Letters
Correspondance

Alternate level of care

Ontario addresses the long waits

All of us involved in the provision of care experience challenges with moving patients efficiently and effectively through our health care system. The term *alternate level of care* (ALC) is a clinical designation that identifies patients who no longer require the intensity of resources or services provided in their current settings and who are waiting for ALC. These patients often wait weeks, months, and sometimes years in acute and postacute hospitals for transfer to ALC settings; this in turn prevents other patients from accessing hospital beds, increases wait times in emergency departments and elective surgical cancellations, and limits hospital surge capacity.

According to the Canadian Institute for Health Information, from 2007 to 2008 ALC patients accounted for 5% of hospitalizations and 14% of hospital days in acute facilities across Canada, which equates to 5200 beds in acute care hospitals being occupied by ALC patients on any given day.[1]

The Ontario Ministry of Health and Long-Term Care is implementing a number of initiatives to reduce emergency department and ALC wait times; however, it is evident that in order to make substantial progress in this area we need more timely and reliable data on the wait times of ALC patients in all acute and postacute hospitals in Ontario. The first key step in the collection of these data is to ensure clinicians are designating patients as ALC consistently in all care settings across the province.

On behalf of the Ontario Ministry of Health and Long-Term Care and eHealth Ontario, the Wait Time Information Program at Cancer Care Ontario worked in close collaboration with health care stakeholders to develop a standardized Provincial ALC Definition. The definition is applicable across the continuum of care for all patient populations and provides guidance for clinicians on when to consider the designation of ALC for patients. On July 1, 2009, all acute and postacute hospitals in Ontario began using the standardized definition to designate patients as ALC, and the Wait Time Information Program continues to support their efforts to ensure the definition is applied consistently within their organizations.

As physicians, we need to continue to play a leadership role in supporting initiatives of this nature, as they will allow us to identify gaps in services and resources in our hospitals and communities, and will help us address the needs of our patients. Therefore, I encourage you to learn more about this important initiative and the steps Ontario is taking to reduce wait times and improve access to care for all patients.

For a copy of the Provincial ALC Definition, please visit **www.cancercare.on.ca/ocs/alc**; if you have any questions regarding this initiative, please e-mail **ALCdefinition@cancercare.on.ca**.

—Peter Nord MD
Vice President Medical Affairs and Chief of Staff, Providence Healthcare, Toronto, Ont
Physician Champion for ALC, Wait Time Information Program

Reference

1. Canadian Institute for Health Information. *Analysis of care in Canada*. Ottawa, ON: Canadian Institute for Health Information; 2009. Available from: **http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=PG_1751_E&cw_topic=1751&cw_rel=AR_2610_E#media**. Accessed 2009 Jul 7.

Excluded detail

I was happy to read the practical suggestions put forth by Dr Kredentser in her June President's Message.[1] I concur with her belief that we all share a responsibility to better promote the discipline (specialty?) of family medicine to the general public and specifically to medical students.

However, the sudden rise in popularity of family medicine as a first choice made by medical students in the results of the 2009 Canadian Resident Matching Service (CaRMS) is easily explained by the inclusion of the 3 French Quebec faculties in CaRMS since 2006. Between 2003 and 2005, graduates of the English-Canadian faculties consistently chose family medicine approximately 26% of the time (there was a tiny increase of about 1.5% per year); from 2006 onward, family medicine as a first choice across Canada rose abruptly to around 30%, without any further tendency to rise or fall afterward.

The 3 Francophone Quebec faculties are following the CaRMS data with some concern, noting worrisome fluctuations from one graduating class to another within each faculty. We promote family medicine as best we can, always on our guard that this volatility might presage a decrease in interest in family medicine. In fact, the

The top 5 articles read on-line at cfp.ca last month

1. **Clinical Review:** Complementary and alternative medicine for the treatment of type 2 diabetes (June 2009)
2. **RxFiles:** Taking the stress out of insulin initiation in type 2 diabetes mellitus (June 2009)
3. **Debates:** Is tight glycemic control in type 2 diabetes really worthwhile? *Yes* (June 2009)
4. **Child Health Update:** Polyethylene glycol 3350 without electrolytes for treatment of childhood constipation (May 2009)
5. **Debates:** Is tight glycemic control in type 2 diabetes really worthwhile? *No* (June 2009)

current Minister of Health and Social Services, Dr Yves Bolduc, ordered the 4 Quebec faculties of medicine to develop comprehensive action plans with the objective of inducing up to 45% (and perhaps eventually 50%) of our graduates to choose careers in family medicine—only time will judge our success.

—Stephen DiTommaso MD FCFP
Montreal, Que

Reference

1. Kredentser S. Marketing family medicine. *Can Fam Physician* 2009;55:669 (Eng), 670 (Fr).

Response

Dr DiTommaso is correct in identifying the inclusion of the Francophone Quebec faculties in the Canadian Resident Matching Service in 2006 as one of the factors leading to the increased percentage of first-year residents choosing family medicine as their first choice. Between 2000 and 2002, just below 30% of students chose family medicine first. This reached an all-time low in 2003 at 25%. Since then we have seen a gradual increase (with a slight dip in 2007). Even within medical schools, there has been substantial variability from year to year. Our challenge is to proactively develop strategies aimed at increasing the appeal of family medicine, and those strategies need to be implemented through all phases of the learning continuum.

—Sarah Kredentser MD CCFP FCFP
Winnipeg, Man

Maternal history

Dr Cameron's article "Nothing to do but wait" details a remarkable story of a home birth performed by Dr Charles Webster in 1892.[1] Beautifully written and including excerpts from Dr Webster's original account of the delivery, the story contains vivid imagery and highlights the physical as well as medical obstacles physicians faced in the late 19th century. The story concludes with the delivery of a stillborn child, along with some practical and medical lessons for physicians.

The epilogue of the article, however, presents cause for concern. A brief reference is made to a declining maternal mortality rate and an increased rate of women giving birth in hospital, suggesting that the shift from women giving birth at home to hospital resulted in reduced risk to the mother. Although this has in fact been the case over many years (the maternal mortality rate in Canada did in fact decrease from the late 19th century to the 1920s and the mid-20th century to present), linking this result to an increase in hospital births as opposed to home births is misleading. In fact, when women initially began giving birth in hospital the maternal mortality rate increased; it was not until great changes occurred to the practice of obstetrics in hospital that the rate declined,