is a necessity.

It is therefore recommended:

1. THAT A SYSTEM OF RECOMPENSE FOR FAMILY PRACTITIONERS IN NIA COMMUNITIES BE INTRODUCED WHICH GIVES THEM A CHOICE BETWEEN AN ON CALL STIPEND WITHOUT FFS BILLINGS AND A LOWER STIPEND WITH FFS BILLINGS.

2a. THAT THE RATE OF REMUNERATION, OUTSIDE OF CLINIC HOURS, BE $30.00 PER HOUR, WITHOUT FFS, FOR ON CALL BOTH WEEKDAYS AND WEEKENDS AND STATUTORY HOLIDAYS IN ALL NIA HOSPITALS,

AND

2b. THAT IN HOSPITALS WITH FEWER THAN 6 PHYSICIANS, THE WEEKEND RATE SHOULD BE INCREASED TO $40.00 PER HOUR, WITHOUT FFS, FROM 1800 HRS. FRIDAY TO 0800 HRS. MONDAY.

OR

3a. THAT THE RATE OF REMUNERATION, OUTSIDE OF CLINIC HOURS, BE $20.00 PER HR. PLUS FEE FOR SERVICE (FFS) FOR WEEK DAYS AND WEEKENDS IN ALL NIA HOSPITALS WITH FEWER THAN 10 PHYSICIANS.

AND

3b. THAT IN HOSPITALS WITH FEWER THAN 6 PHYSICIANS AN INCREASE TO $30.00 PER HR. PLUS FFS ON WEEKENDS AND STATUTORY HOLIDAYS.

Elements of fatigue impact on the ability of the physician to function optimally. It is therefore recommended:

4. THAT PHYSICIANS WHO DO CALL ON WEEKENDS SHOULD NOT BE ON DUTY THE NEXT DAY UNTIL AT LEAST 1400 HRS.

Physicians should be given the option of the stipend or the FFS plus stipend but all physicians in the same hospital should use the same option for the obvious administrative reasons.

Of particular concern is the system of on call for the general practice (g.p.) anaesthetist and g.p. surgeon. While these individuals take call as family practitioners, they are also on call whenever an emergency arises which requires their special skills. If such an emergency arises during the day, this g.p. specialist

must leave his/her office, attend to the emergency and then play catch up with
waiting clinic patients. The emergency at night leaves him/her on call at least twice
as frequently as the regular family practitioner.

Additionally, an interesting argument surrounds the issue of equal pay for equal
work; since the rate of pay for the g.p. anaesthetist is much less than it would be
for a specialist anaesthetist doing the same procedure. I understand that this
problem is being addressed nationally.

It is therefore recommended:

5. THAT THE G.P. SURGEON AND THE G.P. ANAESTHETIST, IN NIA COMMUNITIES, BE PAID $5.00 PER HOUR PLUS FFS FOR EACH EVENING AND NIGHT WHEN THEY ARE ON CALL IN THAT SPECIAL CAPACITY.

I have great concern about the communities which are the practice sites for 1 or 2
physicians. The responsibility of being the sole physician, on call at all times, or 1
of 2 physicians, on call 24 hours in every 48, is daunting, not only from the aspect
of work but from the point of view of stress and life style.

Where there are Diagnostic and Treatment (D&T) Centres, an expanded role for the
nurse should be considered, as discussed later in this report. It may be possible, if
there is a hospital within 45 minutes, to share call with the physicians in that
facility.

Frequent locums, if such were available, could be part of the answer and should be
considered. Guaranteed vacations and CME relief, as is included in contracts at
present, would also help. But there must also be a tangible recognition of the value
of the continuous physician availability.

It is therefore recommended:

6. THAT LOCAL HEALTH AUTHORITIES (RHB/CHC) WORK WITH THE APPROPRIATE DIVISIONS AT THE MINISTRY TO ACHIEVE SOME EQUITABLE MEANS OF SUPPORTING THE PHYSICIANS IN NIA COMMUNITIES WITH NO HOSPITAL AND ONE OR TWO DOCTORS.

6a. THAT WHILE THIS FORMULA IS BEING DETERMINED, SUCH PHYSICIANS BE OFFERED AN ANNUAL BONUS OF $20,000.

This report has not discussed the issues surrounding those specialists, few in
number, who work in smaller hospitals in the NIA communities. However, it is

strongly suggested that consideration be given at the local level (RHB/CHC) to the
problems faced by this particular group.

B. LOCUM COVERAGE:

In communities with fewer than 5 full time physicians, the need for locum coverage
becomes critical. However, in the present situation where call is so frequent and
the remuneration is so haphazard, there is no incentive for young physicians or
physicians in nearby communities to accept short term locum postings in these
communities. It is crucial to realize that in most of the communities where
physicians have withdrawn their services from hospitals, these same physicians
have been serving these communities for many years with onerous on call
schedules. The precipitating factors are tiredness, burn out, decreasing energy,
family resentment and increased public demand. The Northern Locum Program has
helped some communities but has too few available locums, is inflexible as to
availability and the reimbursement is not such as to attract physicians presently
practising in other communities.

It is hoped that the recommended reimbursement for on call will make such
positions more attractive and allow for improved life style for the present
incumbents.

C. DIFFICULTIES AROUND CME:

Continuing medical education (CME) is crucial to the maintenance and upgrading of
the knowledge and skills required to practice safe, quality medicine. This becomes
more significant in remote and rural areas with little or no specialist back-up
especially in responding to emergencies.

The opportunities for continuing medical education and professional support are
much greater for urban physicians, principally because of distances and costs
associated with the location of most CME occasions. Ease of access and the
regular availability of a variety of topics increases the probability of attendance in
urban areas.

It is worth noting that there are areas in this province where 24 hr. call is so
frequent that a physician may have as few as 56 free days per year. From these
he/she must draw time for continuing medical education, for vacation and for the
exigencies of normal living such as the occasional sick day.

There is a movement toward "out-reach" CME whereby programs are brought to rural areas instead of the traditional way of people going to the programs in larger centres. Those involved are encouraged to expand this program so that educational opportunities are available regardless of one's location in the province.

It is therefore recommended:

7. THAT PHYSICIANS IN THE NIA HOSPITALS BE SUPPORTED IN THEIR PURSUIT OF CME BY SUPPLEMENTS GRADED ACCORDING TO THEIR YEARS OF EXPERIENCE, E.G.

   1- 2 YEARS IN RURAL COMMUNITY - $1600 PER YEAR

   3- 4 YEARS $4000

   5-10 YEARS, ETC. $6000

   note: $1100.00 of this money is already available to all physicians in British Columbia.

One needs to differentiate between CME requirements and basic skill requirements for operating in emergency situations in rural and remote communities. While at present there does not seem to be uniformity regarding the requirements around ATLS, ACLS, PALS, NALS, etc., RHBs/CHCs need to establish these base lines. These programs are costly and are not offered in all areas of the province. This, coupled with the need to replace people while they are attending these training sessions, acts as a negative incentive to maintenance of skills. I share the belief that the cost of maintenance of required skills should not have to be borne by the individual.

It is therefore recommended:

8. THAT BASIC REQUIREMENTS BE SET FOR PRACTICE IN RURAL COMMUNITIES AND THAT A PLAN BE FORMULATED TO ALLOW FOR MAINTENANCE OF THESE REQUIREMENTS WITHOUT EXCESSIVE HARDSHIP TO THE PARTICIPANTS, EITHER PHYSICIANS OR NURSES.

D. LOCAL RESPONSIBILITY:

It is evident that most of the problems surrounding the present issues reside in the communities where the rural physicians live and work. Since it is always best to solve problems as close to the source as possible.

It is therefore recommended:

9. THAT THE RESOURCES REQUIRED TO IMPLEMENT THE ABOVE RECOMMENDATIONS, REGARDING CME AND REIMBURSEMENT FOR ON CALL, BE VESTED IN THE REGIONAL HEALTH AUTHORITIES - RHB OR CHC - AND THAT THESE AUTHORITIES BE ENCOURAGED TO INVOLVE LOCAL PHYSICIAN REPRESENTATIVES IN IMPLEMENTATION.

Additionally, since the health authorities interact chiefly with the acute care division of the Ministry, it would seem logical that this division be involved in the implementation of this report.

ISSUES RELATED TO THE PRESENT DISPUTE

A. RECRUITMENT AND RETENTION:

Of the 7000 physicians in British Columbia, some 10% have sought the help of the BCMA's health committee over the past year. Unlike a few years ago, the main presenting problems are not alcohol and drug related but are the problems related to stress.

Among rural physicians the contributing factors are too much time on call with too little sleep, little time for continuing medical education (CME), difficulty in freeing up time either for vacation or family, social time activities.

Medical graduates of the past have expected and accepted to work longer hours, get less time off and see little of family. The goals and expectations of recent medical graduates include a balance between medical practice and social/family life.

The traditional approach of "total commitment" to the practice of medicine is leavened in the newer graduate by a desire for a life style which allows for a social as well as a family life. Young graduates, with a heavy debt load, have clearly stated to me that they can earn more and still have a good life style if they take positions in urban, walk-in clinics rather than in rural practices where the volume does not allow for high earnings and the unpaid on call is so frequent that they have little time for social and family interaction.

In the past the most successful recruitment processes in rural areas have been

those undertaken by the physicians themselves. However, it is becoming more and more difficult to replace those doctors who are leaving and even to recruit locums on short term basis. It is the contention of the doctors that, considering the schedule for on call at the hospitals, the time commitment involved and the lack of payment, there is no incentive for physicians to accept these positions. As well, positions at walk-in clinics in urban areas which require no on call commitments and allow for significant remuneration opportunities are much more attractive to young graduates with high debt loads.

It is interesting to note the dependence of rural communities on graduates of foreign medical schools. One of the frustrations related to recruitment in rural areas is the restrictions placed on foreign graduates as well as the slowness of the immigration response. This in no way signifies a wish to lower the standards of those who are accepted to practice medicine in the province. Rather it speaks to the need to speed up the bureaucratic processes.

In discussions of the recruitment issue with the numerous players, it became apparent that there have been many attempts to come to grips with this problem but that these attempts are, for the most part, fragmented. For example, individual doctors advertise repeatedly for locums and replacements; RHBs and CHCs sometimes duplicate this effort; one division of the Ministry of Health does some recruiting and the Health Employers Association of British Columbia (HEABC) has a partial program. Such duplication of effort tends only to exacerbate the problems of recruitment and increases the cost.

Within the Ministry some attempts have been made to establish a method of recruiting locums. This is also duplicated in some local areas. The Northern Locum Program has been moderately successful and with some integration of other elements around the same problem, could offer a viable option.

There is already a proposal from HEABC which appears to capture the essentials of an effective rural recruitment program. I understand that a Committee is presently reviewing this proposal and a decision will be made in June. It may be worthwhile to consider expanding this to include locum recruitment. Which body becomes responsible for such a program probably will influence its success but whoever that

is, careful attention should be paid to receiving and using medical input from the rural areas.

Most physicians interviewed indicate that even if there is success in recruitment, people do not stay. For example, over the last 6 years there have been a total of 55 locums in Quesnel, of which only a few have stayed for periods of up to a year.

It is contended by the physicians involved and supported by physicians in larger centres that in addition to an interesting and active practice, physicians need to be monetarily rewarded for the work they do. Although the population of smaller communities cannot support a lucrative practice, the service is still needed and arrangements need to be in place to ensure its provision. These arrangements must ensure relief for the full time physicians either through locums, an over supply of physicians in the immediate area, monetary reimbursement or some combination of these. Contracts presently in place for some salaried doctors include guaranteed vacation and CME relief. Non-salaried physicians need the same respite and could use help in locating and attracting locums.

Other provinces have begun to use incentives other than "cash in hand" such as subsidized housing and office space for the first year, relocation allowances and guaranteed time for CME.

There may be a place for some of these considerations in local communities and the discussions and decisions around such items in British Columbia should take place at the local level including the municipality, the RHB or CHC and the local physicians.

There were several discussions around the recruitment of candidates to medical school. It is believed that if we are ever to approach having larger numbers of Canadian graduates work in rural communities, we must admit more rural students to medical school. It was also suggested that scholarship/bursary programs for rural students would help.

It is therefore recommended:

10. THAT A MEDICAL HUMAN RESOURCE PLAN FOR RURAL AREAS BE

DEVELOPED AND THAT THE RHBs, CHCs, MUNICIPALITIES AND RURAL PHYSICIANS BE INVOLVED IN ITS DEVELOPMENT.

11. THAT AS THE MINISTRY OF HEALTH AND THE LOCAL HEALTH AUTHORITIES DEVELOP MEDICAL HUMAN RESOURCE STRATEGIC PLANS, THE ISSUES RELATING TO LIFESTYLE MUST FORM PART OF THE DELIBERATIONS.

12. THAT A SINGLE PROVINCIAL MEDICAL HUMAN RESOURCE RECRUITMENT AGENCY BE ESTABLISHED.

13. THAT THE PRESENT MODE OF REIMBURSEMENT FOR URBAN WALK-IN CLINICS BE REVIEWED AND REVISED TO REFLECT A MORE EQUITABLE SYSTEM, GEARED TO QUALITY SERVICE FOR THE PATIENT BUT ALSO CONSIDERING THE PROVINCIAL PICTURE REGARDING SUPPLY OF PHYSICIANS.

B. MEDICAL EDUCATION FOR RURAL PHYSICIANS:

This is a multifaceted problem requiring the collaboration of the multiplicity of health players including, but not limited to, the government, the Ministry, The University of British Columbia, the University of British Columbia Medical School, the British Columbia Medical Association, the College of Physicians and Surgeons of British Columbia.

The University of British Columbia Medical School does not receive its funding through the Ministry of Health and therefore requires the strong and constant support of the University and the government.

Developing specific programs geared to rural practice requires the collaborative efforts of experienced and qualified practitioners who will bring to the debate/discussion a wealth of reality oriented experience. This is one of the times when anecdotal experience is invaluable. Unfortunately, there is a tendency to vest the development responsibility for such programs in those whose function should be to administer the programs when developed rather than in those with hands on experience.

There are numerous examples in BC of innovative programs, geared to lessen rural medical service problems but hampered by lack of vision or necessary funding to make them viable, e.g. the rural residency program which survives because practitioners support it monetarily. In most jurisdictions in this country the opposite is the case; the physician supervising the resident is paid for his/her input

to the program.

If one of the goals is to increase the number of Canadian graduates serving in rural areas in the province, the necessary funds must be available to support residents in enhancing the skills they need to practice in such areas or to allow practitioners to return to learn or upgrade those skills, for example, a physician who might wish to take a program in palliative care or obstetrics.

It is therefore recommended:

14. THAT STEPS BE TAKEN IMMEDIATELY TO ENSURE THE VIABILITY OF THOSE PROGRAMS WHICH STRENGTHEN AND ENHANCE THE PRACTICE OF MEDICINE IN RURAL AND REMOTE AREAS OF THE PROVINCE.

C. ALTERNATIVE PAYMENTS:

There is a belief among some that alternative methods of payment for physicians, e.g. salaries, is the best solution for the problems associated with recruitment and retention of physicians in rural areas.

There is no doubt that this method of payment is an answer for some areas which have difficulty in recruiting, particularly because the population is too small to support full time medical practitioners.

The Ministry of Health already has several contracts with physicians or groups of physicians throughout the province and a new pilot is just beginning in McBride and Valemount. However, the FFS arrangements which are negotiated through the BCMA for physician services are not likely to disappear in the near future. Therefore, a combination of the two is most likely to be the solution for the present impasse.

Even where there are contracts, concerns are being expressed with regard to the clause which requires these practitioners to "be on call at all times", as well as with the difficulty in attracting locums.

It is therefore recommended:

15. THAT THE RELEVANT BODIES CONTINUE TO PURSUE ALTERNATIVE METHODS OF PAYMENT, WHEN THE OPPORTUNITY EXISTS, AS ONE WAY TO ENSURE VIABILITY OF MEDICAL SERVICES IN REMOTE AREAS.

16. THAT THE PRESENT MEDICAL EMPLOYMENT CONTRACTS BE REVIEWED

WITH THE INCUMBENTS ONCE THEY HAVE HAD SOME EXPERIENCE WITH A VIEW TO REVISING WHERE NECESSARY.

D. COORDINATION OF SERVICES IN NEIGHBOURING COMMUNITIES

There are communities which are in close proximity to communities of similar size with similar medical services.

The current impetus around regionalisation makes this an ideal time for RHBs and CHCs to work with the medical profession in organizing a supportive collaboration among and between such communities.

Some of the benefits of such a collaboration would include:

1. Greater opportunities for medical support.

2. Increased opportunity for time off for vacation, CME, etc.

3. Greater opportunity for continuity of care for the wider population.

4. Less time "on call".

While geography and weather may not make such arrangements feasible for 12 months of the year, even 8 months of working together could have enormous benefits.

It is therefore recommended:

17. THAT THE RHBs AND THE CHCs BE ENCOURAGED TO WORK WITH PHYSICIANS TO DEVELOP COLLABORATIVE MODELS FOR THE SUPPLY OF MEDICAL SERVICES IN RURAL COMMUNITIES WHICH ARE GEOGRAPHICALLY PROXIMATE.

E. INDIVIDUAL OBSTETRICAL CALL

It is the general practice that individual family physicians cover call for their own obstetrical patients even if they are not on general call that night. Since this increases the fatigue factor, it is suggested that the physicians discuss the possibility of having all obstetrics covered by the physician on call, if that physician practices obstetrics.

F. ROLES OF OTHER PROFESSIONALS:

Nurses - The nature of the provision of health care in rural areas has always seen a close collaboration between physicians and nurses particularly in the provision of emergency services.

While the traditional professional roles remain strong, the changing face of health care requires that we review and adjust according to present day requirements. Already in British Columbia pilot studies are being conducted in the role of the nurse as first responder and, in fact, physicians have encouraged this role in many hospitals particularly where there may be only 2 or 3 doctors.

This notion of the nurse as first responder is not new nor is it unique to British Columbia. The concept, in varying forms, has already been tested in several other jurisdictions and proven itself to be an effective adjunct to the physician role. Much time and effort could be saved by reviewing these models and accepting those which fit the BC scene.

The concept is one which should be planned carefully. One cannot simply appoint a nurse to the role of first responder and automatically expect success.

Therefore, it is recommended:

18. THAT A PROGRAM BE DEVELOPED WHICH EXPANDS THE ROLE OF THE RURAL NURSE AND INCORPORATES THE FOLLOWING:

A collaborative understanding with the physicians, RHBs/CHCs, RNABC, BCNU and the Ministry of Health.

Identification and agreement with regard to specific required skills and transfer of functions.

A properly funded educational program designed to equip the nurse with the required skills as well as follow up continuing education.

A planned program of education for the public to increase their understanding and to foster their acceptance of the nurse's expanded role in primary health care.

Adjustment of some existing health legislation to allow for the expanded role of the nurse.

Ambulance service - For many years it was acknowledged that British Columbia had an above average ambulance service with highly trained personnel. It has been said that recently the funding for the provincial system has been reduced to a point where training programs have been cut and the number of full time, fully trained personnel has been decreased particularly in the low and medium volume stations.

During this present job action by physicians which saw many small hospitals having no access to emergency care, the dependence upon the ambulance service was greatly increased. Where emergent cases needed transfer to larger centres, on many occasions either a physician or a nurse was required to accompany the patient. In situations where numbers of staff - doctors or nurses - are limited, this additional demand has further exacerbated the situation.

Even without the job action, in small and remote communities, there is a need to depend strongly on the ambulance attendants. If the support is strictly volunteer and the training is light, acutely ill patients can only be transferred if a doctor or a nurse accompanies.

We have also been told that the extra demands being placed upon ambulance attendants during this time has led to increased fatigue and the potential for less than adequate response.

It is understood that not every small community can support full time, fully staffed ambulance services. However, in those areas where ambulance services are primarily staffed by volunteers, questions have been raised as to the overall capability of these volunteers to adequately meet the need.

There is certainly an increasing use of the Stars service from Calgary by communities in the south east corner of the province. A review of the reasons, the costs and the quality might help to legitimize this use or lead to improvements of the BC ambulance service to this area of the province.

It is therefore recommended:

19. THAT A REVIEW OF THE RURAL AMBULANCE SERVICE BE UNDERTAKEN TO DETERMINE SERVICE AND EDUCATIONAL NEEDS.

G. INVOLVEMENT OF THE LOCAL MUNICIPALITIES:

As I visited various communities I was impressed with the interest and concern expressed by representatives of the municipalities. This has also been demonstrated by the visit of the mayors to Victoria to meet with government leaders.

It is obvious that the provision of health care in these communities is seen as an integral part of the life of the community. The impact of a possible decrease in availability of medical services is seen as having far reaching consequences, such as:

Increased hardship on those needing health services - especially seniors.

Departure of other professionals.

Increased difficulty in recruiting para-medical and non-medical professionals into the community.

Unwillingness of young families to relocate to an area without adequate health services.

This evident interest on the part of municipalities is a supporting component of the settlement of the present issue and the maintenance of a strong health care system. Many of these municipal representatives agreed that for too long they have taken the medical service in their communities for granted and have not seen themselves as significant players in its maintenance. It is recognized, however, that one of the main factors in recruiting new physicians is the acceptance of the physician's family in the community and municipal involvement can play a role in making the transition easier.

It is therefore recommended:

20. THAT THE MUNICIPALITIES, IN RECOGNITION OF THEIR SIGNIFICANT ROLE, CONTINUE TO PARTICIPATE IN THE RECRUITMENT AND RETENTION OF MEDICAL AND HEALTH PRACTITIONERS.

H. NORTHERN ISOLATION ALLOWANCE PROGRAM (NIA)

This program was instituted in 1978 for the purpose of introducing a fee premium for physicians "who live and practice" in eligible, northern, rural and isolated communities. Several years later the program's goal was changed slightly to physicians "who live, practice and take call" in those communities.

The addition of "take call" was not clarified or defined as including hospital call as well as community call for one's patients. Consequently, the physicians involved in the present dispute did not see themselves as acting outside the existing NIA program since they continued to take call for the community.

There is some concern on the part of the physicians that the Ministry intends to reduce the NIA program if payment is introduced for hospital on call.

Over the past number of years this program seems to have undergone several iterations as the number of eligible communities grew from 69 in 1989-90 to 91 in

1997-98 and the numbers of physicians practising and eligible for NIA grew from
212 to 369.

To someone not familiar with the daily operations of the NIA program, it is confusing, not easily understood and less than transparent. It is interesting to note
that these same sentiments are shared by the physicians in the field. For example,
allowances are paid at a rate of 0.2% per isolation point to a maximum of 20.0%
(that = 100 points).

However, in 22 communities with isolation points greater than 100, the physicians
receive the same allowance as physicians in less isolated communities. Also, because NIA is tied to FFS claims, the lower the FFS billings - the lower the amount of NIA - i.e. doctors working in communities with small populations and
therefore relatively low FFS billings receive fewer NIA dollars than their counterparts in larger communities where FFS billings are larger. This certainly
seems contrary to the principles and purpose of the program.

This confusion or, at the very best, lack of clarity, argues strongly that while the
original NIA premise remains sound, the mechanisms and the applications surrounding it may be flawed.

The general principles underlying NIA appear to apply still and generally are accepted by practitioners in the field. However, a program that has been in place
for 20 years and has undergone several changes would be best served by a complete review and revision based upon the same underlying principles.

It is therefore recommended:

21. THAT THE MINISTRY IN CONJUNCTION WITH THE APPROPRIATE STAKEHOLDERS, INCLUDING RURAL MEDICAL REPRESENTATIVES, REDEFINE THE EXISTING NIA PROGRAM WITH A VIEW TO MAKING IT CURRENT, TRANSPARENT AND INTEGRATED WITH THE OVERALL MEDICAL HUMAN RESOURCE STRATEGIES.

CONCLUDING REMARKS

In a society where equity of service provision remains a goal, it is not enough
simply to recognize the differences between practice modes in rural and urban areas of the province.

The thesis of equity of service provision demands that these differences serve as
the under-pinnings for a provincial medical human resource strategy.

It is therefore axiomatic that government be seen to inculcate within its policy
development process an attitude of pro-active engagement rather than one of reaction where service inequities occur.

The recommendations in this report attempt to broker a resolution to the present
impasse and direct the Ministry to future actions which would strengthen the rural
service patterns and allow for positive relationships with important stakeholders.

REPORT OF LUCY C. DOBBIN

Contents: Page

Letter of Transmittal

Introduction 1
Consultant's Process 2
The Current Impasse 3
Background 3

Issues Central to Present Dispute
- On Call Time for Hospital Emergencies 5
- Locum Coverage 8
- Difficulties around CME 9
- Local Responsibility 10

Issues Related to the Present Dispute
- Recruitment and Retention 11
- Medical Education for Rural Physicians 13
- Alternative Payments 14
- Coordination of Services 15
- Individual Obstetrical Call 16
- Roles of Other Professionals 16
- Involvement of the Local Municipalities 18
- Northern Isolation Allowance Program 19

Concluding Remarks 21