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Action for Access

Montreal Organisation Plan for Specialised Medical Services and Medical Staffing

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HEALTH AND WELL-BEING FOR THE POPULATION OF MONTREAL

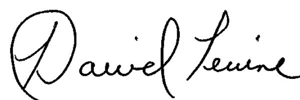
A Collective Challenge

The Regional Board is undertaking a process aimed at providing Montreal with a new strategic plan that will extend from the spring of 2003 to that of 2006. We therefore need to work together to identify our priorities for improving the health and well-being of Montreal's population.

On the basis of the results observed at the end of the 1998-2002 plan for health and access to services, we will have to make choices and implement the most appropriate solutions for efficiently providing prevention, cure, and treatment. This is a major challenge, one that compels us to make the right decisions, and I encourage Montrealers to respond to it.

The findings of this consultation process will enable me to submit a strategic three-year plan to the board of directors of the Regional Board in June of this year. This plan will be a response to the particularities of the Montreal metropolitan area as well as to the national priorities for the entire population of Quebec.

Hoping that the consultation will prove fruitful,



David Levine
President and Executive Director

This document summarizes the Regional Medical Commission's document entitled *Montreal Organisation Plan for Specialised Medical Services and Medical Staffing*. Those interested in more detail can to refer to the full text of the plan and its various appendices (see the last page for locations). Complete information on the consultation organised by the Regional Board is also available on the Board's Web site: **www.santemontreal.qc.ca.**

RÉGIE RÉGIONALE
DE LA SANTÉ ET DES
SERVICES SOCIAUX
DE MONTRÉAL-CENTRE

INTRODUCTION

The role of the Regional Medical Commission is to advise the Regional Board on the organisation and distribution of specialised medical services, in terms of medical staffing, the organisation of medical practice and physicians' remuneration systems. It is within this context that the Montreal Organisation Plan for Specialised Medical Services and Medical Staffing was developed. The plan will be sent out to all medical specialists. The Regional Medical Commission has requested that the plan be submitted for consultation to all of the concerned institutions and physicians. The contribution of medical specialists is essential to achieving the objectives set by the Regional Board, particularly its objectives relating to the hierarchisation of medical services and specialised first-line medical services, the goal of which is to promote a strong first-line in Montreal.

PART 1: THE GENERAL PRACTITIONER-SPECIALIST INTERFACE IN A NETWORK OF ACCESSIBLE MEDICAL SERVICES

In May 2001, the Regional Medical Commission agreed with the Medical Affairs Department that it was time to consider a regional medical services organisation plan. Two key considerations favoured such an approach:

- the creation of the Regional Department of General Medicine, with a view to organizing a functional first-line medical services network; and
- the need to meet specialised medical staffing needs through a regional specialised medical services organisation plan.

The Regional Medical Commission started by studying the hierarchisation of medical services and, by implication, the definition of the fields of practice of general practitioners and specialists for the first, second and third lines. The application of these two basic concepts, in a functional system of medical services, can ensure that the point of entry is the general practitioner, and that the patient gets to see the right doctor, at the right place and the right time so that he/she can access the right service.

Finally, in order to be effective and efficient, first-line medical practitioners must have access to diagnostic techniques and expertise. This is the background against which the guideposts for the organisation of first-line specialised medical services have been established.

Section I - Hierarchisation of medical services within the territory of the Montreal-Centre Regional Board

I. FIRST-LINE SERVICES

As the point of entry into the health care system, first-line services include all routine health services that rely on a non-equipment-intensive infrastructure to provide diagnostic and therapeutic care to people who are living at home when an health care episode occurs or who only require periodic follow-up.

Of all physicians, general practitioners are the best equipped to play the role of first-line integrators and to follow patients. It is to the general practitioners that second-line and third-line physicians return the patients who have been referred to them once the referral objective has been achieved, and whose referral is appropriate and necessary given the physicians' respective levels of competence.

First-line medicine favours group practice, an integrated routine care system and in an integrated on-call network for non-hospital emergency services.

First-line services are dispensed in physicians' offices, CLSCs, hospital emergency departments, health centres, the home, the workplace, educational institutions, rehabilitation centres, residential and long-term care centres (CHSLDs) and other residential facilities. First-line medical services are accessed by direct request by patients (with the exception of patients in rehabilitation centres and CHSLDs).

II. SECOND-LINE SERVICES

Second-line services are mostly specialised health care services for complex health problems that rely on an adapted infrastructure and a diagnostic and therapeutic technology that is equipment-intensive but widely available.

The main providers of second-line services are medical specialists as a whole, as well as general practitioners who work in hospitals (obstetrics, active geriatrics, emergency, palliative care, addiction, public health). While generally dispensed in second-line institutions (general and specialised hospital centres, rehabilitation centres, psychiatric hospitals), these services are occasionally provided in physicians' offices and polyclinics as well.

III. THIRD-LINE SERVICES

Third-line services are ultraspecialised medical services for people with either very complex or low-prevalence health problems.

Recommendations

In order to ensure that the population has access to specialised medical services upon referral, that first-line workers have close links with those working in the second and third line, and that the performance of the first-line acts by medical specialists is kept to a minimum, the Regional Medical Commission recommends that the following steps be taken as quickly as possible so that implementation of the hierarchisation of medical services can get underway:

1. That the Board of Directors of the Montreal-Centre Regional Board adopt the concept of hierarchisation of medical services as described above;
2. That the President and Executive Director of the Regional Board:

   inform all of the Regional Board's departments that he wants to see general and specialised medical services within the jurisdiction of the Montreal-Centre Regional Board organized in a manner consistent with this concept;

   inform all of the management teams, the professional services departments, and the councils of physicians, dentists and pharmacists in the institutions and all of the physicians within the Board's jurisdiction that he wants to see general and specialised medical services of the Montreal-Centre Regional Board organized in a manner consistent with this concept;

   make concerted representations to the faculties of medicine and *Collège des médecins du Québec* to ensure that the training they provide prepares their graduates to adequately perform the duties of first-line, second-line and third-line physicians;

   make representations to the medical federations and the Ministry to get them to adopt this concept and to adopt concrete measures to promote the hierarchisation of medical services (e.g., remuneration method and adjustment of the regional medical staffing plans, budgets and communications network, etc.);

   educate the population on the need to see a general practitioner before seeking specialised services;
3. That the Medical Affairs Department and the Regional Department of General Medicine cooperate closely in organising services in accordance with the hierarchisation concept.

Section II - The organisation of first-line medical services

The organisation of a first-line network is key to the successful functioning of the entire health and social services system. But it is a challenge that cannot be met without providing first-line physicians with the tools they need to play their role, the two indispensable tools being timely and appropriate access to technical/diagnostic facilities and to consultation with specialists.

ACCESS TO TECHNICAL/DIAGNOSTIC FACILITIES

I. FIRST-LINE NEEDS

In the light of the information available to the Regional Board and experience in the field, it seems, if no corrective measures are taken, that the present organisation of access to technical/diagnostic facilities will be unable to meet the needs of first-line medical practice as contemplated here, and will not support the implementation of a system of access to medical services that reduces the use of hospital emergency rooms.

Recommendations

To make the level of access required for the proper management of patients' health problems available, the Commission recommends:

1. That the Regional Board develop, in cooperation with the institutions and walk-in clinics, an action plan to provide access to technical/diagnostic facilities that meets the needs of a well organised first-line network throughout the Board's jurisdiction, on an extended 7-days-a-week schedule that takes clinical situations recognized as urgent, semi-urgent and elective into consideration;
2. That service agreements be signed between the Regional Board and the walk-in clinics to ensure access to technical/diagnostic facilities, at no additional charge, for all patients;
3. That the Regional Board identify and make known to all physicians the list of locations where these services can be made available within the established timeframes;
4. That a joint follow-up committee (Medical Affairs Department - Regional Medical Commission - Regional Department of General Medicine) advise the Regional Board on the orientations to be prioritised, given the identified constraints, to equip the first-line network with the tools it needs to play its role in the various clinical situations throughout the Board's jurisdiction;
5. That the computerisation of the network and the deployment of modern communication technologies be used to support and enable the organisation of first-line medical services;
6. That the Montreal-Centre Regional Board's Medical Affairs Department seek the cooperation of *Collège des médecins du Québec* and the various entities involved in medical training (universities, professional associations and federations) in efforts to optimise the appropriate use of the technical/diagnostic facilities (pre-doctoral training objectives, continuing medical education, design, updating and distribution of user guides);
7. That the Regional Board, in cooperation with the institutions and the clinics affiliated by service agreement, promote the implementation of an evaluation mechanism that will allow for an effective response if waiting times for access to technical/diagnostic facilities become unacceptable;
8. That the Regional Board, report annually to the Regional Medical Commission on the status of these recommendations.

ACCESS TO CONSULTATIONS WITH SPECIALISTS

A number of clinical situations in a family physician's practice may require consultation with a specialist. The need is generally for expertise diagnostic and/or therapeutic expertise or joint follow-up in the case of certain complex problems. It can sometimes also be a matter of a transfer for a specific episode of care (e.g., surgery) after which the specialist returns the patient to the care of the family physician.

I. FIRST-LINE NEEDS

Family physicians call upon a variety of specialists working both in offices or clinics and in hospitals, depending on the clinical status of their patients and the availability of services. General practitioners in Montreal regularly raise two major issues with respect to consultation with specialists:

- Problems of access (waiting periods, lack of information on the location of specialists' offices);
- Communication of the results of the initial consultation and any subsequent visits, as well as the treatment and follow-up plan.

Recommendations

In order to ensure the level of accessibility required for the proper management of patients' health problems, and assuming that medical staffing levels are sufficient, the Regional Medical Commission recommends:

1. That the Montreal-Centre Regional Board make a priority of computerising the offices of referring and consulting physicians and providing them with the necessary links to the Health and Social Services Telecommunications System (RTSS);
2. That the Montreal-Centre Regional Board immediately request and provide support for efforts by the institutions within its jurisdiction to optimize the use of modern communication technologies (fax, secure e-mail) and the clerical support the specialists need to communicate the relevant information to the referring physicians;
3. That the Regional Board's Medical Affairs Department seek the involvement of the *Collège des médecins du Québec* in efforts to improve the quality of the information exchanged by consulting specialists and referring physicians (precisely worded requests for consultation accompanied by all of the relevant information, consultation reports that provide as much information as possible on the investigation, treatment and follow-up plans, follow-up reports with subsequent test results);
4. That the Montreal-Centre Regional Board, in cooperation with the institutions, encourage the use of a standardized summary medical information form when a patient is discharged from hospital. The form could include a copy for the user and/or attending physician, with the original to remain in the patient's file in the place of the summary sheet that is now being used in the institutions. (This kind of form could also be used when patient has been evaluated and treated in the emergency department.);
5. That the Regional Board identify and make known to all physicians the locations where these specialised consultation services can be made available within the established waiting times, and make sure that the information is updated periodically;
6. That the Regional Board ask the medical specialists' associations and the professional services departments of the generalized and specialised hospital centres within its jurisdiction to help choose the means to remove the obstacles to achieving the accessibility objectives in the various sub-regions;
7. That the Regional Board, in cooperation with the institutions, favour the implementation of an evaluation mechanism that makes it possible to respond effectively if the waiting times for consultations in specialised external clinics become unacceptable;

Recommendations (continued)

8. That the Regional Board report yearly to the Regional Medical Commission on the status of these recommendations.

PART 2 - GUIDELINES FOR THE DEVELOPMENT OF REGIONAL ORGANISATION PLAN FOR SPECIALISED MEDICAL SERVICES AND MEDICAL STAFFING (PROSEM)

There are both legal and administrative reasons why the Montreal-Centre Regional Board must adopt a regional specialised medical services organisation plan and a specialised medical staffing plan. Legally, the Health and Social Services Act requires the institutions and the Regional Board to adopt a medical services organisation plan that justifies its use of medical resources. Administratively, Montreal has a supra-regional and regional role to play. The Regional Board must manage the resources assigned to it to provide the population it serves with access the services it needs, on the basis of a defined plan.

The regional specialised medical services and medical staff organisation plan must be based on a global vision of the medical care system, which has to be a vision of integration, because integration is the only approach that can promote the efficiency and accessibility that we want to provide to the entire the population we serve.

The second part of this document lays out the regional specialised medical services and medical staff organisation plan underlying principles. The last stage will be to develop the specialty-based plans and to determine which of them should be given priority.

Section I - Objectives

The first objective of the plan is to develop networks of specialised and ultraspecialised medical services that are capable of meeting the demand for services within acceptable or reasonable timeframes.

The second objective is to enable the institutions to better plan their medical staffing requirements and to enable the Regional Board to develop a regional plan.

Section II - Guiding principles

A. Guiding principles already accepted by the Regional Medical Commission

1- The hierarchisation of medical services

To ensure that the Montreal medical care system is functional, i.e. that enables patients to see the right doctor in the right place and at the right time, the Regional Medical Commission is recommending to the Montreal-Centre Regional Board's Board of Directors, President and Executive Director and Medical and University Affairs Department act as quickly as possible on the strategies required to start implementing the hierarchisation of medical services.

2- Specialised medical services effectively and efficiently linked with a functional first-line via an integrated system of medical services.

Physicians must imperatively have appropriate and timely access to both technical/diagnostic facilities and consultations with specialists.

To that end, the Regional Medical Commission is making specific recommendations to the Regional Board and its Medical and University Affairs Department.

3- The predominant role of the basic or local specialties in the hospital centres with an emergency department

The Regional Medical Commission sees the following specialties as the basic or local specialties required in order for a general and specialisd hospital centre with an emergency room to be functional: anaesthesiology, anatomical pathology, general surgery, obstetrics-gynaecology, orthopaedic surgery, internal medicine, psychiatry and diagnostic radiology.

4- The pooling of supra-regional specialty resources for tertiary and quaternary care

In the interest of quality of care and economy, the two university systems must pool some of their resources. In the present context, this statement of principle cannot be imposed on the institutions concerned, but the Regional Medical Commission nevertheless feels that they must make an effort to study the feasibility of concentrating resources, particularly as regards tertiary and quaternary care.

5- Cooperation-complementarity between institutions with relative autonomy in each of the sub-regions

To alleviate the problems of medical understaffing and medical service access in certain institutions, the Regional Medical Commission proposes a win-win solution of cooperation-complementarity between institutions[1]. An institution that agrees to provide physicians to an understaffed institution will be able to recruit staff above the authorised plan under a staffing plan exemption granted by the Ministry, in addition to being able to use the resources of the institution it is assisting.

Recommendations

This principle translates into the following recommendations:

1- That the Professional Services Directors Committee, using such information as the Medical and University Affairs Department's recent study of actual and anticipated shortages of specialised medical staff, identify to the Regional Board the institutions, departments and specialised clinical services whose situations reflect one or more of the problems mentioned in the premises and which would be interested in participating, on a voluntary basis, in the development of an inter-institution cooperation and complementarity project. Should two institutions would be experiencing staff shortages in the same discipline, the Medical and University Affairs Department will determine which of the two will get additional medical staff under an agreement between the institutions.

2- That the Regional Board and the institutions concerned work together to identify and establish winning conditions for each of the participating institutions, such as:

- the organisation of the targeted medical services, including the on-call system;
- the human and material resources required for effective and efficient use of specialised medical staff, as provided for in agreements; and
- the necessary budgets, with consideration for such things as:
    - the increase in costs where the services are rendered; and
    - the increase in the amount of services rendered.

1 Collaboration-complémentarité entre établissements: partage des effectifs. PROSEM Committee. CMR, May 2002.

Recommendations (continued)

3- That the Medical and University Affairs Department, in cooperation with the Regional Medical Commission, manage medical resources in such a way as to promote the complementarity of services and the sharing of resources, using such means as the exemption mechanism, when appropriate.

4- That the Medical and University Affairs Department secure the Ministry's authorisation to manage medical staffing on a regional basis, in the event of regional shortage of medical staff in a given specialty.

5- That the Professional Services Directors Committee, the Medical and University Affairs Department and the Specialised, Ultraspecialised and Physical Health Rehabilitation Department identify the services in the university institutions that could be provided in non-university institutions, in a framework of complementarity and cooperation between them. This type of cooperation can also be developed between non-university and university hospitals.

In this context, the institution whose service coverage is ensured by the staff of another institution should allow that institution to use its human and material resources for the services that would be transferred there (e.g., use of operating rooms for surgery).

6- That the Regional Board and the Ministry agree to a model contract that they would implement and distribute. The contract would spell out how the institutions would share specialised medical staff and service corridors given their respective missions.

Furthermore, with respect to the access to services and the sharing of resources, the Regional Medical Commission advocates a certain degree of autonomy for each of the six sub-regions within its jurisdiction.

6- The Montreal region's supra-regional role

Montreal being a university region, its university hospital centres, affiliated university centres and institutes have to fulfill a three-fold mission of medical care, teaching and research. These three functions are in many cases performed by the same physicians.

The Regional Medical Commission is of the opinion that this factor has to be taken into account in any organisation plan for services and staffing if the Montreal region is to have the resources it needs to fulfill its mission.

7- An emergency room at the centre of a network in the community

The Regional Medical Commission feels that the chronic overcrowding of emergency rooms in the Montreal area cannot be overcome unless the parties upstream and downstream of the institutions work together.

The Regional Medical Commission subscribes to the territorial system concept as described in the *Guide de gestion de l'unité d'urgence* published by the Ministry in 2000.

B. Other principles requiring consideration

1- An organisation of services based on the population's real needs vs. the current supply of services

The Regional Medical Commission feels that the regional plan must take into consideration both needs and the present supply of services in proposing solutions to accessibility problems.

2- Maintaining a critical mass of patients and medical staff is essential to maintaining the quality of care and professional competence

The Regional Medical Commission is concerned about a number of factors that could hinder the optimisation of care and the professional competence of physicians:

- increasingly difficult access to operating rooms, for lack of resources
- the isolation of medical specialists, for lack of sufficient numbers
- the absence of a critical mass of patients creating conditions that require expertise.

Recommendation

The Regional Medical Commission recommends that the Standing Consultative Committee on Medical Staff Planning in Quebec (*Table de concertation permanente sur la planification des effectifs médicaux au Québec*) consider these aspects and take them into consideration in its next planning exercise. The Commission also recommends that the Regional Board and the institutions agree to concentrate certain types of surgical activities and to facilitate access to their operating rooms.

3- The presence of basic or local specialties in all general and specialised hospital centres and the hierarchisation of recruitment of the requisite staff

The Regional Medical Commission considers that the organisation of medical services in the general and specialised hospital centres must be based on the availability of staff in the local-level specialties (anaesthesiology, anatomical pathology, general surgery, obstetrics-gynaecology, orthopaedic surgery, internal medicine, psychiatry and diagnostic radiology).

4- The concentration of certain specialised medical activities

The Regional Medical Commission endorses the principle of concentrating specialised medical services providing that concentration benefits patients in terms of the accessibility and quality of services.

The Regional Medical Commission has adopted the clinical and instructional framework that should support all efforts to medical staff concentration efforts (see point 5).

5- The clinical and instructional framework that must support the concentration of certain specialised medical services in one or more institutions on the Island of Montreal

Given the guidelines on the organisation of medical services it has already adopted, the Commission considers that if services are concentrated, the following principles must apply:

1. The decision to concentrate specialised medical services must be based on the following imperatives or objectives: increased availability or accessibility, optimisation of practice for complex cases, greater effectiveness, improved efficiency, greater continuity of care.
2. The quality of medical care must be the same, regardless of where the services are concentrated.
3. The necessary professional, material and financial resources must be present or guaranteed in order to ensure quality care.
4. Under no circumstances should the concentration of medical services result in a lower level of quality of resident training; on the contrary, it should ideally add value to the experience of residents.

Recommendation

The Regional Medical Commission wants to be consulted on any plan to concentrate medical services.

6- The establishment of a process to prevent service interruptions

The Regional Medical Commission feels that the network must set up effective mechanisms to prevent interruptions of medical services and would like the Professional Services Directors Committee to review the following solutions and contribute, along with the *Fédération des médecins spécialistes du Québec* and the Regional Board, to their implementation if they are deemed acceptable:

- cooperation-complementarity between institutions of the same sub-region or another sub-region;
- creation of a sub-regional or regional emergency backup bank.

7- The inclusion of the specialised activities of physicians' offices in the organisation of services of the institutions (the affiliated medical clinics concept)

The Regional Medical Commission endorses the concept advocated by the *Fédération des médecins spécialistes du Québec* under which medical specialists' clinics could be an extension of the institutions. The Regional Medical Commission feels that there is a certain urgency that there be an agreement between the parties concerned and that such an approach can generate solutions that make it easier to access important services.

Recommendation

The Regional Medical Commission recommends that the President and Executive Director of the Regional Board approach the Ministry and propose that affiliated medical clinics be established, in cooperation with the *Fédération des médecins spécialistes*.

C. Compliance with generally recognized principles in the health care system

Without taking the time to define the already-familiar principles of universal free care, accessibility, availability, homogeneity, effectiveness, efficiency, quality of care, flow of relevant information, cooperation among caregivers, the Regional Medical Commission would like to confirm that subscribes to their application to the organisation of medical services:

Section III - The development of a methodological framework to define medical staffing need in terms of full-time equivalents

A. Specialised medical staff by institution and by specialty

As of December 1, 2001, there were 3,163 medical specialists in the staffing plan with a ministerial growth objective of 68, which means that there were 3,231 authorised positions as of March 31, 2002. According to billings to the *Régie de l'assurance maladie du Québec* (RAMQ), there were 3,216 medical specialists, for a negative variance of 15.

Finally, the fact that an institution has no practitioners in a particular specialty does not mean that it is not providing services, since it can do so via agreements with other institutions or directly with doctors who have the status of associate staff members.

B. The concept of specialty full-time equivalent (FTE)

The Ministry of Health and Social Services defines a specialty full-time equivalent as a physician whose level of activity is equivalent to the average income of practicing physicians in the same specialty during the reference year. The activity level component is determined the physician's billings to the *Régie de the assurance maladie du Québec* compared to the standardised mean of the billings of practicing physicians in the same specialty during the reference year.

Why should the concept of full-time equivalent be used to calculated specialised medical staffing needs for Montreal-Centre? In the university institutions, the same doctors provide care, teach, do research and perform administrative tasks. Since physicians working in the institutions are paid according to a mixed remuneration system that factors in the various tasks they perform, it is impossible to separate out the clinical aspect using the method of remuneration. Other factors that support the use of the clinical FTE concept include: the feminisation of the profession, the aging of medical specialists and the sharing of medical staff by institutions within and between the regions.

The definition of FTE used by the Ministry is acceptable for the time being, but in the future, it would be more appropriate to base the assessment of staff needs on the services levels determined in a forthcoming service organisation plan.

Recommendation

The Regional Medical Commission recommends that the institutions consider the model suggested by the Association of Anesthesiologists of Quebec in November 2000 in determining their medical staffing needs in each of the specialties.

Section IV - The concept of designated hospital centre

In most cases, the designation refers to the process used by the universities and the Ministry to identify the institutes, university hospital centres and affiliated hospital centres. Given the concept of cost-effectiveness involved in this process, the competition it generates between institutions and the fact that money goes where the services are, the Regional Medical Commission suggests the following principles to the Regional Board as guidelines for the designation of hospital centres for the purposes of organising services:

1) As important as cost-effectiveness may be, designation should be seen primarily, in a context of rationalised resource utilisation, as means of providing quality care.

2) Designations must be granted within the regional medical services organisation plan of the Regional Board. In other words, they must be planned and consulted on internally and externally.

3) The principles the Regional Medical Commission advocated in is clinical and instructional framework for the concentration of certain specialised medical services apply to designation.

Section V - The specialty-based approach

A. Mandatory basic or local specialties in hospital centres with an emergency room

The Regional Medical Commission feels that the institutions must be consulted in the development of a coherent a plan to organize services and staffing by specialty. However, in view of their importance in the first-line interface, the Commission has recommendations to make on the "local" basic specialties, namely: anatomical pathology, anaesthesiology, general surgery, internal medicine, psychiatry, orthopaedic surgery, obstetrics-gynaecology and diagnostic radiology.

Recommendations

The Regional Medical Commission's recommendations regarding these specialities are as follows:

1. All of these specialties with the exception of the obstetrics side of obstetrics-gynaecology must present in all of the short-term care institutions with an emergency room.

2. The medical staffing plan must enable all institutions to recruit the staff they need to ensure access to care and to fulfill their teaching obligations.

   The Regional Medical Commission recommends that the Ministry's staffing plan accounts for the fact that physicians in certain basic specialties do not practice as such, but spend their time working in highly-specialised fields such as intensive care, palliative care, vascular and thoracic surgery, etc. The Regional Medical Commission suggests that these physicians be accounted for in the regional staffing plan, but not included in the specialties.

3. Some specialties such as internal medicine, psychiatry and diagnostic radiology are closely linked with the medical first-line. To the extent that their resources permit, the Regional Medical Commission recommends that these specialties give general practitioners time slots to make it easier for them to consult and access their technical/diagnostic facilities. In the specific case of psychiatry, the Regional Medical Commission supports the plan to set up an effective access system for mental health patients.

4. Finally, the Regional Medical Commission recommends that in the basic specialties, the medical staffing full-time equivalents must be estimated on a basis of a service organisation plan similar to the one produce by the Association of Anesthesiologists in 2000.

B. Other medical and surgical specialties and laboratory specialties

Recommendations

The Regional Medical Commission's recommendations on the other specialties are as follows:

1. The medical staffing plan must enable the institutions to recruit the staff they need to provide access to care and teaching.
2. The Regional Medical Commission recommends that the Ministry's staffing plan account for the fact that in several specialties, doctors spend more time working in highly specialised fields as opposed to practicing their specialty. The Regional Medical Commission suggests that these doctors be accounted for in the regional staffing plan, but not included in the specialties.
3. Some of these specialties are closely linked to the medical first-line. To the extent that their resources permit, the Regional Medical Commission recommends that they devote time slots to general practitioners to make it easier for them to consult and access their technical/diagnostic facilities.
4. Finally, the Regional Medical Commission recommends that in these specialties full-time equivalent medical staffing needs be estimated on the basis of a service organisation plan similar to the one developed by the Association of Anesthesiologists in 2000.

C. The supra-regional specialties

Several factors in the present conjuncture favour a concentration of ultraspecialised services and resources in Montreal-Centre:

1. The lack of human, material and financial resources is resulting in longer and longer waiting lists, which in turn force patients either to endure the adverse health effects or to seek treatment in the private sector or outside of the region or the province.
2. The literature abounds with studies that demonstrate the positive effect on service quality of concentrating services and expertise.
3. The physicians have already supported and have taken part or are taking part in service concentration projects in areas such as neurosurgery and cardiac surgery.
4. The creation of the university hospital centres and the potential complementarity between them or with other institutions in the network suggest that ultraspecialised services should be revisited in a network-wide perspective.
5. The assumptions stated in the document "*Collaboration-complémentarité entre établissements: partage des effectifs*" are equally applicable to the current exercise.
6. The percentage of care episodes in certain specialties, especially paediatrics, suggest that a concentration of services would be beneficial.

Section VI - A regional organisation model of specialised medical services on a sub-regional basis

Any organisation model for the Montreal region must allow for the fact that Montreal is a university region with both a regional and a supra-regional role to play, with its two faculties of medicine, university teaching hospitals, affiliated university centres and institutes.

Given the size of the jurisdiction and size of the population to be served, it is easier to organize medical services sub-regionally. Ideally, institutions in a same sub-region should establish functional lines between each other, whether they have the same mission or not. The model also has to flexible enough to allow for links between the sub-regions.

The Regional Medical Commission's document "*Collaboration-complémentarité entre établissements: partage des effectifs*" can serve as a guide for institutions that agree to network with each other.

Recommendations

The Regional Medical Commission recommends that in the course of the 2003-2005 plan, the Regional Board, and more particularly its Medical and University Affairs Department, work with institution managements and physicians to network the institutions sub-region by sub-region, in order to:

- to improve access to services;
- to make these services available as close as possible to the patients' place of residence; and
- to make better use of resources.

Published by the Service des communications
Direction de l'information et de la planification

Information source:
Montreal Organisation Plan for Specialised Medical Services and Medical Staffing, "*Action for access*" - Regional Medical Commission

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de Montréal-Centre, 2003

Legal Deposit - Bibliothèque nationale du Québec, 2003
ISBN 2-89510-115-9

This document is available:

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- in French under the title: *Plan montréalais d'organisation des services médicaux spécialisés et des besoins en effectifs médicaux, « L'accès en actions » - Résumé*

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