Saskatchewan Paediatric Respiratory Medicine Review

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Joe Reisman completed an undergraduate Bachelor of Arts degree (magne cum laude) at Queen's University, Kingston, Ontario from 1972-1976. A Doctor of Medicine M.D. degree was completed at the University of Toronto between 1976-1980. Dr. Reisman completed his MBA at the University of Toronto Rotman School of Management from 1996-1998.

Postgraduate medical training has included a mixed internship year completed at Mount Sinai Hospital, Toronto (1980-81) and a year of General Surgery in the University of Ottawa Surgery Program (1981-82). A 3-year residency in General Paediatrics (1982-85) and a 3- year Fellowship in Paediatric Respirology were completed at the Hospital for Sick Children, Toronto (1985-88).

In 1988, Dr. Reisman joined the full time staff of the Division of Respiratory Medicine at the Hospital for Sick Children, Toronto. Academic appointments were as an Assistant Professor, Faculty of Medicine, University of Toronto from 1988-1995, and as an Associate Professor from 1995-1999.

Dr. Reisman was the Training Program Director for Paediatric Respiratory Medicine at the University of Toronto from 1995-1999. As well he has functioned as the Co-Chair of the Examination Board for Respiratory Medicine for the Royal College of Physicians and Surgeons of Canada from 1995-2002 and served on the Respiratory Medicine Nucleus Committee of the Royal College. For contributions towards the educational endeavours of the Lung Association, Dr. Reisman received the Special Services Award in 1995 and the Meritorious Service Award in 1997.

Research focus has pertained to clinical trials in the spheres of pediatric asthma and cystic fibrosis. From 1992-1999, Dr. Reisman served as a Co-Principal Investigator (1992-95) and Principal Investigator (1995-99) for the Hospital for Sick Children site of the multi-year, multi-centre, NIH funded, Childhood Asthma Management Program (CAMP). This is the largest pediatric asthma clinical trial ever undertaken. Dr. Reisman is currently working as a Co-Investigator in a variety of clinical trials at the Children's Hospital of Eastern Ontario, Ottawa. In terms of Canadian asthma care, Dr. Reisman has participated in the consensus meetings that led to the most recent (2004) Canadian Asthma Consensus Guidelines (Paediatric).

As of January 2000, Dr. Reisman became the Chief of Pediatrics at the Children's Hospital of Eastern Ontario, Ottawa, and Professor and Chairman of the Department of Pediatrics, University of Ottawa. In his administrative capacity, as well as sitting on a variety of internal and external committees, he has served on the Provincial Council on Child Health for the Province of Ontario, and has been Co-Chair of the Canadian Child and Youth Health Coalition 'Efficiency Indicators' Task Force, and is currently Chair of the Canadian Child and Youth Health Coalitions' National Indicator Advisory Group. He remains active in the delivery of Pediatric Respiratory medical care.

Saskatchewan Paediatric Respiratory Review

Background

Given concerns about the availability of paediatric respiratory medicine subspecialty resources in the Province of Saskatchewan, I was invited to review the state of affairs by the Lung Association of Saskatchewan. The review was completed in both Regina and Saskatoon January 7-9, 2009. I would like to thank Dr. Brian Graham, CEO of the Lung Association of Saskatchewan for his help in arranging a comprehensive schedule of meetings with physicians, nurses and other allied health personnel, Government and Public Health officials, in order to complete the review. I thank the interviewees for their help and insight.

Paediatric Respiratory Medicine- The Subspecialty

The paediatric subspecialty of respiratory medicine has grown significantly over the last 30 years. A separate Paediatric Respiratory Medicine Certification Examination was instituted by the Royal College of Physicians and Surgeons of Canada in 1988. Candidates complete a minimum of two years of training in Paediatric Respiratory Medicine after the completion of general paediatric training. In many cases, a third respiratory research year is also completed. There are currently approximately 52 paediatric respirologists practicing across Canada (1). With very few exceptions, these physicians work in the 16 Paediatric Academic Health Science Centres (PAHSC's) across the country. Royal College Approved Training Programs for Paediatric Respiratory Medicine currently exist in Alberta, Manitoba, Ontario, and Quebec.

Paediatric respirologists have consultation practices; from a clinical point of view, their expertise covers a wide range of congenital and acquired paediatric lung disease including the following:

- Asthma- diagnosis and management, including acute and maintenance therapy
- Cystic Fibrosis- diagnosis and management of this most common lethal genetic disorder of the Caucasian population
- Congenital Lung Disorders- diagnosis and management of congenital disorders such as cystadenomatoid malformations, sequestration, and bronchogenic cysts
- Bronchopulmonary Dysplasia and other sequelae of prematurity

- Oxygen Therapy- management of the child with chronic and ongoing oxygen requirements
- Invasive and Non-Invasive Ventilatory Management- management of sleep and breathing control disorders, and the technology-dependent child
- Chronic cough- diagnosis and management
- Bronchoscopy and broncho-alveolar lavage as diagnostic testing
- Performance and interpretation of paediatric pulmonary function testing and exercise testing
- Pulmonary management of the immuno-compromised child, including children and youth with cancer
- Complicated pneumonia, including empyema- diagnosis and management
- Paediatric Tuberculosis
- Aboriginal lung disease, including severe sequelae of bronchiolitis

In addition to the above areas of clinical expertise, paediatric respirologists play a key role in the education of medical students, general paediatric residents and fellows, and providing continuing medical education for community physicians. As well, they are responsible for training the next generation of physicians with expertise in the diagnosis and management of paediatric respiratory disorders.

Paediatric respirologists contribute to the areas of basic and clinical research, and help push ahead the frontiers of science with new and improved approaches to the diagnosis and management of a wide variety of disorders. As well, research into how to improve and efficiently and effectively manage our health system is carried out by Paediatric Respirologists.

Saskatchewan- The Current Situation

To get a clear picture of what is going on from a paediatric respiratory point of view, a series of interviews was conducted both in Regina and Saskatoon January 7-9, 2009. While a very significant portion of the population lives outside these two urban centres, the physicians, nurses, allied health professionals, government, and lung association representatives represented a breadth of knowledge and experience relevant to the entire Province of Saskatchewan.

Interviewees January 7-9, 2009

Dr. Ram Abdulla; Head of Adult Respiratory Medicine and Head of Medicine, Regina-Qu'Appelle Health Region

Dr. Bruce Holmes; Medical Director, Cystic Fibrosis Clinic, Regina General Hospital

Ms. Val Davies; Executive Director, Cardio, Respiratory and Critical Care, Regina Qu'Appelle Health Region

Ms. Sheryl O'Quinn; Manager of Respiratory Services, Regina Qu'Appelle Health Region

Dr. Moira McKinnon; Chief Medical Health Officer

Ms. Debra Jordan; Executive Director, Acute and Emergency Services Branch, Saskatchewan Health

Mr. Duncan Fisher; Special Advisor to the Saskatchewan Deputy Minister of Health

Ms. Pat Smith; Lung Association of Saskatchewan board member, pharmacist, Respiratory Educator in Community Physicians Offices

Ms. Marilyn Reddy; Past Board Chair, Lung Association of Saskatchewan

Mr. Brent Kitchen; Lung Association of Saskatchewan board member, Respiratory Therapist

Dr. Bill Bingham; Chief and Chairman, Department of Pediatrics, Saskatoon

Dr. Bryce Lothian; Paediatric Respirologist and Intensivist, Saskatoon

Dr. Darcy Marciniuk; Adult Respirologist, Head, Division of Respirology, Critical Care and Sleep Medicine, Saskatoon

Dr. Donald Cockcroft; Adult Respirologist, Saskatoon

Dr. William Albritton; Dean, College of Medicine, University of Saskatchewan

Dr. Frank Scott; Board Chair, Lung Association of Saskatchewan

Dr. Penny Davis; Director of Continuing Professional Learning, College of Medicine

Ms. Elizabeth Ochitwa; Respiratory Therapist, Paediatric Pulmonary Function Laboratory, Saskatoon

Ms. Sarah Sokoluk; RN, Paediatric Intensive Care Unit nurse

Ms. Bonnie Brossart; CEO, Health Quality Council of Saskatchewan

Dr. Dennis Kendel; HQC Board Member, and Registrar, College of Physicians and Surgeons of Saskatchewan

Dr. Mitch Persaud; Community-based Paediatric Allergist, Saskatoon

Dr. Krista Baerg; Division Chief, General Paediatrics, Department of Paediatrics, Saskatoon

Dr. Ayisha Kurji; General Paediatrician, Department of Paediatrics, Saskatoon

Dr. Carla Krochak; General Paediatrician, Department of Paediatrics, Saskatoon

Dr. Angela Jones; General Paediatrician, Department of Paediatrics, Saskatoon

Dr. Susanna Martin; General Paediatrician, Department of Paediatrics, Saskatoon

Dr. David Poulin; Saskatoon Regional Health Authority, VP Medical Affairs

Mr. Marcel Nobert; Saskatoon Regional Health Authority

Ms. Brynn Boback-Lane; Saskatchewan Children's Hospital Foundation

Lung Association of Saskatchewan staff: Brian Graham, PhD; Jan Haffner, BPT, CRE; Bernie Bolley, RN, CRE; Marion Laroque RRT, CRE; Paul Van Loon, MSc.

Dr. Mark Montgomery; Paediatric Respirologist and Cystic Fibrosis Clinic Director, Calgary, Alberta (phone interview)

It can be seen that the list of interviewees was quite comprehensive. As a group, they appeared completely committed to enhancing healthcare in the Province of Saskatchewan, and recognized both strengths and weaknesses in the existing Health Care System. While there was not universal accord, an overwhelming number of those interviewed felt that in general, the paediatric specialties and subspecialties needed significant enhancement in Saskatchewan, and that more specifically, there was a significant need for enhanced access to paediatric respirologist care.

Respiratory Issues in Saskatchewan

The Chief Medical Officer of Health is fully aware of the challenge of dealing with paediatric respiratory health issues across the Province and is dedicated to making improvements. Acknowledged, were the challenges of providing care to a population that is spread out across many smaller centres, and a large, and in many cases, remote geographic area. The challenges of health care delivery in northern communities where tuberculosis, pneumonia, increased prematurity and perinatal mortality, and high smoking rates exist were discussed.

Asthma is one of the leading causes of paediatric hospitalizations. In general, it is the most common chronic condition of childhood, and accounts for more school days lost than any other chronic condition. Reviewing data from 2002/03 to 2004/05 reveal that "Saskatchewan's hospitalization rate for asthma was the 4th highest among provinces in Canada, and was 36% higher than the national average" (2). Importantly, it would seem that there are challenges delivering care according to the accepted current Canadian Asthma Consensus Guidelines. For example, among persons with poor asthma control, 37% were not prescribed any regular preventer therapy, with significant underutilization of inhaled corticosteroids, the gold standard of asthma preventer therapy (3). In addition, only 42% of individuals who would benefit from additional therapy with inhaled corticosteroids, received such therapy. Only 9% of asthma patients received a spirometry test in 2003/04 (3). Saskatchewan is to be commended for aggressively looking at data and benchmarks such as this. It is clear that there is a huge need for increased asthma therapy expertise and enhanced asthma education for healthcare professionals across the Province. In managing asthma, respirologists play a key role in providing education and facilitating learning for pediatric colleagues and specialists-in-training, and clinical assessment and follow-up care, especially for those patients with moderate to severe asthma. As well, in collaboration with organizations such as the Lung Association, they can participate in programs that provide appropriate asthma continuing medical education for community family physicians, nurses, and other allied health personnel.

The challenge of dealing with Aboriginal lung health across the age continuum is very significant. Fourteen percent of Canada's Aboriginal population lives in Saskatchewan, including 75,000 First Nations Peoples, 36,000 Métis, and a smaller number of Inuit. "Aboriginal people…experience much higher rates of hospitalizations 298% higher for respiratory diseases-colds, flu, asthma, tuberculosis- 309% higher for complications of pregnancy, childbirth and puerperium, 328% higher for conditions in the perinatal period, and 279% higher for injuries and poisonings"(4).

A 2008 Canadian Institute of Health Information (CIHI) report (5) has concluded that the vast majority of acute care expenses for those under 15 years of age are for treatment of respiratory illness. Clearly, an organized child and youth lung health strategy could help address this challenge.

It is evident there is a significant challenge in recruiting and retaining physicians in Saskatchewan, particularly in the northern regions. A health human resources plan has

been developed, but the plan seems very susceptible to turnover. Achieving reliability and gaining confidence in such planning has been a challenge.

Dr. Dennis Kendel, Registrar of the College of Physicians and Surgeons of Saskatchewan described a health care culture that has prided itself in being able to make do with the resources it has. Saskatchewan has a lower physician: population ratio and an even lower specialist: population ratio compared to national averages. It would seem that family physicians manage a much wider variety of acute and complex disorders than they would elsewhere. Recruitment and retention of physicians is a significant challenge in Saskatchewan, and this seems to be even more of a challenge when dealing with the specialist population, which Dr. Kendel described as being more transient than the generalists (however, a CIHI report (6) showed that specialists were less likely than family physicians to migrate out of Saskatchewan). When specialists are present, generalists may lose capacity and capability as the specialist handles the challenging cases. If the specialist leaves, due to the fact the generalists may have lost skills, the community may be worse off than if the specialist had never been there. Recruiting and retaining Canadian –trained physicians appears to be a significant challenge. Over 90% of the physicians in rural Saskatchewan were described as being from other lands such as South Africa. It is uncertain whether or not these physicians are as well versed in Canadian respiratory care such as the Canadian Asthma Consensus Guidelines as their Canadian-trained colleagues.

In Saskatchewan, the College of Physicians and Surgeons is hampered compared to the Licensing Colleges in other provinces, by legislation that is stricter regarding recognition of medical credentials from other countries. This makes recruitment of academic specialists from foreign countries considerably more difficult for Saskatchewan. The Registrar did state that the environment with respect to dealing with international medical graduates in Saskatchewan was changing.

The Status of Paediatric Medicine in Saskatoon

The Province's sole medical school is located in Saskatoon. There is an academic Department of Paediatrics made up of 29 paediatric generalists and subspecialists (1). Out of 16 PAHSC Departments of Paediatrics across the country, the Department in Saskatoon ranks 15th in size- the only one smaller being at Queen's University in Kingston Ontario. For comparison, Manitoba, a Western Province with a population not dissimilar from Saskatchewan's has well over twice as many paediatric specialists and subspecialists in its Department of Paediatrics.

While a complete analysis of why Saskatchewan is so under-resourced in terms of paediatric specialties and sub-specialties is beyond the scope of this review, there are certainly some issues worthy of discussion here. In discussions with the Chief and Chair of the Department of Paediatrics, it is clear that given the current resourcing of academic paediatrics in the Province, it is impossible to build an academic department with an appropriate complement of specialty services. Some academic paediatricians appear to be compensated by a combination of fee-for-service and Provincial/University

supplement, while other selected members of the Department are funded by alternate funding schemes. There is no comprehensive Alternate Funding Plan (AFP) to support all members of the Department. In some cases, supplements also come from charitable organizations, such as a professorship for support for a paediatric respirologist from the Lung Association of Saskatchewan. Dr. Bill Bingham has a human resources plan that calls for the recruiting of 20 new specialists and subspecialists, but at this time, and without an AFP, he really has no way to provide them with competitive compensation. These individuals would provide clinical care, train the generalists and other colleagues with the most up-to-date methods and approaches, and help mentor and lead academic clinical research for the Department. In terms of paediatric respiratory medicine, Dr. Bingham felt that a 3 person Division could make significant inroads in the Province's clinical needs as well as enhance the academic mission of the Department.

There is no overarching authority in Saskatchewan, to help drive and create a cohesive strategy for child and youth health in the Province. The regions seem to be quite fragmented in this regard.

Dr. Bingham also highlighted the challenge of recruiting foreign trained paediatric specialists and subspecialists to Saskatchewan compared to several other provinces, and he has had discussions with representatives from the Saskatchewan College of Physicians and Surgeons about this.

While Dr. Bingham was clear in his support for the need of enhanced subspecialty paediatrics in Saskatchewan, including paediatric respiratory medicine, it was less clear whether the Dean of the College of Medicine, Dr. William Albritton (appointed in 2002), supports this model of care, education and research delivery. Although a Paediatric Infectious Disease specialist by training, he very much seemed to emphasize the role generalists could and should be playing. Perhaps in the current system, he has just not been able to recruit and retain subspecialists, and has had to cope with a generalist model. It should be highlighted that the problems and challenges currently facing Pediatric Respirology in the province have not improved under the current generalist philosophy.

With a new Children's Hospital being considered for the not-to-distant future, there is the opportunity for Saskatchewan to demonstrate leadership by reviewing its child and youth health services and models of care, so it may move forward. Although facilities for pediatric respiratory care are being funded, the Children's Hospital will need specialists to make use of these facilities. Respiratory problems are the leading reason for admissions to any children's hospital.

The Status of Paediatric Respiratory Medicine in Saskatoon

Dr. Kumar Ramlall was the first paediatric respirologist to come to Saskatchewan- he was recruited by the Department of Paediatrics in Saskatoon approximately 10 years ago. He left for Alberta about 2 years ago for personal reasons. During his 8 years in Saskatchewan, Dr. Ramlall received $50,000 professorship support per annum from the Lung Association of Saskatchewan. He was viewed as being an exceptional clinical and education resource and appears to be deeply missed.

There is currently an individual in Saskatoon (Dr. Bryce Lothian) who is trained as paediatric respirologist and paediatric intensivist. He devotes approximately 50% of his time to practicing paediatric respiratory medicine, and about 50% of his time to work in the Intensive Care Unit. At this time, Dr. Lothian is considering employment opportunities outside of Saskatchewan for two reasons- (1) non-competitive remuneration for paediatric respiratory medicine, either compared to other provinces or compared to General Pediatricians in Saskatoon, and (2), a lack of paediatric respirologist colleagues to collaborate with and share the clinical load.

Given Dr. Lothian's current interest in ICU care, this currently gives Saskatchewan a total of 0.5 paediatric respirologists for over 1,000,000 total population. This is simply just not sustainable. When Dr. Lothian is away, or when he needs to take leave for family reasons, the respiratory medicine service grinds to a complete halt. Manitoba, again a province of similar size, has 3 paediatric respirologists. It is very hard to maintain any subspecialty with less than 3-4 individuals. It has been recommended by the Canadian Thoracic Society, that a ratio of 1:360,000 general population is reasonable for paediatric respiratory medicine (7). Saskatchewan is clearly far below this!

A critical mass is required for sustainability of a particular discipline. The reality is, that residents coming out of training programs are protected from doing more frequent than 1:4 call by legislation and bargaining agreements. It is not realistic to expect that once they become staff physicians, they will be interested in being on call more frequently than 1:4. As well, having colleagues to collaborate with, for example, to discuss challenging cases with, is crucial for sustainability. Lack of critical mass is a recipe for burnout, and ultimately results in complete loss of the service. Retention and recruitment becomes impossible.

Conversation with Dr. Lothian revealed that his prime interest is ICU and post-ICU care. He has an interest in consultation regarding severe asthma, but in general asthma is of limited interest to him. He does not appear to be interested in running the Saskatoon Cystic Fibrosis clinic, but is willing to consult regarding challenging cases. In terms of patients requiring sleep studies, he sends 30-50 consults per year to Dr. Val Kirk in Calgary but could easily send 200 if space were available. (Dr. Carina Majaesic of Edmonton reports receiving about 35 referrals per month from Saskatchewan for pediatric sleep studies.) He performs approximately 5 bronchoscopies per year (apparently Dr. Ramlall used to perform approximately 50 per year, but now dozens of

children are being sent to Edmonton for bronchoscopies at a high cost both financially and to the children, some of whom could be compromised by air travel).

There is a consensus among physicians and allied health personnel interviewed that while Dr. Lothian was capable, his lack of availability is a significant issue. Concerns included that there is a fear that the Saskatoon Cystic Fibrosis clinic may close. The generalists felt that while they may be able to help in the clinic, respiratory leadership was absent, and is required. Half of the problems they see are respiratory. In general, the wait for paediatric respiratory consultation is viewed as being far too long; children may wait in hospital on the wards for several days waiting for a respiratory medicine consultation. In many situations, children are just not seen and/or referrals are not even requested. Many are referred to Alberta (Calgary and Edmonton), although there is no objective tracking undertaken to fully understand the magnitude of this practice. Similarly, there is a long wait for outpatient respiratory consultations, and clinic nurses felt the need for considerably more physician support. It was noted that there are more markedly premature babies surviving the neonatal period, and these infants may have chronic and complex respiratory needs, including oxygen and technology dependency. The paediatric generalists ranked the need for a properly staffed respiratory medicine group as “urgent” from both a clinical and educational point of view, given the challenge of looking after children and youth with respiratory disorders, especially in the Aboriginal population.

Adult respiratory medicine in Saskatoon is better resourced; there are approximately 10 adult respirologists. Although they are willing to help out when they can, the group recognizes that its expertise does not lie in the diagnosis and management of paediatric respiratory disorders. Adult respirologists felt that paediatric respiratory input for asthma, sleep-related issues, Cystic Fibrosis, complicated pneumonia, and a variety of other paediatric respiratory conditions was deeply needed. As well, they pointed out the tremendous potential for collaborative respiratory research and education opportunities around a variety of rural and Aboriginal lung health issues. A paediatric respiratory group would find a supportive environment with ready input from the adult respirologists, as well as help from an exceptionally supportive Lung Association of Saskatchewan.

Saskatoon has a variety of allied health personnel available for asthma education through the Lung Association and there are interesting and innovative education programs. There was universal accord that there was a significant lack of paediatric respiratory expertise for participation in the wide variety of educational initiatives possible.

The Status of Paediatric Respiratory Medicine in Regina

Interviewees from Regina were open and helpful in providing information about the current status of Paediatric Respiratory Medicine in Regina. Currently, there are no paediatric respirologists in Regina. Consultant paediatric care in general, is provided by 5.5 generalists and one nephrologist. These individuals are essentially private practice physicians funded by fee-for-service. Dr. Holmes, a dedicated generalist has run the

Cystic Fibrosis Clinic for about 21 years, and he has learned to handle most situations through experience and necessity. Consultation back-up is available from Saskatoon, Alberta and Manitoba. There does not currently seem to be a positive, collaborative working relationship between pediatricians in Regina and Saskatoon.

As there is no paediatric respiratory expertise in Regina, generalists are involved in trying to manage technology dependent children, such as those requiring home ventilation. Adult respirologists may be involved in the care of children requiring home ventilation as well. Paediatric pulmonary function testing is only used to a limited extent and the testing is interpreted by adult, not paediatric specialists. Bronchoscopy and bronchoalveolar lavage procedures are performed by otolaryngologists, not paediatric respirologists. Paediatric sleep studies are not available in Regina; potential candidates for such studies would most likely be sent out of Province or simply not have the studies done.

There was a consensus of opinion expressed, that pediatric respirologists with an interest in Paediatric Intensive Care would be a very welcome addition to the healthcare human resources in Regina. Children with complex respiratory needs tend to have what seem to be exceptionally long stays in hospital, and the Intensive Care Unit. Paediatric Respiratory expertise would help manage these types of challenging patients. General paediatricians were felt to be less familiar with current technology and techniques regarding such areas as non-invasive ventilation, ventilatory weaning, and chronic oxygen therapy delivery.

Of note, it was also reported that there were no paediatric allergists in Regina. Children requiring allergy consultation needed to be sent to Saskatoon. Paediatric allergists also can help in the management of moderate to severe asthma, but no such resource exists in Regina,

One of the challenges pointed out by Regina-based physicians was that it would be impossible for a paediatric subspecialist to survive in practice in the current Saskatchewan fee-for-service payment system. They would likely have to supplement their practice with some general paediatrics. Without special Provincial support, or some form of AFP, it was felt that retention of a paediatric respirologist would be impossible.

Particular challenges cited included the need to look after an Aboriginal population that makes up approximately 15% of the total number of patients seen. The Regina-Qu'Appelle Health Region (RQHR) serves 17 southern reserves; this population has high smoking rates, and significant morbidity due to respiratory infections and asthma. While there seems to be a dedicated group of allied health professionals serving this population, there is a significant need for input from appropriate medical paediatric respiratory expertise.

Why an Alternate Funding Plan is Appropriate to Consider

The success of academic tertiary/quaternary paediatrics in Canada over the last 20 years has been significantly positively influenced by the development of AFP's. The first comprehensive department-wide paediatric AFP was completed in 1990 at the Hospital for Sick Children in Toronto (8). Interestingly, I believe its creator, the Department Chair and Chief, Dr. Robert Haslam, hailed from Saskatchewan originally. At that time, without an AFP, the Department would have gone bankrupt; with the AFP, the Department flourished. How do you maintain child protection medical services, or a metabolic diseases service, or an infectious diseases service, in a fee-for-service system?

Fee-for-service compensation generally rewards volume and procedures. Specialty and subspecialty consultation paediatric practice for children with chronic and complex needs becomes impossible in such a system of compensation. This is a major contributing factor to the fact that there is such a shortage of paediatric specialists and subspecialists in Saskatchewan when compared to other Canadian PAHSC's.

Physicians in Ontario's PAHSC's are remunerated through AFP's as opposed to fee-for-service billing. The AFP's are negotiated contractual arrangements that provide the PAHSC department(s) with a global pool of funding to compensate for the full range of clinical and academic activities of the participating members. Without such a model of compensation, it would be impossible to have the stability or flexibility for the members of the PAHSC's to provide complex care or deliver on their institutions' academic missions. Ontario's children have had improved access to specialized child and youth health care because these plans have worked. There is no question that AFP's in Canadian PAHSC's, where they exist, have become the essential mechanism to allow for recruitment, retention, and success of paediatric specialists and subspecialists. There have been successful paediatric AFP's developed in Ontario, Nova Scotia, Alberta, and British Columbia, and it would certainly be worth looking at for Saskatchewan.

Summary

- There is a positive “can do” attitude in the Province - people seem to have become accustomed to coping with limited physician resources, but are hopeful about moving forward. On the down side, non-specialists who are, of necessity, coping with complex pediatric respiratory cases do not have access to optimal techniques, training or consultation for such cases. There is growing acknowledgement that the current situation is untenable. “Can do” too often translates to “do without”.

- The Lung Association of Saskatchewan is extremely dedicated to helping improve respiratory health in the Province.

- Generalists take on more care challenges in pediatric respirology than they might in other provinces.

- Children of Saskatchewan with paediatric respiratory disorders such as asthma, sequelae of premature lung disease, cystic fibrosis, congenital lung malformations, chronic oxygen and technology dependency, complicated pneumonia, TB, sequelae of cancer therapy, sleep disorders and disordered respiratory control, do not have access to appropriate paediatric respiratory medicine subspecialty services.

- Asthma morbidity in Saskatchewan is significantly higher than the national average.

- Aboriginal lung health is a major concern and aboriginal children are disproportionately affected by lung diseases.

- Paediatric respiratory medicine human resources are severely lacking in Saskatchewan with only 0.5 paediatric respirologists for approximately 1 million general population.

- By Canadian Thoracic Society recommendations, the Province should have at least 3 paediatric respirologists.

- Saskatoon was not able to retain its first paediatric respirologist, Dr. Kumar Ramlall, despite the fact he was very committed and dedicated.

- The current situation with Dr. Lothian in Saskatoon is not sustainable, and in fact, he has indicated he is looking to locate outside of Saskatchewan.

- In general, paediatric specialty and subspecialty human resources are in extremely short supply for the Province.

- The lack of a pediatric respirologist affects not only patient care but teaching as well. Pediatric respirology teaching in both Regina and Saskatoon is often conducted by Respiratory Therapists.

- There seems to be communication and lack of trust issues between the paediatricians of Regina, and the paediatric specialists and subspecialists in Saskatoon.

- There is a need for an overarching child and youth health strategy for Saskatchewan.

- An AFP for the entire Department of Paediatrics, rather than only for selected pediatricians, is urgently needed. A Department-wide AFP would help make Saskatchewan more competitive on a national level in terms of recruitment and retention of subspecialists such as paediatric respirologists. The current situation in Saskatoon in which a Pediatric Respirologist receives less compensation than a General Pediatrician makes recruitment almost impossible and is a major roadblock to retaining the only Paediatric Respirologist currently in the province.

- While such a process is being explored, paediatric respiratory medicine urgently needs support; interim locum coverage should be considered as an immediate first step.

Respectfully submitted,

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