CANADIAN ASSOCIATION OF GASTROENTEROLOGY
L'ASSOCIATION CANADIENNE DE GASTROENTÉROLOGIE

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November 23, 2007

The Honourable George Smitherman
Minister of Health and Long-Term Care for Ontario
Hepburn Block
80 Grosvenor Street, 10th Floor
Toronto, ON M7A 2C4

Dear Minister Smitherman,

I am writing on behalf of the Canadian Association of Gastroenterology to urge you to reverse your recent decision to freeze the number of Gastroenterology fellowship training positions in the Province of Ontario.

The Canadian Association of Gastroenterology (CAG) is an organization of over 1,200 members, composed of practicing gastroenterologists, research scientists, students and allied health professionals. In recent years our organization has been increasingly concerned about limitations in access to high quality digestive health care for Canadians. Therefore the CAG instituted a three-pronged approach to provide a framework for addressing the problem. This included: 1) A detailed manpower analysis including a census of who is providing digestive health care in Canada, expected number of upcoming retirements, and current number of physicians in gastroenterology training; 2) A nationwide practice audit to quantify wait times for consultation and endoscopic services based on specific diagnoses, and 3) A consensus conference to establish target maximal wait times for digestive health care services based on reason for referral.

The attached report, which we have sent to your office previously, summarizes the key findings of these initiatives. As you can see, the results are extremely troubling. Not only are we currently failing to meet target wait times for the majority of Canadians referred for specialist care of digestive health problems, but unless something is done this will only deteriorate further in the next few years. Canada already has a serious shortage of digestive health care specialists, which will decline a further 10% in the next decade unless the number of training positions in Gastroenterology is immediately increased. This applies to all provinces, including Ontario. The current deficit in both human and endoscopic resources is particularly concerning given that demand will escalate markedly with institution of the new colorectal cancer (CRC) screening program in the province.

The CAG recognizes that a multi-faceted approach is required to optimally utilize the resources currently available, but there is no doubt that unless we train an appropriate number of new gastroenterologists, access to digestive health care including CRC screening and prevention will be severely compromised.

Given this background, we are deeply concerned about your decision to freeze Gastroenterology training positions in province, and believe that if not reversed this will have serious adverse consequences for the health of Ontario citizens for many years to come. This year there is a wealth of highly qualified and motivated applicants to the 5 Gastroenterology programs in Ontario. We therefore urge you to reconsider your decision and provide appropriate funding so that training positions in our specialty are increased appropriately for the upcoming year.

Sincerely,

William Paterson, FRCPC
President, CAG

Cc: Dr. Linda Rabeneck, Regional Vice President, Toronto-Sunnybrook Regional Cancer Centre
Dr. Des Leddin, Past President, CAG
Dr. Ron Bridges, President Elect, CAG

CANADIAN ASSOCIATION OF GASTROENTEROLOGY
REPORT

Access to Digestive Health Care in Canada

PART I Background

About the Canadian Association of Gastroenterology

Since 1962 the Canadian Association of Gastroenterology (CAG) has been active in research, education and patient care in all areas of digestive health and disease. The Association includes professionals of many different disciplines (gastroenterologists, surgeons, paediatricians, radiologists, basic scientists, nurses, nutritionists, health care ethicists). Today over 1,200 members comprise the CAG. It is the national organization representing Gastroenterology in Canada and has key links with international bodies. In September 2005 the CAG hosted the World Congress of Gastroenterology in Montreal.

About Gastrointestinal Diseases

Gastrointestinal diseases in Canada have an enormous, yet largely unrecognized, financial impact. The economic burden of digestive diseases exceeds that of all other disorders, including mental, cardiovascular, respiratory and central nervous system diseases and cancer.[1] Gastrointestinal diseases are responsible for 15% of the total direct economic burden of Canadian health costs.[1] Unlike many other diseases that are associated with advanced age, digestive diseases often strike individuals in their prime years. The resulting short-term loss of productivity costs Canadian business and taxpayers $1.14 billion per year.

Gastroenterology Resources – Clear as Mud?

A human resource plan to ensure adequate delivery of gastroenterological (GI) health care services is of vital importance to physicians, patients, the public, and government. Yet, determining current resources and estimating future needs is fraught with difficulties. Some services performed by gastroenterologists are carried out by other health professionals including surgeons, internists and specialized nurses. This complicates estimation of the number of professionals providing GI care. Referral rates vary between urban and rural settings and are affected by the number of primary care physicians. Public education can also influence demand. For example, over the past decade increased awareness of colon cancer incidence and its prevention through screening has escalated demand for screening services such as colonoscopy, which now accounts for up to 15% of all gastroenterologist referrals in some areas.

The CAG has approached the problem from the perspective of the patient by asking two questions: *What is the waiting time for a patient to see a GI specialist for consultative or diagnostic/therapeutic services*? and, *Is that waiting time appropriate?* To answer these questions the CAG Human Resource Planning Project was launched in 2004.

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PART II The CAG Human Resource Planning Project

Initiative #1 – What are appropriate waiting times?

In January 2005 the CAG held a consensus conference to develop evidence– and expertise-based recommendations on maximal, medically-appropriate waiting times. The consensus involved numerous stakeholders, including gastroenterologists, general surgeons, internists, provincial gastroenterology associations, family medicine, and government. To complement the professional perspective, feedback from patients was sought. The targets set by the consensus group have been submitted for publication and are summarized in Part III.

Initiative #2 – What are current waiting times for gastroenterology services?

Canadian gastroenterologists have long been concerned with access to digestive health care services in light of anecdotal reports suggesting that patients wait in excess of one year for non-urgent endoscopy in some parts of the country. However, data had not been formally or comprehensively collected on a national basis.

The practice audit in gastroenterology (PAGE IV) program was created to gather these data. In PAGE IV physicians across the country anonymously recorded actual wait time information, including the indication for referral to the gastroenterologist, the time between referral and consultation, and the total time between referral and receipt of diagnostic/therapeutic services. Data were recorded on a palm pilot that physicians carried during the week that they participated in the audit. Subsequently, data were downloaded to a secure central server and database. The PAGE IV program ran from January through October of 2005. Preliminary findings were released in September 2005 and are summarized below. The CAG continues to analyze the wealth of information gathered through the program.

Initiative #3 – Human Resources in Canada

A third and equally important element of resource planning involves understanding available gastroenterology manpower. The number of practising gastroenterologists and their productivity must be considered, along with factors that affect the flow of physicians into (training programs and immigration) and out of (retirement, emigration) the system. As a first step a CAG subcommittee has extracted and analysed data from the Canadian Institutes of Health Information's (CIHI) National Physician Database.

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PART III Key Findings

Initiative #1 – Recommended (Target) Waiting Times

Twenty-four recommendations for the maximal waiting time were prepared by the consensus group (Table 1). All statements followed the standard wording of: "Patients referred with <symptom or sign> should be seen, and if indicated, endoscoped within <time period>." Statements were divided into four acuity categories, and **all symptomatic patients were recommended to be seen within 2 months.** Procedures and testing in asymptomatic patients was suggested to occur within 6 months.

Patients support these recommendations as shown by a survey conducted by consensus physicians. Of 916 patients in six different Canadian cities, 96% felt that the maximal wait to see a GI specialist should be less than 3 months.[1]

Table 1. Summary of recommended maximal waiting times.

Within 24 hours	• Acute gastrointestinal bleeding • Esophageal food bolus or foreign body obstruction • Clinical features of acscending cholangitis • Acute severe pancreatitis (ERCP within 72 hours, if indicated) • Severe decompensated liver disease • Acute severe hepatitis
Within 2 weeks	• High likelihood of cancer based on imaging or physical exam • Painless obstructive acute jaundice • Severe and/or rapidly progressive dysphagia or odynophagia • Clinical features suggestive of active inflammatory bowel disease
Within 2 months	• Bright red rectal bleeding • Documented iron deficiency anemia • One or more positive fecal occult blood tests • Chronic viral hepatitis • Stable dysphagia (not severe) • Poorly controlled reflux/dyspepsia • Chronic constipation or chronic diarrhea • New onset change in bowel habit • Chronic unexplained abdominal pain • Confirmation of a diagnosis of Celiac disease (antibody test)
Within 6 months	• Chronic gastroesophageal reflux disease for screening endoscopy • Screening colonoscopy • Persistent (more than six months) unexplained abnormal liver enzyme tests

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Initiative #2 – Actual Waiting Times

National Findings

In the interim analysis 181 GI specialists nationwide captured information on approximately 5400 patient referrals. One half of patients had a total waiting time (time between family doctor referral and specialist test/procedure) of almost 4 months (15 weeks) and 1 in 4 patients waited more than 7 months (31 weeks).[2] Compared with the 2 month target set by the consensus, this is an abysmal finding.

Alarm symptoms are those that may indicate a serious underlying disease such as cancer. The consensus recommended that all patients with alarm symptoms be assessed within 2 months. However, PAGE data show that only half of the patients with alarm symptoms were seen within this recommended timeframe and 1 in 4 waited more than 4 months.

Missing the Target

Comparison of actual waiting times with recommendations (Table 2) indicates that serious problems exist regarding access to GI health care.

Table 2.

Reason for Referral	Recommended	Actual
Documented iron deficiency anemia	within 2 months	▪ 2 out of 4 patients wait 3 months ▪ 1 out of 4 wait more than 5 months
Positive fecal occult blood result	within 2 months	▪ 2 out of 4 wait more than 2.5 months ▪ 1 in 4 waits more than 5 months
Poorly controlled reflux/dyspepsia, but no alarm symptoms	within 2 months	▪ 2 out of 4 wait more than 5 months ▪ 1 in 4 waits more than 9 months
Dyspepsia and associated alarm symptoms	within 2 months	▪ 2 out of 4 wait 2.5 months ▪ 1 in 4 waits 5 months
Unexplained chronic diarrhea/constipation	within 2 months	▪ 2 out of 4 wait 5 months ▪ 1 in 4 waits 11 months
Clinical features highly suggestive of significant active inflammatory bowel	within 2 weeks	▪ 2 out of 4 wait 4 months ▪ 1 in 4 waits 7 months

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Waiting Times by Province

Waiting times varied by province and the results paint an alarming picture of access to digestive health care. For example:

- Albertans have the longest total wait; for half it is more than 19 weeks, and 1 in 4 wait over 40 weeks
- In New Brunswick half of patients have a total waiting time of almost 15 weeks
- Half of Ontarians wait almost 16 weeks;
- In Quebec the average waiting time is just over 10 weeks; and
- In British Columbia the average wait is over 9 weeks.

Regarding alarm symptoms, the provinces with the longest waiting times are:

- Ontario, where 1 out of 4 patients with alarm symptoms waits 19 weeks from initial referral to procedure or test, and
- Alberta, where 1 out of 4 patients waits over 18 weeks.

***Initiative #3* – The Human Resource Picture**

Data were extracting from CIHI's National Physician Database to estimate the number of gastroenterologists in Canada. Since gastroenterologist numbers cannot be taken directly from the database the following definition was used. A gastroenterologist was considered to be any medical specialist who performs at least 100 upper endoscopies or at least 100 colonoscopies per year.

Based on 2002/2003 data Canada has a total of 550 gastroenterologists or 1.83 specialists per 100,000 population. As Table 3 shows, this is considerably less than in the U.S., France or Australia. Only the U.K. has fewer gastroenterologists and they have implemented a plan to increase the number of GI specialists per 100,000 to about 4. This has begun to pay off with growth of 7.1% over the last few years. Australia has also taken steps to increase specialist numbers by doubling the number of GI trainee positions.

Table 3.

Country	Gastroenterologists/ 100,000 population	Growth (%)
United States	3.90	
France	3.48	+/-0.8
Australia	2.10	1.8
Canada	1.83	???

United Kingdom	1.41	7.1

On their own these data are cause for concern. However, when viewed alongside retirement expectations the picture is nothing short of alarming. Assuming a retirement age of 65 years, 18% of GI specialists are due to retire in the next five years and a whopping 33% will retire over the next 10 years. The picture varies by region and is bleakest in Manitoba/Saskatchewan and Atlantic Canada, where 46% and 38%, respectively, may retire in 10-years time. Looking again at international comparisons Canada's situation is uniquely dismal (Figure 1). These findings indicate that Canada is headed for a serious manpower crisis.

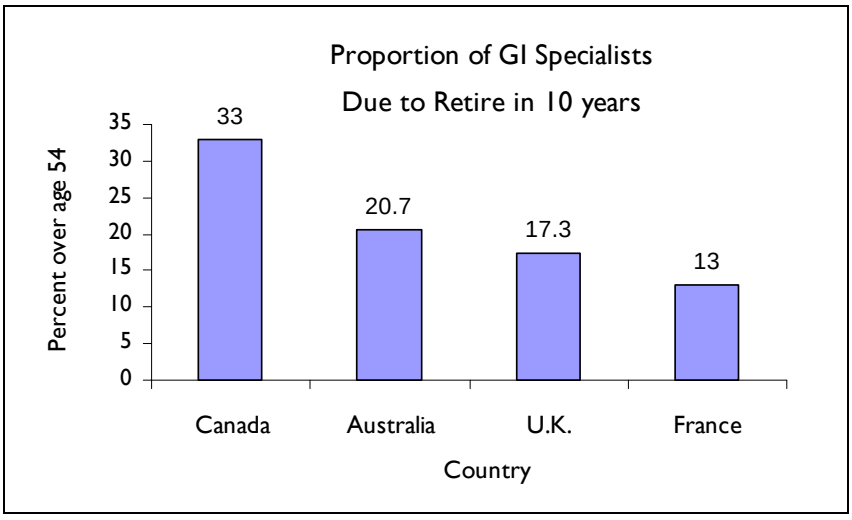

Figure 1.

Colon Cancer – Lethal yet Preventable!

Colon cancer is the second leading cause of cancer death in men and women. Each year 20,000 Canadians receive this diagnosis, one third of whom will die of the disease. Yet considering that the disease is 90% curable when detected early it is inconceivable that there is still no national screening program in place. Published data indicate that less than 1 in 5 eligible patients in Ontario is screened for colon cancer. If a fraction of the $500M spent annually in Canada to treat colon cancer was applied to prevention and screening all Canadians would be much better served.

The risk of colon cancer increases with age. The probability of developing the disease in the next ten years is 1:1000 in the 30-39 age group, but escalates to 1:125 in the 50-59 age bracket and 1:50 at age 60-69 years. Recommendations of the CAG are consistent with international guidelines and recommend screening begin at age 50 for individuals at average risk for colon cancer.[3] With the aging Canadian population demands for screening will increase substantially in coming years, and need to be considered in calculations of manpower requirements.

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PART IV The Way Forward

A Multi-Faceted Approach is Needed

To avert the forthcoming crisis in digestive health care the CAG has estimated that at least **a two-fold increase in gastroenterologists is required**. This does not take into account the anticipated increased demand for colon cancer screening. One straightforward means to begin to address the problem is to increase the number of residency positions in gastroenterology. The CAG strongly advises that this be implemented immediately as one part of a multi-faceted approach.

At its annual scientific meeting in February 2006, the CAG held a number of sessions highlighting the perilous human resource situation and exploring potential solutions. These include means of extending gastroenterologist resources and might involve:

- Family practitioner clinics for flexible sigmoidoscopy
- Training of nurse endoscopists[4]
- Use of gastroenterology physician assistants
- Implementing quality assurance and efficiency programs in endoscopy
- Increased physical resources (endoscopy suites, equipment, etc.)

The CAG welcomes the opportunity to work with key stakeholders including government to look at various options and implement effective strategies.

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