

## Gastroenterological practice in Canada

I write this article as someone who spent the first eight years of her working life as a physician in England, then moved to the United States for three years, and has been on the academic staff at a Canadian medical school for 15 years. This introduction explains why a somewhat comparative approach has been taken to describe gastroenterology as it is currently practised in Canada.

Each province/territory in Canada has its own health care plan, with financial reciprocity between provinces. These systems are funded in the main through the provincial budget with ever decreasing amounts transferred from the budget of the federal government. No one with Canadian citizenship or residency status is denied health care coverage. In theory there is 'universal access' to health care but in reality as the cost of drugs are not covered by most provinces, surgical rather than medical treatment may be the preferred option for some, for example, hiatus hernia repair rather than longterm proton pump inhibitors. There is probably also a certain degree in variation in health care service between the poorly populated northern regions with fewer doctors and the 16 or so major cities in the south.<sup>1</sup> Practice outside the provincial health care scheme is not forbidden but a physician cannot then also bill the government using the current 'fee for service' system for that same patient for any amount. At present there is no limit on the number of consultations a patient can seek, although there is a limitation being introduced on the travel reimbursements for persons from the north of Ontario to travel south for consultation.

There is strict government control of the number of entrants to medical school and the number of training posts for postgraduates. Currently there are 12 adult and three paediatric gastroenterology training programmes. The number of funded positions in each programme has decreased by 50% over the past 10 years. Private funding of trainees is restricted to trainees from abroad and they must guarantee to return home upon completion of their training. Hence entrance to a gastroenterology training programme is very competitive. Applications can only be made after completion of three years of training in internal medicine. Once in a programme there is keen competition within individual programmes for recognition of teaching excellence – that is, if teaching by the staff is judged substandard by the programme director the trainees will be moved to where the teaching is better. There are annual internal reviews of each training programme and the Royal College of Physicians and Surgeons review all training

programmes every six years. It is not unusual for teaching programmes to be put on probation and lose accreditation altogether if no improvement is shown. As a result of these strict procedures the clinical training in gastroenterology in Canada consists truly of education and training rather than apprenticeship alone, and is of a consistently high standard across the country. It should be pointed out that in Canada trainees in internal medicine and all other specialties are only attached to teaching hospitals and most staff at teaching hospitals have a university appointment.

Despite the strict training criteria there is in reality no limitation on who can perform endoscopy in Canada! Countrywide it is probably fair to say that most upper endoscopies are not performed by gastroenterologists but rather by surgeons, internists, and even family physicians particularly in rural areas. There is no enforced council on Medical Education qualification for gastroenterologists and in fact it is not necessary to have passed the Royal College of Physicians and Surgeons diploma in gastroenterology to practise as a gastroenterologist – a fellowship in internal medicine followed by participation in a gastroenterology training programme may be sufficient. Currently there are 500 members of the Canadian Association of Gastroenterology, the members comprise mostly adult and paediatric gastroenterologists, a few members are PhD scientists and general surgeons – only 10% of the total are women most of whom are paediatric gastroenterologists.

Canada is a huge land mass, sparsely populated (total 26 million) and most people live in cities, many of which are very close to the US border. Canada has always been a land of immigrants, but the pattern of immigration has changed over the years. Currently there are 250 000 immigrants a year to Canada – that is, 1% of the population/year are new to the country. Whereas in the past settlement in rural areas took place now most new immigrants choose to settle in the following cities in descending order: Toronto 28%, Montreal 20%, Vancouver 11%, Calgary 3%, Edmonton 3%, and Ottawa 3%. The distribution of new arrivals to Canada is far from homogeneous and hence the effect they make on medical practice is extremely variable. The change in the patterns of immigration has been very rapid and the medical community not surprisingly needs time to adapt to these changes. It is considered politically incorrect to track people according to racial group but the countries of origin of immigrants in 1992 to Canada were: Asia and Pacific 48.7%, Europe 17.3%, Africa and Middle East 16.1%, Central and South

America 15%, and the USA 2.9%.<sup>2</sup> These immigrant populations, tend to maintain their native culture and customs for at least one generation upon arrival in Canada. A tremendous degree of adaptation is required on the part of the immigrant to the Western style of medical practice. It is often difficult to ascertain whether or not misunderstanding between a patient and the doctor is purely cultural or an individual difference of opinion. There is the potential for many such misunderstandings – in my practice in the centre of Toronto 60% of my patients do not have English as their first language. It is most unfortunate that grandparents often have to relate their histories through their grandchildren. Important misrepresentations may take place if you are forced to ask a relative rather than a trained interpreter to explain the nature of a patient's disease.

As the largest immigrant population is Asian the prevalence of hepatitis B across Canada has increased over the past decade<sup>3</sup> and not surprisingly the rate of hepatoma has risen 10-fold in our hospital alone over 10 years (500 cases in 10 years). Oriental cholangitis is a well recognised cause of septic shock in a young person. Ascariasis is common and the screening of stools for silent strongyloides infection must be considered before introducing immunosuppressive treatment. Tuberculous ileitis must be considered in the differential diagnosis of Crohn's disease especially in a refugee who has been 'camp bound' often for quite some time before arrival in Canada. But as is so everywhere else in the Western world irritable bowel syndrome is still the most common diagnosis made by any gastroenterologist and alcohol related liver disease predominates.

Few of us are exposed to handling gastroenterology problems in the natives of the Arctic circle. The prevalence of certain cancers is very different in the Arctic compared with southern Canada. Colon cancer is very unusual in the Arctic, sadly lung cancer is very common probably related to oil burning lights and the high cigarette smoking rate.<sup>4</sup> There is also a high hepatitis B carrier rate (3%)<sup>5</sup> among the inhabitants of the Arctic but hepatitis C is uncommon.<sup>6</sup>

The multicultural nature of Canada is reflected in the demography of the physicians as well as their patients. But recently restrictions have been placed on permitting foreign trained medical graduates to practise in Canada unless recruited to underserved areas. Recruitment of First Nation (Native Canadian) students is only now being actively encouraged to medical schools where the student population is otherwise very diverse, particularly in the medical schools in cities where immigration is greatest.

Although research dollars from the Medical Research Council of Canada have remained stable over the past few years (\$C129 319 000 in 1988 and \$C165 039 000 in 1993) the

percentage going to gastroenterology has decreased from 4.7% in 1988 to 3.7% (\$C6 000 000) in 1993 and fewer applicants have been funded, 76 in 1988 and 61 in 1993.<sup>7</sup> Private foundations like the Crohn's and Colitis Foundation and the Canadian Liver Foundation spent \$C643 000 and \$C700 000 respectively in 1993 for research support for gastrointestinal disease. These private foundations, however, do not provide any salary support for physicians and personal awards towards salary from the MRC are few and the competition demanding. Over the past few years few increases in university funding towards physician's salaries have occurred and as recruiting continues academic staff are expected to generate more and more of their own income from the fee for service practice. This need to 'earn one's keep' can effect academic productivity and may be a disincentive to some young trainees to join the academic field.

The Canadian health care system is constantly being compared in published reports with that of our closest neighbour the USA.<sup>8</sup> Access to certain elective procedures/surgeries in the Canadian system may be slower than the American because both the number of beds and physicians is restricted by the government. In Canada, however, both the clinicians and the patients have a lot more local autonomy – that is, there is comparatively little micromanagement. There is currently no restriction on the activities of the physicians, for example, tests can be ordered, other consultations requested, second opinions generated without any interference from the fee payer – that is, the government. However, with an increasing national debt this degree of freedom of style of practice may not persist. We as physicians need to remain vigilant about maintaining the excellence of the Canadian health care system yet live within the restraints of necessary government cutbacks.

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