Correspondence
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Pain relief

I hope that all hospitals will follow the example of St. Michael's Hospital, Toronto, and have pain services work with the surgical teams as described in the Quill on Scalpel article in the April issue (*Can J Surg* 2005; 48:98-9). I support the use of opioid analgesics for cancer pain; it is part of my practice.

What I want to respond to is the idea that we have to accept second-best medicine because the public system does not allow the most optimum treatment for a patient. In patients with arthritis for whom there is a surgical solution that can provide significant, lasting pain relief, I believe we must not accept the status quo of lack of resources but actively press the system to make surgical solutions available. In such cases I believe that the use of opioid analgesics is not appropriate and is therefore making us as medical practitioners acquiesce to the deficiencies of the public system. I am sad that Drs. Chan and Leung did not question the use of statistics presented in the pain literature.[1] If surgeons' operations were truly in this day and age causing chronic pain in up to 50% of their operative patients, there would be a public outcry. We do refer patients for treatment after surgical procedures, but I feel that this occurs much more rarely than the figures quoted in the table from the pain literature.[2]

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References

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On dissatisfaction

I read with interest the editorial entitled "Dissatisfaction: how it has grown" (*Can J Surg* 2005;48:93-4). I believe that the points made are valid. There are additional factors affecting the surgical workforce and its future planning. With much of our human resource planning we have taken into account only the increasing age of the population and the decreasing number of physicians. We must also be cognizant of the fact that technologic advances open health care options to those who previously were not candidates for treatment. Additionally, the delivery of health care by some of the younger members of the profession may not be as broad-based and their practices not as all-encompassing as those whom they are replacing. Many of the retiring physicians have had broad training, and our training programs are not creating true replacements. Fiscally based cutbacks in hospitals have many of us finding it increasingly difficult to provide the care we are trained to administer to the patients who need our services. It now seems that more work is required to deliver the same necessary care. The beleaguered and burned-out surgeon may be less willing to postpone retirement as institutional loyalty has diminished over the years. This may accelerate the human resource crisis looming on the horizon.

Although no one would dispute the need for the increased number of family doctors, political pressures should not lead to a worsening of the situation by increased emphasis on family medicine at the expense of specialist training. Training positions for specialists must increase at the same time as they increase for family medicine.

Regionalization may be a solution to the issue of superspecialization. There is certainly a need for those highly trained and focused specialists, but we must emphasize throughout our training a need for broadly trained, generally based physicians who are competent to deliver care in areas other than the most highly specialized centres.

Human resource issues must be addressed at both the provincial and the federal levels to generate a plan to provide care for future generations. Simple number crunching will not successfully address the issue, as it does not account for advances in medicine or changing attitudes, values and training. The point made regarding the involvement of surgical experts to give best considered opinion regarding human resource planning is well taken.

As a profession, I believe that we must move away from service provision needs for residency rotation assignment. Servicing of teaching hospitals should not be allowed to control rotations. We must focus more on the skills that our trainees need when they complete training. Much broader based training should be provided, and the subspecialization should occur in the post-fellowship years. Perhaps our training models are not ideal in that the teaching and role modelling is done by a group of superspecialists. I believe that national specialty societies and Royal College specialty committees must seriously address the issue of what is needed in a training program to produce the surgeons to deliver health care to Canadians in the future. This will be a difficult task, as the committees are largely populated by subspecialists, but we will need to put our bias aside and address this issue in a socially responsible fashion.

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I certainly agree with many of the points made in the interesting editorial "Dissatisfaction: how it has grown" (*Can J Surg* 2005;48:93-4). It is difficult to attract the interest of young students and residents into a surgical subspecialty when the dissatisfaction level of the staff surgeons is so high. We have become a rather grouchy lot.

Increased recruitment of young surgeons on staff at hospitals is crucial to provide safe patient care and to produce a lifestyle acceptable to all surgical staff. As medical director of a large academic health centre, when I raise the issue of a surgical recruit at our regional recruitment meetings, the attendees emit a general sigh because of the 1.2- to 1.6-milion dollar budget associated with a new recruit (e.g., operative time, clinic space, office space, beds).

We are trying to turn this around by asking surgical services to come up with 5-year plans (to the best of their ability) regarding manpower and service delivery. We are trying to tie this future recruitment need to ongoing budget cycles so that funds are available for known service needs in the future. With the monies budgeted for and in place, the recruitment of the individual to fill a position becomes a much easier task.

A commitment to young recruits early should aid in stabilizing services and make everyone's work more satisfying. This process is only in its infancy, but it seems to me that service delivery planning over a 5-year period needs to lead recruitment. Presently, we must compete for new recruitment dollars annually. Using a regional approach to recruitment tied to service delivery has significant advantages.

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I found the editorial in the April issue (*Can J Surg* 2005;48:93-4) excellent and agree with all the points raised.

It is my feeling that presently in Canada the biggest problem facing medicine is the shortage of general practitioners. I do agree that surgeons are also short in supply, but the major problem facing the patient population is finding a family doctor. The system needs to make family practice more appealing (i.e., more remunerative and less onerous).

One of the ways I believe this problem could be addressed would be to look carefully at the "core curriculum" presently being used in medical schools. This curriculum requires students to set their career path after roughly 2 years of medicine. I believe this system robs the country of better potential physicians, as it is extremely difficult for a student at that time in the course of training to make such an important decision. With the core curriculum, once a path is chosen there is an unwavering ideal that it cannot be changed.

During my training years, many students chose several different paths before settling on the best one for them. It took me 5 years of family practice to realize that I would be much happier in orthopedics, and it wasn't difficult for me to go and get this training and do what I enjoy doing very much. I do not believe that this is possible at present.

Other major issues relate to lack of adequate facilities to provide elective care.

Some improvements have been made, and interesting public–private partnerships have been developed. In the Kelowna area, the local health region has contracted out some outpatient surgical services to a private operating room facility. More of this, I think, would help offset the lack of adequate facilities across the country. The contract that was developed between the health region and the private clinic was developed de novo. It was an excellent document and perhaps could be used in other areas. When this contract was being developed, no similar contract was available to be used as a template.

Governments need to focus on increasing the numbers of alternate-level care beds to free up acute care beds and allow hospitals to work more efficiently.

Our area has been approached by the University of British Columbia's Medical School to help in training residents and students, which is proving to be a significant challenge and I think will be very interesting over the next few years.

Although many of us practising in the Kelowna region would like to return something to the community, part of the reason that we practise in a semirural area is to get away from the university and academic setting. This kind of conflict will be difficult to work out and will require significant cooperation between the universities and the local hospitals.

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