Liaison and Engagement Consultant
Final Report

January 7, 2011


Table of Contents

EXECUTIVE OVERVIEW .................................................................................................................. 1

1 INTRODUCTION .............................................................................................................................. 1

  1.1 THE FUTURE OF MEDICAL EDUCATION IN CANADA POSTGRADUATE PROJECT ....................... 1
  1.2 THE LIAISON AND ENGAGEMENT CONSULTANT ROLE .......................................................... 1
  1.3 THE LIAISON AND ENGAGEMENT CONSULTANT TEAM ....................................................... 1

2 METHODOLOGY ............................................................................................................................. 2

  2.1 STRATEGY .................................................................................................................................... 2
  2.2 IMPLEMENTATION ....................................................................................................................... 3

3 EMERGING THEMES ........................................................................................................................ 4

  3.1 STRENGTHS OF THE CURRENT PGME SYSTEM ....................................................................... 6
  3.2 PURPOSE OF PGME ..................................................................................................................... 7
    3.2.1 Skills Required to Meet Population Needs ............................................................................ 7
    3.2.2 Trends in Patient Care ........................................................................................................ 8
    3.2.3 Distribution of Medical Services ....................................................................................... 9
    3.2.4 Health Human Resource Planning .................................................................................... 10
  3.3 GOVERNANCE AND PROCESSES .......................................................................................... 10
    3.3.1 Governance ....................................................................................................................... 10
    3.3.2 Leadership ........................................................................................................................ 11
    3.3.3 Student Selection ............................................................................................................... 11
    3.3.4 Resident Assessment ......................................................................................................... 12
    3.3.5 Accreditation .................................................................................................................... 13
    3.3.6 Length of Training ............................................................................................................ 13
    3.3.7 Streaming ........................................................................................................................ 14
    3.3.8 Flexibility of Training ........................................................................................................ 15
    3.3.9 Resident Association Agreements .................................................................................... 15
  3.4 PEDAGOGY .................................................................................................................................. 16
    3.4.1 Innovative Models of Education ....................................................................................... 16
    3.4.2 Curriculum Improvements ................................................................................................ 16
    3.4.3 Faculty Development ........................................................................................................ 17
    3.4.4 Adoption of Technology .................................................................................................... 17
    3.4.5 Competency-based Education .......................................................................................... 17
    3.4.6 Distributed Medical Education ....................................................................................... 18
    3.4.7 Sharing of Best Practices in the Delivery of PGME ............................................................ 18
  3.5 TRANSITIONS .............................................................................................................................. 18
  3.6 HUMAN AND FINANCIAL RESOURCES .................................................................................... 19
    3.6.1 Human Resource Shortages .............................................................................................. 19
    3.6.2 Issues with Current Funding ............................................................................................. 19
    3.6.3 Expectations of Continued Financial Pressures ................................................................. 20
  3.7 CONCLUSIONS ............................................................................................................................ 20

4 PROPOSAL FOR ROUND 2 CONSULTATIONS ................................................................................. 21

APPENDIX A: STANDARDIZED REPORTING TEMPLATE ...................................................................... 22
APPENDIX B: MASTER SCHEDULE OF CONSULTATIONS ................................................................. 23
APPENDIX C: SUMMARY RESPONSES FOR QUESTION 1 - STRENGTHS ........................................... 28
APPENDIX D: SUMMARY RESPONSES FOR QUESTION 5 - BLUE SKY IDEAS .................................... 30
APPENDIX E: SUMMARY OF THEMES, NOVEMBER 15, 2010 ............................................................. 51
APPENDIX F: STANDARD FEEDBACK FORM FOR ROUND 2 CONSULTATIONS .................................... 58
EXECUTIVE OVERVIEW

Contract: Liaison and Engagement Consultant

Lead Consultant(s): Dr. Sarita Verma, Dr. Kamal Rungta, Dr. Salvatore Spadafora, Dr. Sarkis Meterissian

Methodology: The Liaison and Engagement Consultants conducted over 100 in-person and teleconference consultations with a broad range of stakeholders in the postgraduate medical education (PGME) community. The purpose of these consultations was to raise awareness of the project and solicit opinions and ideas for the FMEC PG Steering Committee’s consideration in formulating its recommendations. All stakeholders were asked to describe the strengths, vulnerabilities, risks and opportunities within PGME, and suggest “blue sky” ideas to innovate or strengthen the current PGME system.

Date: Consultations were undertaken from August 2010 to December 2010. This report is based on consultations completed by December 17, 2010.

Theme 1: Strengths of the Current PGME System

- The university-based approach to the delivery of PGME was broadly recognized as a strength for a variety of reasons, including a strong focus on education (rather than on service delivery), support of evidence-based medicine, and exposure to opportunities for clinical research.

- Accreditation was also widely accepted as a strength of the system due to the presence of rigorous national standards that produce consistently high quality graduates, and to the on-site peer reviews associated with accreditation.

- The CanMEDS framework is generally (with some exceptions) perceived as an excellent approach to describe all competencies of a physician, although there is some concern that the teaching and assessment of these roles needs improvement.

- Additional strengths included the scope and quantity of clinical exposure, the national CaRMS match and the quality and dedication of PGME faculty.

Theme 2: The Purpose of PGME in Canada (i.e., how well is PGME delivering in the context of population needs today, and possible needs in the future).

- There was considerable concern expressed about the disconnect between society’s needs and the outputs of PGME (e.g., trend to specialization when more generalists are needed, lack of education and resources for chronic disease management, too many residents in surgical specialties and too few in needed fields such as geriatrics and mental health). The emerging priorities of health care in Canada, which were enunciated as a serious crisis in mental health, aging and marginalized populations (First Nations populations), were noted by many stakeholders to be reflective of the need to better align the system with society’s needs.

- There was general consensus that, in order to educate competent and confident health professionals who work in an inter-professional environment, PGME must change to focus on the needs of patients rather than the needs of residents. Stakeholders encourage the PGME system to achieve the full potential of the CanMEDS framework, embrace inter-professional care in a meaningful way, and pay more than lip service to patient safety and patient satisfaction.
• The PGME system was criticized for its inability to graduate sufficient physicians who are prepared to practice in remote, rural and northern communities or with vulnerable populations. Communities and populations are turning to other health care professionals (e.g., nurse practitioners), putting the role of the primary care physician at risk.

• Many stakeholders felt that there is a critical need for a national health human resources plan that is data driven and takes into consideration population demographics and developing trends in health care, with input from and participation of all primary care health care professions.

• The focus on educating physicians in PGME who have a higher university and extended specialty education, rather than on health professionals who might be able to span the boundaries between specialties, represents a need for a fundamental linkage between professional education and health service delivery. It was unclear whether the PGME system would have the courage to make such a dramatic, bold shift.

Theme 3: Governance and Processes of PGME in Canada (i.e., how the PGME process is organized and managed).

• There was general agreement among educators and some regulators that governance for PGME is very complex and should be streamlined.

• The processes associated with accreditation are onerous, and the written feedback is seen as insufficient to help the program directors effect meaningful change.

• The assessment of medical residents is frustrated by the lack of information that follows the learner from undergraduate to postgraduate settings, the lack of reliable tools for assessment of non-medical expert roles, and the fear among supervisors that a failed resident might respond with legal actions.

• Training can be unnecessarily protracted. Creative approaches to streaming may help to shorten the total training time.

• Resident Association agreements were generally believed to have improved many wellness issues experienced by residents; however, many stakeholders (especially educators) felt that these agreements had gone beyond wellness issues and were creating issues for educators.

Theme 4: Pedagogy in PGME (e.g., educational methods, novel curricula, emerging content).

• Stakeholders are looking for innovative models of education (especially in light of the reduction in work hours), including competency-based education.

• Although PGME tries to teach inter-professional care (IPC), these efforts are relatively unsuccessful. There is also a need for intra-professional learning (i.e., among the various specialties within medicine).

• Faculty development requires an investment to ensure that all faculty are trained in teaching and assessment (including CanMEDS roles), and that the quality of teaching faculty is sustained even in distributed sites.

• Educators and residents saw potential for increased and more effective use of existing and emerging technologies in PGME, including simulation, web-based learning, and telecommunications options (e.g., Ontario Telemedicine Network). These techniques would facilitate the spread of distributed medical education (DME).
**Theme 5: Transitions** (i.e., the movement of medical learners from undergraduate (UG) to postgraduate (PG) to independent practice (i.e., continuing education and professional development [CEPD]).

- Stakeholders felt that PGME could prepare learners more effectively for these transitions.
- A greater focus is needed on continuous (i.e., life-long) learning.

**Theme 6: Human and Financial Resources**

- The recent expansion of PGME across Canada has met with challenges in securing sufficient faculty, particularly at DME sites. This shortage is attributed to the reluctance of preceptors to take on teaching responsibilities that will reduce their capacity to meet their current clinical workloads, especially without any financial remuneration.
- Funding issues were mentioned primarily by educators, who were concerned about the sustainability of the PGME system, which is hugely subsidized by clinical practice plans and hospitals. While residents expressed concern about the need to address inequities in the remuneration for their rotations, other stakeholders sometimes suggested that residents should not be paid for these rotations, particularly if the work week is reduced further, as is currently expected.
- Many stakeholders believe that the current fiscal challenges of our provincial and federal governments will continue for some time. Accordingly, it is important that PGME, and the medical profession in general, demonstrate that they are operating as cost-effectively as possible.
1 INTRODUCTION

1.1 The Future of Medical Education in Canada Postgraduate Project

The Association of Faculties of Medicine of Canada (AFMC), the College of Family Physicians of Canada (CFPC), le Collège des médecins du Québec (CMQ) and the Royal College of Physicians and Surgeons of Canada (RCPSC) have formed a coalition to undertake The Future of Medical Education in Canada Postgraduate Project (FMEC PG Project).

The goal of the FMEC PG Project is to conduct a thorough review of postgraduate medical education (PGME) in Canada, establish whether the structure, content and processes of the current system are designed for the best possible outcomes to meet current and future societal needs, and formulate recommendations for change.

This 18-month initiative is focused upon evidence gathering and analysis, consultation and engagement, formulation of recommendations for changes to the Canadian PGME system, and some early dissemination of project findings. An extension for the vetting of recommendations emerging from the FMEC PG Steering Committee has been granted until March 31, 2012.

The FMEC PG Project is building on the evidence and momentum generated by the FMEC MD Education Project (August 2007-March 2010) in its exploration of the highly interrelated PGME environment.

1.2 The Liaison and Engagement Consultant Role

As part of the FMEC PG Project, a Liaison and Engagement Consultant was retained with a mandate to liaise between the Steering Committee and the Canadian PGME community, assisting the FMEC PG Steering Committee to extend its presence to a pan-Canadian PGME audience. A key part of this role involved liaising with stakeholder groups in the PGME community, keeping them uniformly apprised of project activities and developments while engaging them to identify issues, concerns, priorities and successes relevant to the FMEC PG Project in the stakeholders’ respective contexts.

The Liaison and Engagement Consultant role is intended to focus on sharing information, facilitating discussion, listening, acknowledging, understanding, reflecting and analyzing. Its key elements are building trust in the FMEC PG Project process, creating effective partnerships and preparing the PGME system for change.

The Liaison and Engagement Consultant work is only one of many inputs that will be used by the FMEC PG Steering Committee to formulate recommendations. The full project includes, for example, an environmental scan, public consultations, a survey of program directors and international comparisons.

1.3 The Liaison and Engagement Consultant Team

The University of British Columbia (UBC), the University of Toronto (U of T) and McGill University (McGill) established a coalition to undertake the Liaison and Engagement Consultant role as a joint project led by Dr. Sarita Verma, Deputy Dean of the Faculty of Medicine at the University of Toronto, as Lead Consultant, in close collaboration with the Vice Dean of PGME at the University of Toronto (Dr. Salvatore Spadafora) and the Associate Deans of PGME at McGill University (Dr. Sarkis Meterissian) and
the University of British Columbia (Dr. Kamal Rungta) as Co-Consultants. Collectively, this team is referred to as the LEC Team in this report.

2 METHODOLOGY

2.1 Strategy

The Request for Proposals (RFP) for the Liaison and Engagement Consultant listed a number of key stakeholders. Our LEC Team expanded on this list by identifying relevant national, provincial and local stakeholders to be included in the consultations. The proposed list of stakeholders, which was approved by the FMEC PG Steering Committee on June 15, 2010 included:

- Educators (e.g., Deans, PG Deans, UG Deans, Program Directors, Education Councils),
- Academic Chairs,
- Students and Residents,
- Government,
- Nursing and Allied Health Disciplines,
- Hospital Associations,
- Medical Associations, and
- Colleges (e.g., The Royal College of Physicians and Surgeons of Canada [RCSPC], the College of Family Physicians of Canada [CFPC] and their provincial counterparts).

As the first round of consultations evolved, there were multiple requests for additions to the list of stakeholders, and extra consultations were held at the request of the FMEC PG Management Committee. However, not all requests could be accommodated within the very short timeframes available to meet the contract deliverables.

For each stakeholder group, the LEC Team proposed an engagement strategy specific to the group's circumstances, including, for example:

- A telephone or in-person interview with one or more participants.
- A presentation and discussion at a previously scheduled or special purpose meeting.
- A written or verbal request to a representative of some stakeholder groups (e.g., Royal College subspecialty committees) to submit input.
- A letter from the Steering Committee inviting input from individual members of target organizations.
- Town Hall meetings and/or focus groups, to be arranged by the target organization.

All consultations were designed to solicit input on five discussion topics:

1. What do you believe are the three best features of PGME in Canada?
2. What do you believe are the three most significant vulnerabilities of PGME in Canada?
3. What do you believe are the three most significant opportunities in the future of PGME in Canada?
4. What do you believe are the three most significant risks in the future of PGME in Canada?
5. If PGME in Canada had unlimited resources and no political or organizational limits, what innovative solutions or approaches would you recommend?

The standardized reporting template provided to stakeholders for their submissions is provided in Appendix A.

2.2 Implementation

The consultations were undertaken by the LEC Team as follows:

- Dr. Sarita Verma led consultations with national stakeholders.
- Dr. Kamal Rungta led the consultations with stakeholders in British Columbia, Alberta, Saskatchewan and the Territories.
- Dr. Salvatore Spadafora led the consultations with stakeholders in Manitoba and Ontario.
- Dr. Sarkis Meterissian led the consultations in Quebec and the Atlantic Provinces.

In all instances, we worked hard to engage the Postgraduate Deans of Medicine at the medical school(s) in each province to assist in these consultations. At their discretion, the Postgraduate Deans were encouraged to conduct consultations with stakeholders at their institution, and to submit a written summary of the discussions.

The LEC Team developed a standardized process to ensure consistent messaging and common processes were used for all consultations:

- A step-by-step guide with instructions for initiating and confirming the consultation, as well as activities to prepare for and document the proceedings.
- An invitation to the target stakeholder(s), which could be tailored to reflect the specific consultation strategy and/or unique circumstances of the stakeholder group.
- A one-page overview of the FMEC PG Project and an introduction to the Liaison and Engagement Consultant role.
- A list of the five questions about strengths, weaknesses, risks and opportunities, as well as a ‘blue sky’ question.
- A reporting template for each of the five questions.

A master schedule of all consultations was developed as a reporting mechanism to the FMEC PG Steering Committee. This master schedule included all relevant information (e.g., organization or individual to be consulted; lead consultant; date, time and location of consultation). This list was circulated weekly to advise FMEC PG Steering Committee members of upcoming consultations, and as an invitation for them to participate. One or more Steering Committee members was present at most of the consultations.

An abbreviated copy of the final master schedule (as at December 31, 2010) is provided as Appendix B.

Summary notes from all consultations were provided to the FMEC PG Secretariat on a weekly basis and were used as the foundation of this summary report of themes from those consultations. The compendium of the summary notes (as at December 31, 2010) is provided as a companion document to this report.
The first round of LEC consultations was substantially completed by December 17, 2010. Milestone dates for this first round are shown in Table 1.

**Table 1: Milestones for Round 1 of the LEC Strategy**

<table>
<thead>
<tr>
<th>Event</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>LEC Team is awarded the contract</td>
<td>April 22, 2010</td>
</tr>
<tr>
<td>LEC Strategy is approved by the FMEC PG Steering Committee</td>
<td>June 15, 2010</td>
</tr>
<tr>
<td>Contract is received and executed</td>
<td>August 31, 2010</td>
</tr>
<tr>
<td>National consultations begin</td>
<td>August 31, 2010</td>
</tr>
<tr>
<td>Regional consultations begin</td>
<td>October 4, 2010</td>
</tr>
<tr>
<td>Consultations are substantially completed</td>
<td>December 17, 2010</td>
</tr>
</tbody>
</table>

In total, 108 consultations were completed. The distribution of these consultations by stakeholder category and by geography is presented in Table 2.

**Table 2: Distribution of LEC Consultations by Stakeholder Category and Geography**

<table>
<thead>
<tr>
<th></th>
<th>National Consultations</th>
<th>Regional Consultations</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>West (BC, AB, SK)</td>
<td>Central (ON, MB)</td>
</tr>
<tr>
<td>Educators *</td>
<td>10</td>
<td>12</td>
<td>7</td>
</tr>
<tr>
<td>Academic Chairs **</td>
<td>11</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Students and Residents</td>
<td>2</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Government</td>
<td>1</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Nursing and Allied Health Disciplines</td>
<td>6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Hospital Associations</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Medical Associations</td>
<td>2</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Specialty Colleges***</td>
<td>7</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>42</td>
<td>28</td>
<td>14</td>
</tr>
</tbody>
</table>

* Deans, PG Deans, UG Deans, Program Directors, Education Councils and other Faculty Committees.
** National Associations of Academic Chairs
*** College of Family Physicians of Canada, Royal College of Physicians and Surgeons of Canada, Provincial Colleges.

### 3 EMERGING THEMES

In this section, we present a compilation of the comments made by stakeholders, organized under general themes. Many of the comments were made in response to more than one question (e.g., stated as both a vulnerability and a risk). In order to assist the interpretation of the comments in a meaningful way, this report has reorganized the comments into themes. Our aim is to eliminate duplication by grouping comments according to relevant and forward thinking topics for consideration of the FMEC PG Steering Committee. Where categories of stakeholders had unique or differing views or priorities, these are highlighted under each topic.
For organized summaries of the comments to the five questions, please refer to the following documentation:

- Comments about the strengths of the Canadian PGME system (question 1) are identified as one of the themes, and provided in more detail in Appendix C.

- Comments about vulnerabilities, risks and opportunities (i.e., questions 2, 3 and 4) were very similar in nature (e.g., the same issue was often described as a vulnerability, a risk or an opportunity). Therefore, comments from all three of these questions are summarized under broad themes in this chapter.

- ‘Blue sky’ ideas (provided in response to question 5) are reproduced in Appendix D, organized by topic. Although many of these ideas reflect the vulnerabilities, risks and opportunities described in the responses to questions 2, 3 and 4, the summary of ‘blue sky’ responses are detailed in the appendix because they provide potential strategies and solutions to address the issues raised.

The commentary provided in the following sections reflects the views, opinions and ideas of the stakeholders and does not necessarily reflect the opinions of the LEC Team.

Please note that during the course of these consultations, individual participants were assured that comments would not be ascribed to individuals. However, each stakeholder contact approved the content and wording of the summary of the consultation and understood that these would be transparently reported. The completed reports of all stakeholder consultations are provided in a companion document to this report.

The broad themes are organized as follows:

- Strengths of the Canadian PGME system. This section is taken directly from the responses to the first question. As noted above, this is the only section that is described independently of the responses to the other questions because the responses were highly consistent among stakeholder groups and because many of the strengths were not mentioned again in the context of the other themes.

- The purpose of PGME in Canada (i.e., how well PGME is delivering in the context of population needs today, and possible needs in the future).

- The governance and processes of PGME in Canada (i.e., how the PGME process is organized and managed).

- Pedagogy (e.g., educational methods, novel curricula, emerging content).

- Transitions (i.e., the movement of medical learners from undergraduate (UG) to postgraduate (PG) to independent practice (i.e., continuing education and professional development [CEPD]).

- Financial and human resources.

Many of the issues raised are relevant for one or more of the above categories, but have been documented in only one location (with cross references where appropriate) to reduce duplication.
Although we have tried to give a sense of how common certain comments and ideas were among various stakeholders, we have not included counts or frequencies for any of the comments for a number of reasons:

- The mandate of the LEC Team was to act as an ambassador providing two-way communications for the FMEC PG Project in order to raise awareness of the project and to provide the FMEC PG Steering Committee with a sense of general themes and concerns within the PGME community. This component of the project was never intended to be a formal qualitative or quantitative research study.

- Any attempt to quantify the frequency of comments would be misleading, as some consultations were with only one or two people, and others were with 20 or more. Assigning equal weight to a group of two and a group of 20 would not accurately reflect the number of individual stakeholders who expressed this concern. Additionally, in the larger groups, some of the opinions were not necessarily shared by all participants.

- Stakeholders were asked to provide opinions and ideas, which are, by their very nature, not necessarily evidence based. The FMEC PG Steering Committee will have more scientific data from other components of the FMEC PG Project (e.g., the environmental scan, surveys, public consultation, international comparisons).

For the same reasons, we have not assigned any weights or priorities to the various themes.

In November 2010, as an interim report to the FMEC PG Steering Committee, the LEC Team provided a summary of the most frequent responses to the five discussion topics. This summary received extremely positive feedback. The PowerPoint presentation is appended as Appendix E.

### 3.1 Strengths of the Current PGME System

Across all stakeholders groups, there were highly consistent messages regarding the perceived strengths of the Canadian PGME system.

The university-based approach to PGME was consistently lauded for a variety of reasons:

- With the university having overall responsibility for the education of residents, the focus generally places education above service delivery, which is not always the case in other jurisdictions (e.g., where hospitals provide residencies independent of any university programs and service delivery may at times take priority over education).

- The practice of medicine in a university environment is more likely to be based on the best evidence, which provides instruction in best practice and an appreciation among residents of the need to consistently engage in evidence-based practice throughout their careers.

- In a university environment, residents will have more opportunities to participate in clinical research, which may encourage them to pursue clinical research as a career.

The accreditation process was also frequently cited as a major strength of the Canadian PGME system for many reasons:

- The presence of national accreditation standards ensures that all Canadian programs produce a consistent quality of graduate.
• The rigour of the national standards has resulted in the system producing high quality physicians, whose education and value are recognized internationally.

• On-site reviews are welcome (and preferred to paper-based reviews conducted remotely). As well, the peer review process (i.e., where physicians involved in PGME – rather than non-physician administrators - review training programs) is believed to be very appropriate.

The CanMEDS framework, which is organized around seven roles (i.e., medical expert, communicator, collaborator, health advocate, manager, scholar and professional) is valued as a means to highlight all of the required competencies of a successful physician beyond just medical expertise. (Note to the reader: Although CanMEDS was often cited as a strength of the system, there were mixed views on how this framework is currently used in PGME.)

The scope and quantity of clinical exposure is a strength of the Canadian system. However, this characteristic of the PGME system was also felt to be somewhat at risk with the current expansion of UG and PG medical education programs, as well as the growing need for training of other health professionals such as nurse practitioners and physician assistants.

The national Canadian Residency Matching Service (CaRMS) is seen to be fair and transparent, although there was some criticism of specific processes (e.g., in-person interviews).

Many participants commented on the high quality and dedication of PGME faculty. Particularly notable was the volunteerism of clinical teachers across academic and distributed sites, which was cited as a significant strength.

3.2 Purpose of PGME

A common theme among stakeholders was gaps and challenges in addressing society's needs for medical care. These gaps were expressed as skills required and geographic distribution of medical services. Stakeholders identified an opportunity to address these gaps through a national health human resource planning exercise for all health professionals.

3.2.1 Skills Required to Meet Population Needs

There was considerable concern expressed about the perceived disconnect between society's needs and the supply and mix of physicians produced through the PGME system.

There was widespread concern that the PGME system needs readjustments to produce the right mix of generalist vs. specialist physicians. Most stakeholders felt that society's need for generalist medical care was much greater than the need for specialization. Although both are necessary, there was a sense that the pendulum had swung too far towards specialization. In addition, the trend towards specialization has resulted in the care being fragmented among multiple physicians with a loss of continuity of care and of responsibility for the patient by any one physician. Consultations with non-medical stakeholders reinforced the perspective that patients would prefer to have a more holistic approach to healthcare, which is not seen to be part of the educational culture of PGME.

Stakeholders were not unanimous about the need for less specialization. For example:

- Some surgical stakeholders felt that any shift to generalism was a threat to surgical specialties.
- Some specialties (e.g., diagnostic imaging, psychiatry) felt that their specialty should be taught as part of all specialties or even subsumed into other specialties.

A frequent comment was the need to rebalance the relative mix of specialties. For example, stakeholders suggested there was a need for:
- More family physicians and fewer Royal College specialists (i.e., more physicians in family medicine than is currently the case).
- More specialists in medicine and fewer in surgical specialties. It was often noted that the current capacity for surgical specialty education was driven more by the hospitals' service needs and resident choice (for high profile, high income potential "cutting" specialties) than by society's need for these specialists.
- More specialists in geriatrics and fewer in paediatrics (to reflect the changing demographics and associated health care needs of the Canadian population).
- More clinician researchers (although this view was not shared by government stakeholders).

Many stakeholders commented on the need to align PGME with the patient and population priorities of health care in Canada, such as the serious crisis in mental health, the impact of an aging population and the needs of marginalized populations (e.g., Aboriginals).

### 3.2.2 Trends in Patient Care

Stakeholders had very strong opinions about the link between trends in health services delivery, quality improvement and the educational context.

Some stakeholders commented that unprecedented, rapid technological advances, knowledge dissemination and evidence-based practice were not adequately informing the curriculum in PGME across all specialties.

There was considerable commentary that, in order to educate competent and confident health professionals who work in an inter-professional environment, the PGME environment must change to address the needs of the patients rather than the needs of the residents.

The focus in PGME on educating physicians who have a higher university and extended specialty education, rather than on health professionals who might be able to span the boundaries between specialties, represents a need for a fundamental linkage between professional education and health service delivery. Stakeholders were uncertain whether the PGME system would have the courage to make such a dramatic, bold shift in its focus.

Although it was broadly recognized that CanMEDS is an excellent framework to describe the roles and competencies of contemporary physicians, there are limitations to the teaching and assessment of these roles within PGME, due in part to a lack of these competencies among supervisors and a lack of reliable tools for assessing these competencies in residents. There is also a need to bring the CanMEDS framework into continuing education and professional development (CEPD) to help physicians who are already in practice to understand these roles, acquire the needed skills to achieve competency in these roles, and use them in their day-to-day practice.
Although inter-professional care (IPC) is taught in PGME, there was concern among some educators and allied health professionals that these skills were not necessarily well modelled by preceptors, and were often abandoned once the resident was in independent practice. It was felt that residents did not learn to appreciate and respect the roles of other health professionals and how to work in a team environment. As our health care sector continues to have severe financial pressures, which are unlikely to be alleviated even in the medium term, the inter-professional model of care will become increasingly favoured by governments and the Canadian population as a way to use our high-cost medical resources as cost-effectively as possible.

Society has also begun to focus more on patient safety and patient satisfaction. PGME does not yet sufficiently educate or prepare physicians to practice successfully to work in collaborative teams focused on patient safety and patient satisfaction as cardinal outcome metrics. Patient-centered care, rather than learner-centric care and disease-based practice (e.g., organized around a chronic condition such as diabetes) rather than institution-based practice (e.g., organized around a variety of acute conditions) were expressed as two changes that should occur in postgraduate education.

Lack of residents’ experience in continuity of patient care was seen as an important issue by a number of stakeholder groups, and was attributed partly to duty-hour restrictions and on-call limitations, but also to a lack of exposure to the delivery of care in ambulatory and other settings where a resident could follow one patient over time.

3.2.3 Distribution of Medical Services

In addition to concerns about the skills of medical practitioners, there were also concerns about the persistent inability to attract and retain physicians into remote, rural and northern communities. Residents often prefer to practice in larger tertiary centres and/or urban communities. Some of the reasons for this mal-distribution of medical resources were proposed as follows:

- Medical education and postgraduate education are most often located in larger communities, and associated with academic health science centres (i.e., tertiary or quaternary centres). After 10 years of learning, practising and living in these large centres and communities, moving away from their lifestyle or community roots (e.g., family) may be a daunting hurdle for new physicians. Even those who initially express a desire to return to their home communities often change their mind during their decade-long educational program.

- Many new graduates are reluctant to practice where there is no tertiary centre, as they have limited experience with such independent practice and feel ill prepared to undertake that degree of independence.

- The lifestyle of physicians in smaller communities is perceived to be unattractive (e.g., more frequent call, limited networks and backup).

- The existing incentives appear to be ineffectual in overcoming the barriers for new physicians to choose to practice outside of urban centres.

These challenges are compounded for some vulnerable populations (e.g., Aboriginals), where a lack of physicians places a huge burden on those physicians who do choose to work in these communities. Physicians practicing in these communities also need enhanced skills in cultural fluency related to medical care for vulnerable populations.
As shortages of primary care physicians continue to be acute in some locations, the local population is turning to alternative practitioners (e.g., nurse practitioners) to meet the care needs. Some stakeholders felt the expanded use of nurse practitioners is a threat to the medical profession's role in the delivery of primary care.

3.2.4 Health Human Resource Planning

One reason for the noted disconnect between the "outputs" of PGME and society's needs was that there is little effective formal planning for health human resources.

The comments suggested that there is a critical need for a national health human resources plan that is evidence driven, and takes into consideration population demographics and developing trends in health care, with input from and participation of all primary care health care professions.

The suggested approach to a national health human resources plan would include:

- Maximizing the scope of each primary health care profession to ensure that all available human resources are used cost-effectively. The planning process should address the role and need for physicians, nurse practitioners, nurses, pharmacists, and physiotherapists at a minimum.
- Incorporating the potential impact of changes in models of care, advances in technology and new research.
- Recognizing the "feminization" of the medical workforce, and the work/life balance choices of the incoming generation of both male and female medical students.
- Examining supply and demand issues on a pan-Canadian basis, recognizing the internal migration of physicians and other health professionals across provincial boundaries.
- Creating the Health Human Resource Observatory\(^1\).

There was some concern expressed that with the recent expansion of medical schools across Canada, the pendulum might be swinging too far, resulting in a surplus of some specialties in the near term. Without a more effective approach to health human resources planning, we will not be able to avoid such repeated swings between surplus and shortage in future.

3.3 Governance and Processes

3.3.1 Governance

There was generally agreement among educators and some regulators that governance for PGME is very complex. Views were mixed on the value of two separate organizations for specialty certification: the Royal College of Physicians and Surgeons of Canada (RCSPC) and the College of Family Physicians of Canada (CFPC):

- Some felt that having only two colleges, and indeed just one for all RCSPC specialties, was a strength of the Canadian system. The competition between the two colleges was described as healthy, and likely to nurture innovation.

\(^1\) The Health Human Resource Observatory is a proposal for a formal structure for the collection and analysis of Canada's disparate data sets and the collection of data where needed. The observatory would be broadly constituted and representative of federal, provincial and territorial governments, the public, a wide range of health care provider groups, health system managers and researchers.
Others felt that the two colleges should be merged into a single entity. This would introduce consistency for some fields that are covered by both colleges (e.g., emergency medicine, palliative medicine), and simplify the accreditation process for these programs.

Many stakeholders felt that the complex regulatory and organizational context of PGME makes it slow to respond to change. One major contributing factor is the sheer number of organizations that have roles in the regulation of qualifications and practice (i.e., RCSPC and CFPC and their provincial counterparts, College des médecins du Quebec, Medical Council of Canada, Federation of Medical Regulatory Associations of Canada and its provincial regulatory authorities), as well as other stakeholders that influence PGME, including the government (as funder and policy maker), universities and hospitals.

Regardless of the structure of PGME governance, the governing bodies noted frustrations in the process of planning medical education in an environment where government policy, with its two- or three-year horizon, can have wide-reaching and long-lasting impacts on medical education and delivery of care. Some also reported that the Resident Association agreements were increasingly interfering with the educators' ability to design and deliver an effective curriculum.

3.3.2 Leadership

Some stakeholders felt that the medical profession, starting with PGME, needs to demonstrate leadership in recognizing the profession's responsibilities for meeting society's needs, including meaningful participation in health human resource planning and processes for ensuring that the PGME system nationally produces the mix and distribution of physicians that are needed in Canada now and in the future. Fears were expressed that if PGME does not "step up to the plate", other authorities (e.g., government) may do it for the profession.

Stakeholders pointed to a lack of professionalism, the loss of moral authority and the 'erosion of public accountability' within the medical profession. Some stakeholders, particularly among the medical associations, felt that physicians need to be better trained and prepared to take a leadership role in health care.

3.3.3 Student Selection

Stakeholders often questioned whether the medical schools’ admissions departments were doing a good job of selecting suitable candidates for medical school. The use of academic achievements (e.g., a high grade point average, high scores on exams, other postgraduate degrees) as a primary criterion was questioned, especially given its inability to screen for other desired characteristics related to non-medical expert CanMEDS roles. If changes are made in UGME admission processes, the impact on PGME would be felt as these “new” medical students select and begin their residencies four years later.

Residents felt that PGME would benefit from more career counselling for medical students in UGME so that graduating medical students could chose the right postgraduate program, with the “right” program being one that interests them and one for which they have an aptitude and there are employment opportunities. This type of counselling could also help to identify residents who are underperforming perhaps because they are not in the right specialty. Identifying a mismatch between skills and the chosen specialty earlier in the resident’s education would be invaluable for both the resident and the PGME system.
The issue of student selection was identified as a significant contributing factor to the maldistribution issue. The lack of graduates willing to practice in small, rural, remote or northern communities was identified as a symptom of the UGME's inability to either identify candidates who are most likely to want to practice outside of tertiary centres and/or the lack of incentives to overcome the desires to stay in tertiary centres.

The challenge is particularly acute for some populations (e.g., First Nations communities), which are suffering from a critical shortage of primary care practitioners. The use of academic criteria to screen candidates for medical school is biased against candidates who might make excellent physicians in their home communities, but whose environment did not provide opportunities to excel academically. Admitting these high-potential candidates into medical schools, and providing them with appropriate remedial training, mentoring and encouragement were identified as strategies to begin to address the maldistribution issue for these populations.

3.3.4 Resident Assessment

The need for significant redesign, alignment and upgrading of resident assessment was described as follows:

- Some parts of the student records do not follow the learner from UG to PG to practice, making it difficult for supervisors (and ultimately the colleges) to identify undesirable trends in learner or practitioner behaviour until after the learner has been licensed as a physician.

- If past performance and assessment information on students and residents were available at all stages, it would be easier to identify disturbing performance trends, and to justify remedial action much earlier.

- Many stakeholders, including residents and educators, called for more frequent or ongoing assessment, with less emphasis on the final examinations. This was proposed as a strategy for identifying performance issues earlier in the education program. “Failing to fail” was identified as a prominent issue among educators and regulators, with an express desire that remediation not be viewed so negatively. Indeed, one stakeholder suggested that the specialty-specific training requirements (SSTRs) and time for training be seen as minimums, recognizing that many residents will need additional time to become competent.

- There is a perceived gap in the development of self assessment skills for residents.

- The "unionization" of the resident population was also reported to be affecting educators' motivation to provide meaningful assessments of residents, and was causing some educators to “fail to fail” underperforming residents because of the resulting additional workload to justify or defend the assessment and provide remediation.

- The increasingly litigious relations between residents and educators has made some educators reluctant to give a student or resident a bad assessment. One educator noted that he had his lawyers on speed dial as a defense mechanism for the risk of litigation following an unsatisfactory assessment.

Although CanMEDS roles were generally accepted as a desirable framework for PGME, the ability to teach and assess competency in these roles is frustrated by a number of factors:

---

2 Many stakeholders used the term “evaluation” rather than assessment. Since evaluation is more often used to refer to program evaluation, we have used the term “assessment” in this report to avoid confusion.
• There are no reliable models or tools for the assessment of CanMEDS competencies. Supervisors (e.g., academic chairs, educators) do not feel confident in assessing these competencies, especially in the increasingly litigious environment.

• Some supervising physicians have not accepted the importance of the non-medical expert competencies and, therefore, do not provide an appropriate role model for their residents, nor do they feel that a critical assessment of these skills is necessary.

3.3.5 Accreditation
While accreditation was praised as a strength of the PGME system, stakeholders also expressed concerns about the standards, structure and time-intensive administrative burden of the accreditation-related processes:

• The current accreditation standards are perceived as overly rigid, which frustrates efforts to innovate or introduce flexibility into educational programs. The process of making change within accreditation and the lack of consistency across the country within specialties and within universities was raised as a serious concern.

• The accreditation standards for some specialties were believed to be no longer relevant for contemporary practice. Changes to the standards involve a cumbersome process, which is perceived as neither nimble nor well informed.

• The accreditation process is onerous for the participating universities. Significant time is dedicated to the process by program directors, but they receive only limited, written feedback. Internal processes within universities for quality assurance and surveillance of standards are not uniformly applied or randomly spot checked, allowing some programs to create a false front at a site survey that is not representative of the usual operations.

• The time lag between accreditation visits is perceived as too long (six years), such that an entire class of specialists or three classes of family physicians could graduate without curricular review.

3.3.6 Length of Training
The length of postgraduate training was a common discussion topic, with many dimensions.

Many stakeholders felt that many specialty programs were unnecessarily protracted:

• The trend to subspecialization and increasing complexity of medical practice in general may contribute to even longer training requirements.

• Many residents are opting for one or more fellowships. Stakeholders speculated that this sometimes reflected a lack of confidence in the resident’s readiness for independent practice, and sometimes the desire to be more employable, especially in specialties where employment opportunities are currently limited (e.g., cardiac surgery).

• The two-year Family Medicine curriculum was lauded by some, but perceived as too short by others.

• Many physicians, especially subspecialists, only enter practice in their mid-thirties, which is much later than for any other profession.

• The past and expected future reductions in the work week may contribute to even longer training periods, if the approach to education is not radically changed.
Suggestions to shorten training included a variety of ideas for graduated licensure where a physician could practice as a generalist for a period of time (e.g., several years), before entering specialist training. Another suggestion was to licence physicians for a core scope of practice, and provide funded three- to six-month sabbaticals for practising physicians to return to training to acquire additional credentials. Many stakeholders felt this would make all physicians more appreciative of the family physician’s role in medical care, while others felt that residents should be allowed to focus on their chosen specialty immediately at the start of training.

### 3.3.7 Streaming

Stakeholders felt that strong consideration should be given to multiple models of learning that allow for early streaming into one of three routes:

- **Generalism with optional re-entry to specialize or subspecialize.**
- **Clinician scientist such as MD PhD or Clinician Investigator Program.**
- **Immediate specialization in areas of acute societal need or highly technical subspecialties.**

Views on streaming (and the timing of the choice of specialization) were mixed, even among residents:

- Some stakeholders felt that medical students should not have to choose a specialty in their first or second year of medical school, before they have a chance to experience the full range of possibilities. It was noted that some specialties require electives that must be planned from the beginning of medical school if students wish to be considered for that specialty in the CaRMS match.
- Other stakeholders felt that medical students should be allowed to specialize immediately if they are certain of their chosen specialty.
- Yet others felt that there should be more flexibility in the system so that a student or resident could change specialties mid-stream. Some residents would value a system in which the educational program for each resident could be tailored to meet the individual's career goals. This view was not shared among all stakeholders, and some felt that this trend to "self-indulgent" learning was causing the system to bend over backwards for a small minority of students.
- One suggested approach to reducing the pressure to pick a specialty early in a student's medical education would be to reduce the number of PGY1 entry specialties, leaving subspecialization until later years. Another frequent suggestion was the return of the rotating internship.

There were a few suggestions (among program directors and some undergraduate deans) that not everyone needed to have the same core education, and that technical specialists, for example, do not necessarily need the same core medical education as generalist practitioners. Such an approach would result in immediate streaming (not desired by all stakeholders), but could work to shorten the overall training period (desired by many). However, others felt that a narrow scope of training within the more technical fields would contribute to the loss of the overview of the patient as a whole.
3.3.8 Flexibility of Training

Stakeholders commented that there is a need for improved flexibility within the PGME system. The need for flexibility was raised in relation to several aspects of PGME:

- Residents are asking for more flexible career paths, including rotations and educational programs more tailored to individual needs.
- The opportunity to re-enter formal education to re-train or to update skills within a specialty was identified by many stakeholders as desirable, but difficult in the current system.
- The PGME system was seen as unable to respond quickly to needed changes. For example, it was suggested that a community could be mobilized more quickly than a bureaucracy to support residents in underserved regions.

3.3.9 Resident Association Agreements

Resident Association agreements were generally believed to have improved many wellness issues experienced by residents (e.g., excessive work hours, bullying and harassment). However, many stakeholders (especially educators) felt that these agreements had gone beyond wellness issues, and were creating challenging issues for educators.

For example, the recent reduction in work hours (and the expected further reduction) was viewed as having potentially undesirable implications:

- As the work week is shortened, the service to education ratio must be adjusted so that either the emphasis will shift towards education or the length of training will be extended. There is a risk that there will be little time for service delivery in the future.
- As the service delivery element of resident education is reduced, hospitals will have to find other health care professionals (e.g., hospitalists, more specialists, nurse practitioners) to perform the services currently handled by residents, at incremental cost to hospitals at a time when hospital budgets are under intense financial pressure.
- Changes in on-call limitations and work week hours overall affect the continuity of care, which has an impact on the quality of patient care and the learning experience of the residents.
- Residents may find that their salaries are reduced or eliminated as the service component is reduced.

Some stakeholders felt that the trend to a shorter work week could be an effective catalyst for innovation in the PGME curriculum and teaching methods.

There was also a sense among stakeholders, including residents, nursing and allied health, that the agreements had not gone far enough in addressing some of the holdover negative educational practices that are sometimes still employed. Other high stress professions were identified that do not tolerate the same brutal techniques (e.g., exhaustion, bullying, breaking them down before building them up) to prepare residents for the responsibilities they will eventually have to assume.
3.4 Pedagogy

3.4.1 Innovative Models of Education

Great interest was expressed by several stakeholders in several models of education including (but not limited to) the competency-based approach undertaken as a pilot by Orthopaedic Surgery at the University of Toronto. Stakeholders strongly encouraged the FMEC PG Steering Committee to consider multiple pilots as proof of principle studies that aim for a reduction in the length of training by deleting unnecessary components that may be redundant and streamline the production of generalists in seminal, foundational specialties such as core internal medicine, psychiatry, general surgery, paediatrics, anaesthesiology, obstetrics and gynecology, medical imaging and laboratory medicine in practice in rural and medium-sized communities in Canada.

Models should incorporate harmonization across multiple jurisdictions and multiple institutions in Canada. This would require a reduction of inter-jurisdictional barriers between provinces and an integration of curricula across medical schools so that residents can harvest the best experiences in all settings such as quaternary care settings, urban academic health science centres and community-based settings, which are more likely to be their location of future practice. Such models do not currently exist, and there was strong encouragement to develop and begin testing, with flexibility from all the various certifying organizations and regulatory authorities.

3.4.2 Curriculum Improvements

Stakeholders expressed concerns about gaps in residents’ abilities to provide effective inter-professional care (IPC).

Although it was acknowledged that there are efforts in PGME to teach IPC, these efforts are viewed as relatively unsuccessful for a variety of reasons:

- Supervisors are not trained to practice within an inter-professional model of care, and, therefore, are unable to provide a meaningful role model for this approach to patient care. Often, the attitudes of the supervisor (being "in charge" of the team and ultimately responsible for all elements of patient care) are transferred to the residents by the supervisor’s example.

- With the exception of some unique work environments such as family health teams in Ontario, the practice environment for new graduates is not always conducive to a team-based approach to care. Not all individual or group practices have easy access to the resources needed for inter-professional care.

- Under current fee-for-service funding models, clinicians are not remunerated for adopting an inter-professional model of care in private practice.

Notwithstanding these comments, some stakeholders in nursing and allied health noted that the more recently graduated physicians are generally (but not always) better trained in this regard than older physicians. Some felt that this might be further improved through common core science classes with medical students, nurses, and allied health students all attending the same classes.

Some stakeholders noted that there is also a need for intra-professional education so that all physicians, regardless of their specialty, develop an appreciation and respect for their medical colleagues. This comment was sometimes extended to the need for a greater understanding and appreciation of non-western medical or alternative care techniques (e.g., naturopathy, Chinese medicine, acupuncture).
A less frequently cited gap was the need to teach residents about clinical systems (e.g., cardiac sciences), rather than focusing on narrow specialties or subspecialties (e.g., cardiology, cardiac surgery).

### Faculty Development

As noted earlier, the quality and dedication of the teaching faculty was identified as a strength of the PGME system. However, there was a general sense that there are gaps in faculty development as a support for new and experienced supervisors:

- Many educators felt that they did not have the skills or tools to assess non-medical expert competencies (e.g., within the CanMEDS roles).
- Some supervisors do not practice or value the CanMEDS roles and, therefore, cannot model them for their residents.
- Within a centralized academic health science centre, it is relatively straightforward to orient, develop, monitor and assess physician faculty; however, the logistics of faculty recruitment, development, support and assessment are much more complicated with the increasing use of distance medical education strategies across the country. The recent and continuing expansion in PGME positions across Canada will make these challenges even more acute.

### Adoption of Technology

Educators and residents saw potential for increased and more effective use of existing and emerging technologies in PGME:

- Increased use of simulation was a frequent suggestion for addressing a variety of issues in PGME, from the risk of reduced clinical exposure to creating more opportunities to practice inter-professional care. It was also proposed that simulation was consistent with current trends in health care towards greater emphasis on patient safety, as residents would no longer be practising techniques for the first time on a live patient.
- The use of web-based learning techniques would be particularly useful for DME.
- Educational technology including communication tools such as the Ontario Telemedicine Network (OTN), email and social networking sites could be used more extensively and potentially very effectively.

### Competency-based Education

There was general interest in moving forward with competency-based education, which is perceived to offer the benefits of potentially shorter duration of training for many residents, and a greater emphasis on skill acquisition than on time spent in a rotation. There was also a belief that competency-based education would contribute to ongoing rather than episodic assessment.

Not all stakeholders were as enthusiastic. Many educators expressed a variety of operational and education concerns with competency-based approaches including the requirement for more supervisory time and the need to be well managed to avoid administrative hurdles (e.g., challenges with frequent or sudden changes in scheduling of rotations and associated service delivery disruptions). It was also viewed as expensive to implement. Some also felt that there is value in repetition, even once the technical skills are acquired, particularly in the development of non-medical competencies and confidence in one’s own abilities. There was also the worry that competency-based education would
narrow the scope of assessments to only those competencies that are easily quantified (e.g., technical expertise and knowledge), marginalizing the other desired attributes of the contemporary physician.

3.4.6 Distributed Medical Education

Distributed medical education (DME) was generally perceived as necessary, given the recent and continuing expansion in PGME. DME was often cited as an opportunity for PGME because it prepares residents to practice in a community setting. The PGME system's ability to prepare residents for community practice was often noted as a weakness.

There were, however, concerns about some of the challenges associated with the successful implementation of DME, including the increased need for faculty development and support, the complexities of accreditation, and the logistics of identifying and dealing with poor resident performance. Despite these challenges, most stakeholders felt that DME was a worthwhile and important trend in PGME.

3.4.7 Sharing of Best Practices in the Delivery of PGME

Several opportunities were identified to reduce duplicated efforts in PGME:

- Each program at each university currently has to develop and deliver a curriculum for CanMEDS competencies. It was proposed that these modules be shared across programs to reduce the need for each program to develop and implement them independently. Where content needs to be tailored to a specific specialty, the sharing could be between programs across universities.
- Within a specialty, some of the educational materials could be shared across universities, to give all residents access to the same resources.

3.5 Transitions

The need for meaningful integration across the "silos" of the different levels of medical education (i.e., UG, PG and CEPD) was frequently mentioned:

- There is a need for more emphasis on continuous learning, from the commencement of medical school, until the licensed physician retires from medical practice.
- Residents and educators found that the transition from UG to PG and from PG to independent practice was too abrupt. Suggestions to smooth these transitions included the return of the rotating internship, graduated licensure, and a model of more gradual reduction of supervision throughout the residency.
- There needs to be greater emphasis on life-long learning in PGME, so that new physicians understand the importance of continuing their education throughout their careers.
- The fee-for-service funding model, which pays the same for services provided by a recent graduate as for a physician with years of experience, suggests that there is no value to learning after the physician is licensed. One stakeholder expressed it well in saying “practice is education”, meaning that there should be some reward for maintenance of competence within your specialty.

Some residents expressed a need for enhanced support in the preparation for transition to independent practice such as:
- Contract negotiation (for their first employment contract),
• Practice management, and
• Community-based practice (due to the lack of community-based rotations).

3.6 Human and Financial Resources

3.6.1 Human Resource Shortages

The recent expansion of PGME across Canada, with the resulting strategy of distributed medical education (DME) has met with challenges in recruiting preceptors for residents at DME sites. Many reasons are given for the shortage of willing preceptors, including the following:

• Supervision of residents is time consuming, and reduces the physician’s capacity to handle their existing clinical workload. Therefore, a supervising physician’s capacity for patient care and associated income are reduced.

• Increasingly, community preceptors are recruited as volunteers, with no remuneration for their teaching activities (although there are some exceptions). Community preceptors are not always willing to continue working as volunteers.

Challenges in recruiting sufficient faculty are not limited to the DME sites. In academic centres, where residents have traditionally contributed significantly to service delivery, the implementation of a shorter work week for residents has reduced their availability for delivering clinical care (e.g., on-call). Therefore, it is becoming less attractive for physicians to take on residents. Expectations of an even shorter work week in the future will aggravate this situation.

3.6.2 Issues with Current Funding

Funding issues were mentioned primarily by educators, who noted concerns about the sustainability of the PGME system, which is hugely subsidized by clinical practice plans and hospitals. Additionally, government funding to universities has not changed much in most provinces over the last decade, nor has it kept up with the increasing cost of educating postgraduate residents. The protected time for education, the failure to keep up with the student to faculty ratio (i.e., inability to hire more faculty as enrollments increase), and limited infrastructure such as space for teaching continue to dilute the educational environment.

Educators felt one of the biggest financial challenges was finding the time (preceptor time, repeat rotations), to ensure adequate supervision, assessment and, when necessary, remediation for international medical graduates (IMGs), who are thought to be not as prepared for PGME as Canadian medical graduates (CMGs). The recent increase in IMGs in PGME programs has taxed the faculties’ ability to ensure these residents receive the supervision and attention they need.

Many educators felt that preceptors should be remunerated for their time and efforts, which is currently not always the case. The wide variability of stipends for clinical community preceptors across the country was often noted.

Residents were also concerned about inequalities in the remuneration of residents across the country. Some expressed the view that all residents should receive the same salary, regardless of their specialty and the province in which they are training. Educators, however, suggested that the resident salary, which was originally intended to remunerate residents for service delivery, should be reduced as the resident work week is shortened, and the education to service ratio increases.
Some stakeholders expressed the view that policies for residents’ education and salaries need to be consistent with other professions. For example:

- Trainees in other health care professions are not paid during clinical placements and residencies.
- Allied Health and other professions felt that, comparatively, medical education is well funded and has access to up-to-date technology.
- Some government stakeholders felt funding was adequate, and that teaching (i.e., educating the future generation of physicians) is part of the medical profession’s social contract and should not be funded.

3.6.3 Expectations of Continued Financial Pressures

The financial situation of Canada’s federal, provincial and territorial governments continues to be bleak, with little expectation that this will improve in the medium term. Some stakeholders were concerned that budgetary pressures may yet result in cuts to university and hospital budgets, as well as physician remuneration. The PGME system was urged by some stakeholders to prepare for these financial challenges by:

- Demonstrating that medical education is operating as cost-effectively as possible. This may include the adoption of technology to reduce the labour intensity of medical education and service delivery.
- Working with other health professions to ensure that the scope of practice of other health professionals is maximized in practice, as physicians have become a very expensive resource in our health care system.

3.7 Conclusions

This first round of consultations from August 31, 2010 to December 17, 2010 was an intense period involving 108 significant conversations with a diverse and engaged group of stakeholders. The LEC Team was extremely well received, and every stakeholder consultation was enthusiastic and opinionated. As a result, we have a robust sense of the high degree of commitment to PGME in Canada across all domains and an expectation that the FMEC Steering Committee will consult broadly as its recommendations emerge.

Ongoing consultation will be critical in order to avoid and pre-empt a loss of confidence in the process. Of note, there is increasing curiosity about the implementation steps of FMEC MD and desire to see linkages between that phase of the project and the PG phase.

In the course of these multiple consultations, the LEC Team found that some groups had been consulted more than once. Thus, it is likely that we have reached saturation and would not propose a broad disseminated similar approach for the second round of consultations. We would, therefore, conclude at this stage that the momentum has been generated and would be poised to suggest an efficient and highly-effective, yet sophisticated, approach to phase 2, as proposed in the next section, for vetting of the emerging recommendations from the FMEC PG Steering Committee. This approach to the next round of consultations would be informed not just by this report, but also by the environmental scan, the program directors’ survey, the public consultation and the international comparisons.
4 PROPOSAL FOR ROUND 2 CONSULTATIONS

This report is being used as one of many inputs to the FMEC PG Steering Committee on which it will base its report and recommendations.

The LEC Team is proposing the following process for liaison and engagement with the PGME community to review the Steering Committee's draft recommendations:

1. Once the draft recommendations are available (expected in April 2011), the LEC Team would send the recommendations to all stakeholders who were involved in the first round of consultations. The recommendations would be circulated electronically, soliciting the stakeholders' input on the overall content and direction of the recommendations and identification of any major omissions. A standard form would be provided to collect the input. (See Appendix F for a draft template.)

2. The LEC Team would conduct additional consultations with up to 10 national organizations to solicit feedback on the recommendations. A list of the targeted organizations is provided in Table 3.

3. At each of the 17 medical schools, the PG Deans Advisory Committee should organize 'town hall' meetings to consult with their key stakeholders. The LEC Team would assist in the planning and execution of these meetings. In addition, central coordination for schools sharing in the consultations among regional, provincial and national constituencies could be facilitated by the LEC team.

Table 3: Proposed Target Organizations for Round 2 Consultations

<table>
<thead>
<tr>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Association of Canadian Academic Health Organizations (ACaho)</td>
</tr>
<tr>
<td>Association of Faculties of Medicine of Canada (AFMC)</td>
</tr>
<tr>
<td>Canadian Association of Internes and Residents (CAIR)</td>
</tr>
<tr>
<td>Canadian Federation of Medical Students (CFMS)</td>
</tr>
<tr>
<td>Canadian Medical Association (CMA)</td>
</tr>
<tr>
<td>College des médecins du Quebec (CMQ)</td>
</tr>
<tr>
<td>College of Family Physicians of Canada (CFPC)</td>
</tr>
<tr>
<td>Federation of Medical Regulatory Associations of Canada (FMRAC)</td>
</tr>
<tr>
<td>Medical Council of Canada (MCC)</td>
</tr>
<tr>
<td>Royal College of Physicians and Surgeons of Canada (RCSPC)</td>
</tr>
</tbody>
</table>

In addition, we suggest that an opportunity be provided for a discussion forum at the Canadian Conference on Medical Education (CCME) in May 2011 and the International Conference on Residency Education (ICRE) in September 2011. This could be led by members of the FMEC PG Management Committee.

This second round of consultations would take place beginning in April 2011, and continue until November 2011. At the completion of the second round of consultations, a summary report will be prepared for the FMEC Steering Committee.

Of note, any new timelines, deadlines and deliverables would be subject to an amended contract for the LEC Team.
### Appendix A: Standardized Reporting Template

**Liaison and Engagement Consultant - Meeting Summary Report**

Please complete in Microsoft Word and return to fmec.pg@utoronto.ca

<table>
<thead>
<tr>
<th>Stakeholder information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
</tr>
<tr>
<td>Title:</td>
</tr>
<tr>
<td>Organization:</td>
</tr>
<tr>
<td>Phone:</td>
</tr>
<tr>
<td>Email:</td>
</tr>
</tbody>
</table>

**Description of stakeholders represented:**

Steering Committee member:

<table>
<thead>
<tr>
<th>1.</th>
<th>What do you believe are the three best features of postgraduate medical education in Canada? (Said another way, what must NOT be changed.) <em>(Please list in order of priority.)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2.</th>
<th>What do you believe are the three most significant vulnerabilities of postgraduate medical education in Canada? (Said another way, what must be changed or strengthened.) <em>(Please list in order of priority.)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3.</th>
<th>What do you believe are the three most significant risks in the future of postgraduate medical education in Canada? <em>(Please list in order of priority.)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4.</th>
<th>What do you believe are the three most significant opportunities in the future of postgraduate medical education in Canada? <em>(Please list in order of priority.)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5.</th>
<th>If postgraduate medical education (PGME) had unlimited resources and no political or organizational limits, what innovative solutions or approaches would you recommend?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

Thank you for your contribution!

For further information on this project, go to: [http://www.afmc.ca/fmec/](http://www.afmc.ca/fmec/)
### Appendix B: Master Schedule of Consultations

<table>
<thead>
<tr>
<th>Organization</th>
<th>Lead Consultant</th>
<th>Steering Committee Representative</th>
<th>Date of Consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EDUCATORS - Deans of Medicine</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AFMC</td>
<td>Sarita Verma</td>
<td>Anne-Marie MacLeLLan</td>
<td>18-Nov-10</td>
</tr>
<tr>
<td>AFMC</td>
<td>Sarita Verma</td>
<td>Anne-Marie MacLeLLan</td>
<td>18-Feb-10 *</td>
</tr>
<tr>
<td>Council of Ontario Faculties of Medicine - Full COFM</td>
<td>Sarita Verma</td>
<td>Maureen Shandling Jay Rosenfield</td>
<td>29-Oct-10</td>
</tr>
<tr>
<td>Conférence des recteurs et des principaux des universités du QC</td>
<td>Sarkis Meterissian</td>
<td>Pierre Leblanc</td>
<td>5-Oct-10</td>
</tr>
<tr>
<td><strong>EDUCATORS - Postgraduate Deans of Medicine</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FMEC-PG Advisory Committee (at RCSPC ICRE)</td>
<td>Sarita Verma</td>
<td>Pierre Leblanc</td>
<td>23-Sep-10</td>
</tr>
<tr>
<td>Alberta PGME Advisory Group</td>
<td>Kam Rungta</td>
<td>Bruce Wright</td>
<td>18-Nov-10</td>
</tr>
<tr>
<td>Council of Ontario Faculties of Medicine - PGE Committee</td>
<td>Sarita Verma</td>
<td>Maureen Topps Jay Rosenfield</td>
<td>21-Oct-10</td>
</tr>
<tr>
<td>Conférence des recteurs et des principaux des universités du QC</td>
<td>Sarkis Meterissian</td>
<td>Pierre Leblanc</td>
<td>6-Oct-10</td>
</tr>
<tr>
<td><strong>EDUCATORS - Undergraduate Deans of Medicine</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Council of Undergraduate Associate Deans (CUAD), UBC Faculty of Medicine</td>
<td>Kam Rungta</td>
<td></td>
<td>4-Oct-10</td>
</tr>
<tr>
<td>Council of Ontario Faculties of Medicine</td>
<td>Sarita Verma</td>
<td>Jay Rosenfield</td>
<td>20-Oct-10</td>
</tr>
<tr>
<td>Conférence des recteurs et des principaux des universités du QC</td>
<td>Sarkis Meterissian</td>
<td>Pierre Leblanc</td>
<td>6-Oct-10</td>
</tr>
<tr>
<td>Association of American Medical Colleges (AAMC)</td>
<td>Nick Busing (for Sarita Verma)</td>
<td>Ian Bowmer</td>
<td>7-Nov-10</td>
</tr>
<tr>
<td><strong>EDUCATORS - Program Directors</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National FM Program Directors</td>
<td>Sarita Verma in Kam Rungta</td>
<td>Ivy Oandasan</td>
<td>16-Oct-10</td>
</tr>
<tr>
<td>Association of Canadian University Departments of Anesthesia (ACUDA)</td>
<td>Sal Spadafora</td>
<td>Frederick D’Aragon</td>
<td>21-Nov-10</td>
</tr>
<tr>
<td>Program Directors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UBC Faculty Residency Education meeting</td>
<td>Kam Rungta</td>
<td></td>
<td>26-Oct-10</td>
</tr>
<tr>
<td>University of Calgary Postgraduate Program Directors</td>
<td>Jean Jamieson</td>
<td>Bruce Wright</td>
<td>19-Nov-10</td>
</tr>
<tr>
<td>University of Saskatchewan Program Directors</td>
<td>Kam Rungta</td>
<td></td>
<td>4-Nov-10</td>
</tr>
<tr>
<td>University of Saskatchewan Department Heads</td>
<td>Kam Rungta</td>
<td></td>
<td>4-Nov-10</td>
</tr>
<tr>
<td>University of Manitoba Program Directors</td>
<td>Sal Spadafora</td>
<td>Michael West</td>
<td>26-Nov-10</td>
</tr>
<tr>
<td>Schulich PGME Committee and Program Directors</td>
<td>Maureen Morris Chris Watling</td>
<td></td>
<td>3-Nov-10 8-Dec-10</td>
</tr>
<tr>
<td>McMaster University Program Directors</td>
<td>Mark Walton</td>
<td></td>
<td>24-Nov-10</td>
</tr>
<tr>
<td>Northern Ontario School of Medicine Program Directors</td>
<td>Maureen Topps</td>
<td></td>
<td>29-Oct-10</td>
</tr>
<tr>
<td>Organization</td>
<td>Lead Consultant</td>
<td>Steering Committee Representative</td>
<td>Date of Consultation</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>-----------------------</td>
<td>-----------------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td><strong>Organization</strong></td>
<td><strong>Lead Consultant</strong></td>
<td><strong>Steering Committee Representative</strong></td>
<td><strong>Date of Consultation</strong></td>
</tr>
<tr>
<td>Program Directors &amp; Martin Gardner, Associate Dean, PGME, Dalhousie</td>
<td>Sarkis Meterissian</td>
<td>Josh Tepper</td>
<td>24-Nov-10</td>
</tr>
<tr>
<td>Program Directors &amp; Asoka Samarasena, Associate Dean, PGME, Memorial</td>
<td>Sarkis Meterissian</td>
<td>Jim Rourke, Ford Bursey</td>
<td>25-Nov-10</td>
</tr>
<tr>
<td><strong>EDUCATORS - Other</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>University of Alberta Faculty Learning committee</td>
<td>Kam Rungta</td>
<td></td>
<td>19-Nov-10</td>
</tr>
<tr>
<td>PGME Steering Committee and Alberta IMG Advisory Group - Joint meeting including the Alberta Ministry of Health, Alberta Health Services and Covenant Health</td>
<td>Kam Rungta</td>
<td></td>
<td>18-Nov-10</td>
</tr>
<tr>
<td>University of Saskatchewan Department Heads</td>
<td>Kam Rungta</td>
<td></td>
<td>4-Nov-10</td>
</tr>
<tr>
<td>Faculty of Medicine, Education Council (FOMEC), UBC</td>
<td>Kam Rungta</td>
<td></td>
<td>14-Sep-10</td>
</tr>
<tr>
<td>Faculty of Medicine, Education Council (FOMEC), U of T</td>
<td>Sarita Verma</td>
<td></td>
<td>11-Aug-10 **</td>
</tr>
<tr>
<td>Faculty of Medicine, Education Council (FOMEC), U of T</td>
<td>Sarita Verma</td>
<td>Josh Tepper</td>
<td>13-Oct-10</td>
</tr>
<tr>
<td>Hospital University Education Committee (HUEC), U of T</td>
<td>Sarita Verma, Sal Spadafora</td>
<td>Maureen Shandling, Jay Rosenfield</td>
<td>15-Sep-10</td>
</tr>
<tr>
<td>Edudeans, U of T</td>
<td>Sarita Verma</td>
<td>Jay Rosenfield</td>
<td>6-Oct-10</td>
</tr>
<tr>
<td>Postgraduate Education Council (PGEC) Committee, University of Ottawa</td>
<td>Paul Bragg</td>
<td>Ford Bursey</td>
<td>27-1 Oct-10</td>
</tr>
<tr>
<td>NOSM Academic Council</td>
<td>Maureen Topps</td>
<td>Jill Konkin</td>
<td>13-Jan-11 *</td>
</tr>
<tr>
<td>Staff, Memorial</td>
<td>Sarkis Meterissian</td>
<td>Ford Bursey, Jim Rourke, Asoka Samarasena</td>
<td>25-Nov-1</td>
</tr>
<tr>
<td>Chairs of Clinical Departments, Memorial</td>
<td>Sarkis Meterissian</td>
<td>Ford Bursey, Jim Rourke, Asoka Samarasena</td>
<td>25-Nov-10</td>
</tr>
<tr>
<td>CFPC Section of Teachers (SOT) Council</td>
<td>Sarita Verma</td>
<td></td>
<td>9-Nov-10</td>
</tr>
<tr>
<td>CCME Plenary for one hour</td>
<td>Sarita Verma</td>
<td>Jerry Maniate, Jay Rosenfield</td>
<td>10-May-11 *</td>
</tr>
<tr>
<td><strong>ACADEMIC CHAIRS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anesthesia</td>
<td>Sal Spadafora</td>
<td>Jill Konkin, Frederick D'Aragon, Jay Rosenfield</td>
<td>9-Jan-11 *</td>
</tr>
<tr>
<td>Family Medicine</td>
<td>Sarita Verma</td>
<td>Ivy Oandasan</td>
<td>16-Oct-10</td>
</tr>
<tr>
<td>Medical Imaging</td>
<td>Sarita Verma</td>
<td></td>
<td>28-Sep-10</td>
</tr>
<tr>
<td>Medicine</td>
<td>Kam Rungta</td>
<td></td>
<td>29-Oct-10</td>
</tr>
<tr>
<td>Obstetrics/Gynecology</td>
<td>Sarita Verma</td>
<td></td>
<td>5-Dec-10</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>Sarita Verma</td>
<td></td>
<td>23-Oct-10</td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>Sarita Verma</td>
<td></td>
<td>**</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>Sarita Verma</td>
<td></td>
<td>16-Oct-10</td>
</tr>
<tr>
<td>Pathology and Laboratory Medicine</td>
<td>Sarita Verma</td>
<td>Shawn Mondoux</td>
<td>29-Sep-10</td>
</tr>
<tr>
<td>Organization</td>
<td>Lead Consultant</td>
<td>Steering Committee Representative</td>
<td>Date of Consultation</td>
</tr>
<tr>
<td>--------------</td>
<td>----------------</td>
<td>-----------------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>Sarita Verma</td>
<td>Maureen Shandling</td>
<td>23-Sep-10</td>
</tr>
<tr>
<td>Radiation Oncology</td>
<td>Sarita Verma</td>
<td>***</td>
<td></td>
</tr>
<tr>
<td>Surgery</td>
<td>Sarita Verma</td>
<td>Ford Bursey</td>
<td>30-Oct-10</td>
</tr>
<tr>
<td><strong>NATIONAL ASSOCIATIONS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Council of Canada (MCC)</td>
<td>Sarita Verma</td>
<td>Ian Bowmer</td>
<td>24-Oct-10</td>
</tr>
<tr>
<td>Indigenous Physicians Association of Canada</td>
<td>Sarita Verma</td>
<td>2-Dec-10</td>
<td></td>
</tr>
<tr>
<td>Canadian Resident Matching Services (CaRMS)</td>
<td>Sarita Verma</td>
<td>24-Sep-10</td>
<td></td>
</tr>
<tr>
<td>Association of Canadian Academic Health Organizations (ACAHO)</td>
<td>Sarita Verma</td>
<td>Jim Rourke</td>
<td>***</td>
</tr>
<tr>
<td><strong>ALLIED HEALTH ASSOCIATIONS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Canadian Nurses Association (CNA)</td>
<td>Sarita Verma</td>
<td>Todd Watkins</td>
<td>19-Nov-10</td>
</tr>
<tr>
<td>Canadian Association of Schools of Nursing (CASN)</td>
<td>Sarita Verma</td>
<td>***</td>
<td></td>
</tr>
<tr>
<td>Canadian Association of Social Workers (CASW)</td>
<td>Sarita Verma</td>
<td>19-Oct-10</td>
<td></td>
</tr>
<tr>
<td>Canadian Association of Occupational Therapists (CAOT)</td>
<td>Sarita Verma</td>
<td>14-Sep-10</td>
<td></td>
</tr>
<tr>
<td>Canadian Physiotherapy Association (CPA)</td>
<td>Sarita Verma</td>
<td>31-Aug-10</td>
<td></td>
</tr>
<tr>
<td>Canadian Association of Speech-Language Pathologists and Audiologists (CASLPA)</td>
<td>Sarita Verma</td>
<td>***</td>
<td></td>
</tr>
<tr>
<td>Canadian Pharmacists Association (CPA)</td>
<td>Sarita Verma</td>
<td>Todd Watkins</td>
<td>**</td>
</tr>
<tr>
<td>Canadian Dental Association (CDA)</td>
<td>Sarita Verma</td>
<td>Todd Watkins</td>
<td>****</td>
</tr>
<tr>
<td>Canadian Public Health Association (CPHA)</td>
<td>Sarita Verma</td>
<td>14-Sep-10</td>
<td></td>
</tr>
<tr>
<td><strong>GOVERNMENT</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advisory Committee on Health Delivery and Human Resources (ACHDHRR)</td>
<td>Sarita Verma</td>
<td>Ken Harris, depending when it is.</td>
<td>21-Oct-10</td>
</tr>
<tr>
<td>Council of Ministries of Education (CMEC)</td>
<td>Sarita Verma</td>
<td>***</td>
<td></td>
</tr>
<tr>
<td>Postgraduate Planning Task Force (British Columbia)</td>
<td>Kam Rungta</td>
<td>14-Dec-10</td>
<td></td>
</tr>
<tr>
<td>Saskatchewan Ministry of Health</td>
<td>Jean Jamieson</td>
<td>10-Nov-10</td>
<td></td>
</tr>
<tr>
<td>Nunavut Department of Health and Social Services</td>
<td>Jean Jamieson</td>
<td>Karen Mazurek</td>
<td>1-Dec-10</td>
</tr>
<tr>
<td>Department of Health/ DHAs of Nova Scotia</td>
<td>Sarkis Meterissian</td>
<td>Markus Martin</td>
<td>24-Nov-10</td>
</tr>
<tr>
<td>Capital Health/ IWK Leadership</td>
<td>Sarkis Meterissian</td>
<td>24-Nov-10</td>
<td></td>
</tr>
<tr>
<td><strong>PHYSICIAN COLLEGES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>College of Family Physicians of Canada (CFPC)</td>
<td>Sarita Verma</td>
<td>Jim Rourke</td>
<td>30-Nov-10</td>
</tr>
<tr>
<td>Royal College of Physicians and Surgeons of Canada (RCPSC) Office of Education</td>
<td>Sarita Verma</td>
<td>Ken Harris</td>
<td>29-Sep-10</td>
</tr>
<tr>
<td>Royal College of Physicians and Surgeons of Canada (RCPSC) Committee on Education</td>
<td>Sarita Verma</td>
<td>Ken Harris</td>
<td>17-Nov-10</td>
</tr>
<tr>
<td>Organization</td>
<td>Lead Consultant</td>
<td>Steering Committee Representative</td>
<td>Date of Consultation</td>
</tr>
<tr>
<td>-----------------------------------------------------------</td>
<td>-----------------------</td>
<td>-----------------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Federation of Medical Regulatory Authorities of Canada (FMRAC)</td>
<td>Sarita Verma</td>
<td>Karen Mazurek</td>
<td>25-Oct-10</td>
</tr>
<tr>
<td>College of Physicians and Surgeons of BC (CPSBC)</td>
<td>Kamal Rungta</td>
<td></td>
<td>21-Oct-10</td>
</tr>
<tr>
<td>College of Physicians and Surgeons of Alberta (CPSA)</td>
<td>Kam Rungta</td>
<td></td>
<td>19-Nov-10</td>
</tr>
<tr>
<td>College of Physicians and Surgeons of Saskatchewan (CPSS)</td>
<td>Kam Rungta</td>
<td></td>
<td>4-Nov-10</td>
</tr>
<tr>
<td>College of Physicians and Surgeons of Manitoba (CPSM)</td>
<td>Sal Spadafora</td>
<td></td>
<td>26-Nov-10</td>
</tr>
<tr>
<td>College of Physicians and Surgeons of Ontario (CPSO)</td>
<td>Sal Spadafora</td>
<td></td>
<td>30-Nov-10</td>
</tr>
<tr>
<td>College des médecins du Québec (CMQ)</td>
<td>Sarkis Meterissian</td>
<td>Karen Mazurek</td>
<td>18-Oct-10</td>
</tr>
<tr>
<td>College of Physicians and Surgeons of Nova Scotia (CPSNS)</td>
<td>Sarkis Meterissian</td>
<td>Karen Mazurek</td>
<td>24-Nov-10</td>
</tr>
<tr>
<td>College of Physicians and Surgeons of Newfoundland and Labrador</td>
<td>Sarkis Meterissian</td>
<td>Karen Mazurek</td>
<td>25-Nov-10</td>
</tr>
<tr>
<td>Yukon Medical Council</td>
<td>Kam Rungta</td>
<td></td>
<td>****</td>
</tr>
</tbody>
</table>

**MEDICAL ASSOCIATIONS**

<table>
<thead>
<tr>
<th>Organization</th>
<th>Lead Consultant</th>
<th>Steering Committee Representative</th>
<th>Date of Consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canadian Medical Association (CMA)</td>
<td>Sarita Verma</td>
<td>Maureen Topps</td>
<td>5-Nov-10</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ken Harris</td>
<td></td>
</tr>
<tr>
<td>British Columbia Medical Association (BCMA)</td>
<td>Kam Rungta</td>
<td></td>
<td>21-Oct-10</td>
</tr>
<tr>
<td>Alberta Medical Association (AMA)</td>
<td>Kam Rungta</td>
<td>Karen Mazurek</td>
<td>19-Nov-10</td>
</tr>
<tr>
<td>Saskatchewan Medical Association (SMA)</td>
<td>Kam Rungta</td>
<td></td>
<td>****</td>
</tr>
<tr>
<td>Manitoba Medical Association (MMA)</td>
<td>Sal Spadafora</td>
<td></td>
<td>****</td>
</tr>
<tr>
<td>Ontario Medical Association (OMA)</td>
<td>Sal Spadafora</td>
<td></td>
<td>16-Dec-10</td>
</tr>
<tr>
<td>Quebec Medical Association (AMQ)</td>
<td>Sarkis Meterissian</td>
<td></td>
<td>27-Oct-10</td>
</tr>
<tr>
<td>Medical Society of Nova Scotia (MSNS)/Doctors Nova Scotia</td>
<td>Sarkis Meterissian</td>
<td>Jim Rourke</td>
<td>10-Nov-10</td>
</tr>
<tr>
<td>Newfoundland and Labrador Medical Association (NLMA)</td>
<td>Sarkis Meterissian</td>
<td>Markus Martin</td>
<td>25-Nov-10</td>
</tr>
<tr>
<td>Fédération des médecins spécialiste du Québec (FMSQ)</td>
<td>Sarkis Meterissian</td>
<td></td>
<td>26-Nov-10</td>
</tr>
<tr>
<td>Yukon Medical Association (phone consultation with Yukon representative to the Canadian Medical Association)</td>
<td>Jean Jamieson</td>
<td></td>
<td>30-Nov-10</td>
</tr>
<tr>
<td>Fédération des médecins omnipracticiens du Québec (FMOQ)</td>
<td>Sarkis Meterissian</td>
<td></td>
<td>10-Nov-10</td>
</tr>
</tbody>
</table>

**HOSPITAL ASSOCIATIONS**

<table>
<thead>
<tr>
<th>Organization</th>
<th>Lead Consultant</th>
<th>Steering Committee Representative</th>
<th>Date of Consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ontario Hospital Association (OHA)</td>
<td>Sal Spadafora</td>
<td>Markus Martin</td>
<td>8-Dec-10</td>
</tr>
<tr>
<td>Health Association Nova Scotia</td>
<td>Sarkis Meterissian</td>
<td></td>
<td>24-Nov-10</td>
</tr>
<tr>
<td>Organization</td>
<td>Lead Consultant</td>
<td>Steering Committee Representative</td>
<td>Date of Consultation</td>
</tr>
<tr>
<td>------------------------------------------------------------------</td>
<td>----------------------</td>
<td>-----------------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Newfoundland and Labrador Health Boards Association</td>
<td>Sarkis Meterissian</td>
<td>Jim Rourke</td>
<td>25-Nov-10</td>
</tr>
<tr>
<td>STANDARDS AND RESIDENTS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Canadian Associations of Internes and Residents (CAIR)</td>
<td>Sarita Verma</td>
<td>Jerry Maniate Mathieu Dufour</td>
<td>26-Sep-10</td>
</tr>
<tr>
<td>Canadian Federation of Medical Students (CFMS)</td>
<td>Sarita Verma</td>
<td>Jill Konkin</td>
<td>16-Sep-10</td>
</tr>
<tr>
<td>Professional Association of Residents of British Columbia (PAR-BC)</td>
<td>Kam Rungta</td>
<td></td>
<td>8-Nov-10</td>
</tr>
<tr>
<td>Professional Association of Residents of Alberta (PARA)</td>
<td>Kam Rungta</td>
<td>Mathieu Dufour Frederick D'Aragon</td>
<td>19-Nov-10</td>
</tr>
<tr>
<td>Professional Association of Interns and Residents of Saskatchewan (PAIRS)</td>
<td>Kam Rungta</td>
<td></td>
<td>4-Nov-10</td>
</tr>
<tr>
<td>Professional Association of Residents and Interns of Manitoba (PARIMS)</td>
<td>Sal Spadafora</td>
<td></td>
<td>26-Nov-10</td>
</tr>
<tr>
<td>Professional Association of Interns and Residents of Ontario (PAIRO)</td>
<td>Sal Spadafora</td>
<td>Mathieu Dufour Frederick D'Aragon</td>
<td>30-Nov-10</td>
</tr>
<tr>
<td>Federation des médecins residents du Québec (FMRQ)</td>
<td>Sarkis Meterissian</td>
<td>Frederick D'Aragon</td>
<td>29-Nov-10</td>
</tr>
<tr>
<td>Federation des médecins étudiante du Québec (FMEQ)</td>
<td>Sarkis Meterissian</td>
<td>Frederick D'Aragon</td>
<td></td>
</tr>
<tr>
<td>Professional Association of Residents of the Maritime Provinces (PARI-MP)</td>
<td>Sarkis Meterissian</td>
<td>Mathieu Dufour Frederick D'Aragon</td>
<td>24-Nov-10</td>
</tr>
<tr>
<td>Professional Association of Interns and Residents of Newfoundland (PAIRN)</td>
<td>Sarkis Meterissian</td>
<td>Mathieu Dufour Frederick D'Aragon</td>
<td>25-Nov-10</td>
</tr>
<tr>
<td>OTHER STAKEHOLDERS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>L’Association québécoise d’établissements de santé et de services sociaux (AQESSS)</td>
<td>Sarkis Meterissian</td>
<td>Frederick D’Aragon</td>
<td>4-Nov-10</td>
</tr>
<tr>
<td>Provincial Health Regions (Saskatchewan)</td>
<td>Kam Rungta</td>
<td></td>
<td>4-Nov-10</td>
</tr>
<tr>
<td>Federation des médecins omnipraticiens du Québec (FMOQ)</td>
<td>Sarkis Meterissian</td>
<td></td>
<td>***</td>
</tr>
<tr>
<td>BC Medical Directors</td>
<td>Kam Rungta</td>
<td></td>
<td>8-Oct-10</td>
</tr>
</tbody>
</table>

* Consultation is scheduled, but has not yet been completed.
** Not a full consultation (e.g., discussion of best strategy to collect input from stakeholder group).
*** Provided feedback in writing.
**** No response to invitation for consultation.
Appendix C: Summary Responses for Question 1 - Strengths

Question 1: What do you believe are the three best features of postgraduate medical education in Canada? (Said another way, what must NOT be changed.) (Please list in order of priority.)

Most frequent responses (in no particular order):

- University based system
  - Focus stays on education, rather than purely service delivery
  - Creates appreciation for evidence-based learning
  - Creates opportunity to pursue research
- National, high quality accreditation standards (consistency across Canadian programs), and assessment/examinations
- On-site peer review
- CanMEDS framework
- Scope and quantity of clinical exposure (although this is perceived to be somewhat at risk with expansion of UG and PG medical education programs, as well as the need to train other health professionals such as nurse practitioners and physician assistants. Responsible for direct patient care (graded and supervised)
- National CaRMS, which is fair and transparent (subject to some qualifications)
- Excellent and dedicated faculty

Less frequent responses (in no particular order, organized by themes):

Educational experience:

- Single payor medical insurance with access for all, providing wealth of clinical, teaching and research material. Also trains future physicians in a society that values medical care as an equal right for all persons.
- Integration of clinical care, education and research
- Incorporation of distributed medical education
- Exposure to current technology and equipment
- Strong core science curriculum
- Focus on evidence-based care
- Good balance of apprenticeship (particularly in technical specialties) and academic training
- One-to-one apprenticeship/mentorship
- Linkages between UG and PG -well-prepared for transition
- Great research opportunities
- Multitude of specialty streams available in Canada
- Presence of learners raises quality of performance in healthcare system and promotes lifelong learning and research in these institutions
- Emphasis on cultural competencies

Educational processes:

- Two-year family medicine curriculum (Ontario, Quebec)
- Embedded in the medical care system
• End point of residency (rather than continuing as a resident or junior staff for years before becoming a consultant)
• Protected time for learning (e.g., academic half days)
• Oral exams (not exclusively written)
• Solid foundation in generalism, first year is generalist year.
• Flexibility in postgraduate training to allow residents to customize their education in support of personal career goals. Also flexibility to accommodate changes in practice

Regulatory environment:
• Residents are registered with the College
• Professionally-led regulation
• Only two regulatory bodies (RCPSC and CPSC)

Resident support:
• Residency debt deferral
• Recognition of learner as an adult, with appropriate remuneration and limits on work hours
• Commitment to supporting residents during training, that involves significant resident input
• National CaRMS match
• Access to research funds, and to academic, clinical and community resources, including on-line resources
• Social, practice management and leadership support from PARA and family support from the AMA
• Financial support for education, conferences, electives, etc.,

Standards and Resident Assessment:
• Well established specialty committees in each specialty/subspecialty that are supported by the Royal College
• Oral exams provide a standard of attitudes and behaviours as well as knowledge and skill
• Rigorous and regular assessment of residents with ITERs and FITERs.
• Employability within Canada and internationally
• Clear goals, objectives and expectations

Infrastructure:
• Commitment to providing sufficient PG training positions for graduating medical students
• World class facilities and state-of-the-art equipment
• Programs taught and administered by clinicians
• Structured education goals
• Use of hospitalists to handle the "non-teaching" clinical workload
• Geographic distribution of medical schools across Canada
• Well funded
• Potential to use the PGME infrastructure (program director and clinical teaching facilities) as a resource to the community in providing assessment, advice and opportunities for upgrading clinical skills of community clinicians
• Flexibility of programs to innovate and meet local needs while maintaining high national standards
• Ability of programs to adapt and respond to shifts in medical practice and evolving needs
• Re-entry training for physicians
Question 5: If postgraduate medical education (PGME) had unlimited resources and no political or organizational limits, what innovative solutions or approaches would you recommend?

Purpose of PGME - Skills Required to Meet Population Needs

Shift to Generalism - in Education

- Promote family medicine at the beginning of the curriculum with contacts in the field in general practitioners’ offices. We believe that students’ current exposure to hospital settings with a multitude of specialists or generalists, which limits their practice to the hospital world, gives a false view of reality.
- Delay specialization: all residents should first do two years of family medicine or general medicine and then practice in a rural area before choosing a specialty.
- Create a well defined generalist training experience that could increase the efficiency of generalist training with each specialty (using a competency-based approach over the first 3 years for example in psychiatry) and providing a senior residency stream with a menu of specialized streams that meet societal needs (e.g., Aboriginal Health, homelessness). Therefore, the generalist training experience would be streamlined to essential domains and greater time could be given to residents to develop skills in essential specialty areas.
- Embrace generalism in a more meaningful way.
- Consider shortening the training for general specialties to provide an incentive.
- Educate proportionally more family physicians.
- Reduce the number of specialists. Referrals are driven based on availability, so if there were no specialists, there family physicians’ role would be much different. In Sweden, the family physician is the “uber specialist”.
- Create more incentive to train and to practice as a generalist. Current perceptions of the generalist lead very few learners to pursue this path. This is largely due to the medical culture in hospitals as well as the unique patient profiles that these generalists treat.
- Review quotas for subspecialists vs. generalist practice (needs to be done by government).
- Promote initial training in primary or secondary centres with a greater proportion of preceptors who are family physicians to encourage general practice outside of tertiary centres; in general, maximize opportunities to participate in well-supported community-based medicine and distributed learning centres.
- Alter the recruitment criteria for medical school to encourage recruitment of students interested in family medicine and rural practice.
- Ensure we have the right mix of family physicians and specialists. And we cannot count family physicians with focused practices as part of the supply of family physicians.
- Focus on generalism and primary care (meaning that we need to train more generalists and primary care physicians and we need to focus on teaching generalism and on primary care).

Shift to Generalism - in Practice

- Make everyone practice as a generalist before being allowed to specialize.
- Adopt an approach similar to the South Central Foundation in Alaska, which has a strong primary care base, supported by inter-professional teams. Physicians are not paid based on credentials. Although this system spent 2.5 times as much on primary care as other jurisdictions, its total health
care costs are lower. Family physicians have a high satisfaction rate, as they are doing good work and have good working relationships with other health care providers.

- Follow the Swedish model where primary care is provided mostly by nurse practitioners, and family physicians are consultants.
- Other jurisdictions (e.g., 1952 UK Health Act and South Africa’s Regional Medical Officer role), do have a system where each physician is required to practice as a family physician before entering specialist training.

Trends in Patient Care

Models of Care
- Develop a one-stop shopping process that is built on the harmonization of multiple post MD systems, creates efficiency in costs and routes to licensure and is respected between all specialties as well as other models of health service delivery that are also non MD based but equally valued and remunerated.
- Create a really strong primary care model, with at least 50% of physicians being family physicians. Develop a highly regarded program in health care management at all levels so physicians can have more say in how health care is delivered in our country.

Health Human Resource Planning

National HHR Plan
- Break down provincial barriers and provide a national health human resource strategy that feeds into the PGME system provincially and nationally.
- Begin with a clear idea of health human resource requirement for health care in Canada based on the health care needs of our population (to improve population health), not on the interests of universities, hospitals or physicians. Then define what foundational training should be and where the break off points should be.
- Conduct a national level assessment of IMG’s to feed into locally developed programs, tailoring local programs to local HHR and healthcare conditions. These programs may require additional resources to ensure adequate orientation to the Canadian healthcare system and to the range of CanMEDS competencies.
- Create a physician human resource plan, based on evidence and created through informed, meaningful and respectful dialogue between physicians, government and the public.
- Identify accurate and updated projections of health human resource need within each Specialty/Subspecialty, and liaison with funding agencies (staff positions and training positions) so that the number of training positions can be optimally linked with the number of funded positions. The Royal College must assist in the funding and liaison (e.g., Ministries of Health) for this important initiative.
- Encourage greater focus on physician resource planning and more effective career counselling that takes into account physician supply and demand.
- Contribute to and improve physician resource planning.

Planning Forum
- Have distinct residency tracks of variable duration, with guaranteed funding, for academic careers, hospitalists, community and remote regions based on population needs.
- Solicit input from stakeholders to assist in setting the direction of the health-care system.
- Establish a national table with physicians and other health professions to explore change (e.g., theory-based practice, common fields of knowledge)
• Establish a joint planning process for HHR, involving the Canadian Medical Forum (CMF) as the physician forum. The HHR forecasting model developed as part of joint project of the Ontario Medical Association (OMA) and Ontario’s Ministry of Health and Long-Term Care (MOHLTC) is a tool that could be built on to create a national model. No model will be perfect, but we need to start somewhere.

• Implement centralized and well coordinated strategic workforce planning amongst CFPC & Royal College so that the number of residency positions matches the demand for the type of physicians needed across Canada (fewer wasted resources training people in residencies for which minimal job opportunities).

**Implementation and Evaluation**

• Match the number of positions to the HHR needs.

• Change residency positions based on need. We would have enough positions for GPs who wish to return to a residency program as well as for Canadian medical grads at foreign medical schools.

• Align residency positions with HHR needs.

• Match outputs to national HHR plans. The provincial funding for health makes it difficult to adopt a national (not jurisdictional) physician human resource plan. Physicians and PGME needs to be part of the solution of the government may impose solutions, potentially compromising quality.

• Provide support for evaluation and feedback to improved programs and ensure they are meeting societal needs. This could be achieved through a survey of graduates with a mechanism for providing feedback to the programs.

• Rationalize training with manpower needs.

• Connect HHR needs to residency quotas in Canada.

• Pay PG residents more if they are enrolled in a specialty for which there is an identified need (e.g., pay family medicine residents more.)

• Increase enrollment to help alleviate the shortage of physicians.

• Create mandatory return of service programs for northern DME sites.

• Create programs to attract residents to high need specialties (e.g., mental health).

**Distributed Medical Education (to Support HHR Planning)**

• Push the training out to where the need is and provide adequate support for high quality education in these distributed sites (will need both $ and other resources).

• Include inner cities and other opportunities to work with underserved and vulnerable populations in distributed medical education (DME).

• Insist on remote or small community rotations.

• Increase decentralization.

• Increase opportunities for learners to spend more time at distributed sites with adequate accommodations and clinical preceptors to allow them to develop non-tertiary and rural skill sets.

• Encourage more DME training to help with health human resources (HHR issues) based on the expectation that more would be trained in rural areas and ultimately choose to practice there.

• Train all family physicians and the majority of specialists outside the big cities to encourage rural practice.

• Provide opportunities for family physicians to upgrade and enhance their skills to provide targeted skills at the rural and regional level.

• Further develop education in regional centres (between UHCs and local institutions).
**International Medical Graduates/ Canadian Students Abroad**

- Develop a system to recognize, assess and compare foreign qualifications on a Canada-wide basis. PGME needs to be part of the solution in providing gap training and bridging for IMGs.
- While it is important to provide an opportunity for IMG’s to integrate into the Canadian system, the ideal will be for Canada to become self-sufficient for health human resources.
- Give Canadians studying abroad the same access to postgraduate training as IMGs.
- Increase recruitment of CSAs.

**Governance and Processes**

**Licensing and Regulatory**

- Have the residents do their exam in 4th year, and they can practice in the 5th year as independent practitioner in a learning environment.
- Create a novel licensing system tied to a mastery-based lifelong curriculum.
- Implement cross-country licensure.
- Coordinate better between jurisdictions.
- Reduce the number of routes to licensure that have proliferated in last many years, as we are at risk of having too many doors open.
- Reduce from two certifying colleges to one. We have too much heavy governance in PGME – hospitals, universities, colleges, and it must be streamlined.
- Ensure that provincial authorities would only accept one standard for specialist/subspecialists. Ideally that standard should be established by the RPCSC but with recognition of physicians who had medical training outside of Canada.
- Align accreditation, licensing and practice standards. Increase training and evaluation in areas of safety and quality, inter-professional practice, leadership, and professionalism. Provide support and training in transitions in practice.

**Selection/Admissions**

- Develop a selection process that incorporates not only academic excellence but also skills in team-based care and interpersonal communication.
- Shift focus of admission for UG and PG from master-PhD research types, perhaps other CanMEDS like communication and teaching; to achieve well-rounded physicians.

**Educational Processes**

- Develop an integrated medical education program with complete decompartmentalization of undergraduate and postgraduate education and early exposure to patients in the acquisition of basic theoretical knowledge, simulation-based learning and clinical exposure. Each stage should include strong preparation for the next stage.
- Develop fellowship models across the continuum and IPE.
- Use distributed education.
- Use out-patient clinic learning
- Develop interdisciplinary resident-run clinics supervised by attending physicians
- Create more opportunities for direct teaching of junior and senior medical students - junior medical students through distinct resident-run workshops on clinically-oriented teaching on physiology and pathophysiology, and senior medical students through call-protected lecture time.
- Provide a mechanism to introduce innovation into medical education while maintaining well recognized standards.
• Implement program development that includes all healthcare workers with full scope of practice i.e., maternity with team based care using midwifery, family medicine obstetrics, FRCSC obstetrics, maternal-fetal –medicine (tertiary), fetal surgery (quaternary)
• Provide better teaching of professionalism
• Incorporate interdisciplinary learning
• Teach more efficiently: resident work hours, patient safety, life balance

**Non-medical Expert roles**
• Immerse medical students earlier into non-expert roles.
• Achieve full potential of CanMEDS, both in teaching and in assessment by valuing the non-medical expert roles and adopting teaching and assessment methods to support this, with the ability to fail residents who are found wanting.
• Provide residents with formal curriculum on CanMEDS roles of manager especially as they get ready to graduate.

**Service vs. Education**
• Organize the PGME system to focus on education, with front loading of knowledge and clinical exposure that is not service delivery oriented.
• Given the apparently endless debate about the balance of workload and learning, consider a training model in which “work” and “learning” are explicitly defined, paid for, and assessed in separate but complementary processes where the totality of clinical experience including professionalism is defined, documented and assessed by experts in that area and the totality of knowledge and skills is defined, assessed and documented by independent experts in that field such that necessary standards in both areas are aggregated for initial certification and ongoing maintenance of competence. This may become a necessity if occupational safety standards mandate in law the maximum “working” hours each week or month for a PG trainee/resident.
• Develop dedicated teaching units / with different funding formulas to support the educational goals / patient focused not fiscally focused
• Harmonize the role of the resident so that they are a student from beginning to end, and avoid the employee/employer relationship.
• Find the perfect service to education ratio; or no service in the ratio.
• Reduce the amount of ‘scut work’ and increase the amount of clinical learning/teaching.
• Reduce the workload so that residents can pursue individual cases of interest and maximize learning opportunities, without compromising their responsibilities to the hospital for service delivery.
• Provide physician assistants or nurse practitioners to help with discharge planning and logistics so residents can spend more time on education and direct patient care.

**Professional Educators**
• Hire professional educators (PhDs) to plan and help PDs implement teaching programs. Have paid educational experts teach and design cases.
• Incorporate teachers from other Faculties – for example business.
• Integrate more non-physician educators for non-clinical skills until we have enough clinical educators within the profession with expertise in teaching and evaluating these skills.
Resident Assessment: Frequency, Tools and Faculty Support

Frequency
- Provide a mechanism and resources for external assessment of residents during training, not just as part of a summative examination. A group of clinician educators with expertise in assessment could be identified nationally and/or within each university to assist individual programs.
- Develop a modular or graduated examination/assessment system to more easily identify and deal with poorly performing residents and to free residents from the ‘all or nothing’ final exam.
- Provide more and more useful feedback to residents (i.e. regular feedback, not just at the end of a rotation).
- Assess residents through multiple means beyond the high-stakes end-of-training examination.

Resident Assessment Tools
- Incorporate competency-based objectives.
- Develop/utilize assessment tools including continuous workplace assessment to accurately determine competence of those wishing to enter and/or continue practice.
- Improve the tools used to mark resident physician progress; tools could include examinations, and other assessment methods. Improve the definition of goals and objectives for residency skills and procedures; enhance the objectivity of assessments.
- Develop better assessment tools and processes, especially for skill-based and ‘essential’ competencies (e.g. communication, professionalism).
- Ensure that the in training assessment system has an element of “360 degree” involvement of other health professionals, with emphasis in the assessment of communication skills and professionalism.
- Consider recent work of the ACGME in the US, which is engaged in the “Milestones project”, a broad effort in all the specialties to define the specific competencies for different levels of residents and to improve the assessment of residents. Internal Medicine, Pediatrics and Surgery have already completed this work and the other specialties are working on it. (please see the ACGME website).
- Mandate collaboration in assessment of CanMEDS roles.
- Be open to other forms of assessment. Eliminate certification examinations, which would be replaced by a series of examinations as being done by those training to be actuaries.
- Review the relevance of a written examination to assess knowledge. Favour longitudinal assessment. (Example: series of examinations as done by actuaries).
- Ask the college to provide better assessment and examination tools, for medical expert and other roles (e.g., seminars, examination question banks, assessment tools).

Accreditation and Standards
- Establish a single college for the full continuum from admission into medical school all the way through to independent practice.
- Rationalize our accreditation standards and integrate CACMS/LCME.
- Within 3 years, establish a Canadian accreditor to accredit both UG and PG., while ensuring that graduates are still recognized to practice in the United States.
- Design a system that is flexible and responsive to population needs for health care delivery, informed by recent graduates and addresses gaps between what practice is really like out there, and what the specialty committee requirements are.
- Institute accreditation reform with auto-assessment and spot checks.
- Require the Royal College and specialty committees to budget the costs of proposed residency streams and assess the impact of their proposals prior to implementation.
• Off-load responsibilities for post-graduate training and examinations to the specialty societies. For example, CAP would be responsible for Anatomical Pathology and CANP would be responsible for Neuropathology.
• Set specific clinical experience standards, such as case numbers and diversity.
• Involve the medical regulatory community with setting the direction for the Royal College and College of Family Physicians in terms of learning objectives and assessment.

Streaming
• Look outside of the medical profession (e.g., engineering, business, legal) for examples of different models for educating professionals where there are distinct areas of specialization without the need for extensive common/core training.
• Start with the end in mind for an individual (i.e., train for the competency - not everyone needs all the training)
• Eliminate the 4th year of medical school because it is basically an audition year. Stop asking students to pick a specialty and subspecialty in the 3rd or 4th year of their undergraduate program. The CaRMS process is very disruptive.
• Bring back the rotating internship. This provides flexibility for residents to experience more clinical medicine before making a decision about career goals. It also provides residents with generalist skills and a foundation that can be used to change career focus or return to training to upgrade skills.
• Bring back the rotating internship and opportunity to get into the specialist training option within 2-3 years of internship completion...know what you really want to do when you grow up.
• Bring back the rotating internship year and general medical license
• Introduce an undifferentiated year after graduation from medical school before applying into CaRMS.
• Consider reinstating the common PGY1.
• Reinstate the undifferentiated 1st year of PG. All of the first and second year of PG training could be conducted outside of tertiary teaching hospitals and decanted to more regional, peripheral hospitals or even in the community. Medical graduates could get a restricted licence to practice after these two years, and practicing for a period of time with the restricted licence could be that requirement for any subsequent post-grad training.
• Identify 5 or 6 core specialties that take a learner to licensure. If a resident wants to specialize further (e.g., beyond internal medicine), that could be the fellowship process. In effect, every physician would become a generalist. If we still have too many wanting to do superspecialization, we can tell them they can practice part-time as a generalist (i.e., take turns for on-call) and part-time as a specialist.
• Integrate training from undergraduate through post graduate, with early streaming to shorten training. Increase flexibility in programs while balancing need for generalists and subspecialists; focus specialty training on professional requirements and eliminate non essential lengthy components of training. These measures will increase ability to align training with HHR.
• Re-introduce the rotating internship.
• Create an education model where physicians can be streamlined much earlier into areas of specialization (e.g., like engineering, where learners are stream in first year into chemical, mechanical or other area of specialization). Training should be tailored to what the physician will ultimately be doing (e.g., if you know that you will be a general surgeon in a small community, do you really need a two-month rotation in transplantation?
**Flexibility of Training**

**General**
- Provide more flexibility in training.
- Establish flexible training programs and a competency-based assessment approach against established objectives, with opportunities for extended training if needed by some residents.
- As most PGY1 years are one of general training, we should consider these credits or this entire year to be transferrable from one specialty to the next if a student wishes to transfer to a new specialty. Transfers at this time should be made much easier. This essentially completes the goal of the rotating internship without lengthening training.

**Tailored Learning Paths**
- Create individualized learning paths according to achievement of competencies based on defined performance indicators.
- Design programs to meet individual resident's needs identified through a comprehensive, ongoing, assessment of faculty supervisor.
- Allow residents to proceed through programs at their own “pace” based on ability but balanced with the need for prescribed time in “core” rotations.
- Take smartest 23-year olds applying to the program and accept them in whatever specialty they want. Then give them the first six months of career sampling/education of what their life would be like 10 years down the road. This would harmonize their training and create competence in that field.
- Create a flexible trajectory for residents with flexible duration of training and flexible remedial stations in the spirit of competency–based education.
- Make residency training more flexible both in terms of its length and its content. Competency training provides some opportunities but this needs to be supported through an increased emphasis on life-long learning and self reflection. Training could be set at a minimum number of years so that remediation would not be seen as so negative.
- At the beginning of and throughout the residency program, allow the resident to meet with the Program Director to design a tailor-made customized residency program for each resident in line with the goals of the resident for their future practice (i.e., residents are treated as partners/active participants in their own learning objectives).

**Transfer and Re-entry**
- Improve transfer opportunities while in residency; improve the opportunity for family physicians to pursue additional areas of interest or to retrain in a different specialty.
- Allow physicians to move seamlessly in and out of the academic environment as needed, for example to maintain competency or upgrade skills.
- Increase flexibility for re-entry and transfer between programs.
- Provide more flexibility in training programs, specifically more opportunity for re-entry training.
- Vary medical experiences throughout the physician’s career so that no one is tied to only one profession.
- Allow undecided medical students to do a PGY1 "undecided year", which would be like an augmented clinical clerkship. Or, change PGY1 into generalist training (e.g., Family Medicine, Paediatrics) only.

**Resident Support - Financial, Educational, Personal, Developmental**

**Financial**
- Stop paying residents for clinical placements.
• Create an equitable payment model between specialties to allow residents to follow their interests and aptitudes rather than being dictated by earning capacity, with financial incentives to practice in areas of need.
• Provide resources in distributed education to meet the needs of physician couples and residents with families.
• Address and improve financial burden on resident physicians (i.e., reduce tuition, increase bursaries, increase salary, increase call stipends).
• Increase funding for research and conferences.

Educational
• Move away from contractual arrangements regarding work hours that are uniform across all residents; protect junior residents, and let more senior residents perform more work.
• Reduce work hours.
• Improve housing/resources for residents in rural rotations
• Wipe out medical school debt. It stifles options for alternate career pathways.
• Enhance research support for residents during post-graduate medical education.

Personal
• With a more student-based outlook in mind, look into more centralized interviewing for CaRMS. It is deleterious to students’ learning and financial positions to spend a long period of time in 4th year crisscrossing the country for CaRMS interviews, and this time could be much better spent. Each program could have a central interview date and location that included all schools. The location could be made to rotate amongst Canadian schools.
• Provide career counseling to undergraduates – to help balance individual aptitude and interests with societal needs. Balanced remuneration is also important.
• Improve methods of addressing and managing harassment and intimidation; develop methods to challenge the hidden curriculum.
• Have enough service providers to relieve residents of their service requirements

Developmental
• Empower and support resident physician organizations to participate in non-clinical education; for example, resident physician conferences hosted by residency associations – topics could include leadership and advocacy.
• Provide more resources for resident enrichment.
• Provide more residency spots that are well supported (i.e. have good resident-faculty ratios, high volume of hands-on experience, sufficient equipment and physical space). This could increase the number of IMG and non-IMG spots, helping to address the issue of doctor shortage.
• Allow residents to have a sabbatical (beyond global health rotations) within medicine to learn the context of their work.
• Ensure that there is funding in place for residents to attend at least one major meeting per year in addition to the Royal College. This would free departmental budgets for other needed expenses.
• Newly graduated physicians who enter a high stress situation (e.g., practising in a rural or remote community, far from tertiary support, with excessively long hours or work and more frequent on-call than they are accustomed to), may handle the stress of these situations if they are "stress inoculated" prior to the change. Without a "stress inoculation, they are at high risk of burn out or mental health issues.
• Return to mentorship and to building genuine role models (the very essence of medical education).
• Create mentorship programs in UG and PG, particularly to help with career decisions.
Pedagogy

Inter- and Intra-professional Learning

- Require that residents spend 20% of training time in other specialty or profession.
- Develop true inter-professional curricula.
- Bring back a common first clinical year.
- Provide contact and collaboration with other health professionals (inter-disciplinary work).
- Integrate inter-professional learning and teaching seamlessly into PG teaching (e.g., medicine, nursing, physiotherapy, RT)

Teaching IPE

- Incorporate an inter-professional shadowing experiences for residents
- Develop a common first year of training (intra- and inter-professional).
- Collaborate across disciplines to meet the needs of vulnerable populations.
- Create collaborative learning modules that are inclusive of all clinical disciplines and that have significant clinical components.
- Develop inter-professional teams of educators – led by physicians but supported by professional educators through medical education research and faculty development.
- Create inter-professional educational opportunities with allied health professionals using simulation.
- Enable inter-disciplinary learning and assessment around case based scenarios (paper and real) and both learning and assessment in team based simulation case models.
- Significantly increase commitment and support for the development of new inter-professional / inter-disciplinary education models associated with undergraduate and post graduate medical education. Research has illustrated that significant benefits can be obtained from inter-professional collaboration in primary care (see for example - http://www.chsrf.ca/reports/interprofessional_Collaboration_e.pdf). There are numerous examples where physician and pharmacist collaborations in all health care settings produce significant benefits (for example a Pub Med literature search using the terms “physician pharmacist collaboration” identified 225 publications on the subject). Inter-professional education is complex to plan and implement. In order to expand, enable and reinforce inter-professional collaboration, there is a need to refine existing models and develop innovative new approaches to inter-professional educational. There is a need for a greater focus on post graduate inter-professional / inter-disciplinary processes and models.

- Have more health partnerships across provinces to meeting training and patient needs.
- Increase training in inter-disciplinary team work. Few settings currently offer real inter-disciplinary practice, and when physicians begin practising medicine, they are poorly equipped when called upon to share patient care with other health professionals without knowing each one’s potential contributions and limitations and without knowing the role of conductor that they must often assume.
- Look at the mentor system in Nova Scotia, where a resident or intern is paired with someone with a chronic disease (including mental health). In a new inter-professional training program in Dalhousie, the resident must stay with the patient (e.g., follow them around, go home with them, hear and see what it is like to live with chronic pain).
- Investigate the website: www.ccmhi.ca, which provides evidence of the benefits of collaborative initiatives (e.g., brainstorming around patient care can be conducive to work satisfaction and reduce burn out).
• Provide a multidisciplinary forum on the role of the physician in patient access to non-physician health care services.
• Residents and new docs have talked about burden of responsibility they feel. Put a greater emphasis on collaboration and training to work with other disciplines (to understand roles and skills of other professionals) to help alleviate this burden. Train physicians with respect and as a whole person, not just a mind and skilled hands to do technical things.
• Include short-term placements with healthcare professionals other than physicians and nurses.
• During medical education/training, provide exposure to other professionals involved in patient care for specific disease entities.
• Facilitate a true collaborative care, team-based learning model. Interprofessional care can be particularly effective in addressing some problems with no home in current practice.
• Develop PGME that is truly patient centered and delivered by teams.

Intra-professional Education
• Have more cross-program teaching e.g., CM/public health + 1st case curriculum overlap
• Starting at the training level, develop more collaboration between disciplines (e.g., Mental Health, Medicine) to tear down the silos and reduce competition (e.g., for resources, training sites).
• Help specialties develop a culture of understanding, where all specialties understand the role, capabilities and challenges of other specialties, which will contribute to the development of interdisciplinary practice.
• Use a program development model that includes all healthcare workers with full scope of practice, i.e., maternity with team based care using midwifery, family medicine obstetrics, FRCSC obstetrics, maternal-fetal—medicine (tertiary), fetal surgery (quaternary).
• Require all residents in RCPSC specialty programs to have a meaningful longitudinal community placement, with a family physician or with a generalist specialist in their field.
• Encourage inter-specialty, inter-collegial opportunities like inter-disciplinary rounds.
• Make specialty residents do more generalist rotations so that they understand general practice and transitions of care from primary to specialty care, with a view to breaking down barriers and smoothing the transitions. This may also help to build trust and respect between generalists and specialists (and non-physician providers), with an ultimate goal of better patient care.

Scope of Practice
• Abolish reserved medical acts. Train so anyone can perform certain procedures (e.g., ultrasound scan).
• There is room to delegate some acts. There is much room for inter-professional education and cross training.
• Change how risk is shared. Physiotherapists are willing to be fully accountable for their practice. Are MDs willing to share responsibility and risk? Is society primed to be able to accept non MD prescriptions?

Curriculum Improvements

Educational Content
• Ensure that all senior residents/PG trainees participate in formal educational processes that assure an adequate knowledge of health care systems and structures as well as the roles and responsibilities of other healthcare professionals.
• Provide all trainees with some understanding of how the healthcare system works and how to effect positive change within it. There should also be opportunities for some trainees to undertake
additional management training (e.g., MD/MBA or MBA/management fellowship) to ensure physicians have a strong and equal voice in healthcare decision making.

- Ensure that senior residents/PG trainees undergo a formal educational process on education and assessment and participate in a mandatory training/mentoring process with at least one more junior trainee.
- Ensure that senior residents/PG trainees undergo a formal educational process on assessment and are involved formally in the assessment of other trainees.
- Provide a better understanding of public health and emergency preparedness and response.
- Increase emphasis on public health and preventive medicine. While this is being taught at the undergraduate level, it needs to be re-emphasized throughout postgraduate training.
- Provide all PG trainees in all programs with additional training in social determinants of health. Physicians of the future (family physicians and specialists) not only need to be able to recognize when social factors are playing a role in the health of their individual patients (and make appropriate interventions and / or referrals) but also to use their leadership roles advocate for change that will improve overall health of vulnerable populations, for example the Aboriginal population.
- Recognize the importance of mental health issues in overall health and ensure that all residents are equipped with the skills to address these in their practices. Mental health is not just the purview of psychiatrists and family physicians. Mental health issues are increasing and have an impact on all specialties.
- Include organizational / system-change management as a core competency in every residency program.
- Include the concept of population health issues.
- Develop and apply principles of practice management.
- Include mandatory leadership and systems training
- Work to develop graduates who have clinical and non-clinical skills, and are well prepared through formal training to function in a system and to take on leadership roles in that system, recognizing that we need more leadership and less management.
- Include comprehensive quality training
- Integrate primary palliative care competencies into each postgraduate residency program
- Tie into health care costs.
- Make international health mandatory as a rotation in residency.
- Incorporate an international health elective into PGME training.
- Consider advancing the role of systems advocate: training in best-practice resource usage (i.e., medical testing, etc) and health economics to encourage responsible decision-making outcomes in a resource-limited system.
- Provide cultural training to allow colleagues to better communicate, cooperate, and work together as well as facilitate improved care for individuals from different backgrounds.
- Enhance exposure to community medicine and public health initiatives across all residencies.
- Make the book "Planet Medicine" required reading for all residents. This book reviews all different types of healing modalities, North American healing, energy medicine, shamanism medicine, and all forms of alternative medicine.
- Teach more than the business end of medicine, where physicians will not make a patient booked a separate visit for a pap smear, another for a breast scan, and another for any other ailment or to ask questions about any condition or treatment.
- Provide education in the emotional aspects of illness, mental health, alternative health strategies, patient counseling and motivation and inter-personal communication.
Faculty Development and Support, Appreciation, and Remuneration

Faculty Development and Support

- Provide more opportunities for faculty development, and allow faculty time for these activities.
- Improve training and support for medical educators.
- Support program directors and other educators. Clinicians who do wish to teach need dedicated time and appropriate remuneration. And while not everyone needs to teach, everyone should be a role model for professionalism.
- Invest in “train the trainer” programs that include adequate prior and ongoing assessment of suitability of trainers as role models and mentors.
- Triple the budget for PGME to allow for the development and implementation of major innovations to engage teachers and encourage them to become educational leaders.
- Invest in ongoing faculty development for teaching in PG education. Make sure we have enough PG teachers, but if we are looking for teachers in the community, we need to provide sufficient training, remunerate them appropriately, and have the residents provide a service component to offset the additional teaching workload for the community physician. Ask these new teachers for a long-term commitment.
- Ensure that each trainer/mentor and assessor is provided with useful feedback on strengths and weaknesses of their contributions to residents and are offered meaningful opportunities for continuing improvement.
- Increase academic staff trained to teach health sciences.
- Reward clinical educators in smaller centres who are not hospital based.
- Provide more faculty development for teachers and program directors.
- Provide education support for more educators.
- Invest in faculty development.

Faculty Support

- Provide faculty development to help clinical teachers describe, characterize and document unprofessional behaviours more effectively.
- Support and ensure faculty teach and model the behaviors we want to see (perhaps by using a common assessment process for preceptors as well as residents).
- The financial and non-financial incentives to being a trainer/mentor and assessor should be such that trainers/mentors and assessors will be motivated to respond positively to apparent criticisms of weaknesses rather than cease involvement.

Faculty Appreciation and Reward

- Reward scholarship for all, but particularly for community based teachers.
- Make the role of program directors and members of the residency program committee coveted positions with appropriate remuneration and academic status. The better the RPC and PDs are, the better the quality of the program for training of residents.
- Value the role of teacher (relative to the roles of clinician and researcher) more explicitly in PGME. Promotion and prestige of clinical staff who have an academic focus teaching medical residents will be valued and recognized through promotion.
- Value our clinical educators and provide them with adequate remuneration and a program of recognition within the academic community. Altruism will only extend so far.
- Recognize and reward trainers/mentors and assessors, celebrate outstanding trainers/mentors and assessors.
- Recognize educational scholarship as well as basic science and clinical research.
• Value clinical teaching.

**Faculty Remuneration**
• Increase reimbursement for clinical teachers.
• Provide appropriate resources available for both research and teaching. This includes appropriate healthcare resources to support clinical teaching.

**Simulation and Other Technology**

**Use of Simulation**
• Establish simulation centres with full time educators in all hospitals.
• Increase and integrate the use of simulation for training and recertification.
• Increased use of simulation both in education and assessment.
• Find a method to accommodate increasing cohorts of students into clinical practice settings. For example Increase funding for simulation stations.
• Increase simulation and off-line training.
• Enable inter-disciplinary learning and assessment around case based scenarios (paper and real) and both learning and assessment in team based simulation case models.
• Embrace simulation for both core training and as an adjunct (e.g., simulated patient care experience).
• Create real and simulated learning and assessment opportunities for residents to assess and manage populations of patients and people. As a component of this concept, develop opportunities for residents to learn excellence in “indirect” care i.e., providing shared care, consulting to other health professionals and providing care to groups and organizations through development of policy and advocacy. (for example immunizations, infection control, child health)
• Establish skills and simulation labs outside academic centers
• Embrace technology to reduce the labour intensity (and costs) of health care education. Maximize the use of technology in teaching.
  • Remember that Athabasca has become a well-known university to do your MBA, and it does not even have a campus.
  • Engage in distance education, using on-line modules and telecommunications technologies, give all residents a smart phone, introduce clinical decision support systems and use videoconferencing, webinars and telemedicine to their full potential, share email addresses with patients.
  • Use simulation more, particularly for surgical training. It is safer from a patient perspective.
  • Our residents are ready for more technology (e.g., residents are reluctant to do rotations in hospitals that do not have electronic patient records. Technology has changed our lives so much in the last 10 years, and will change them again in the next 10. We need to take advantage of these advances.

**Electronic Medical Records**
• Maximize access to leading-edge technology and technology-facilitated opportunities including telemedicine, electronic medical records (EMRs), and high quality simulation-based teaching. Start by using technology to address easy-fix errors such as inappropriate prescribing due to indecipherable handwriting.
• Use electronic medical records comprehensively and consistently throughout hospitals and clinics, with ongoing and effective training rolled out over time on how best to use this resource to improve efficiency & communication.
- Promote and enable application of state of the art electronic health records and IT systems to be used to facilitate learning and the application of knowledge, skills and attitudes in a timely and effective manner in patient care.
- Support a sustainable clinical faculty. Electronic teaching resources should be investigated and implemented appropriately to expand the capacity of the current clinical teachers.

**Telecommunications**
- Enhance electronic connectivity for healthcare delivery, teaching and research. This could include ITS support to link and manage large data sets, increased and improved tele-health to support rural and remote health services. The training centres can continue to be a provincial resource and a hub of expertise.
- Expand PG training to meet the needs of the future for example remote tele-health.

**Other Technology**
- Integrate technology into PGME and provide support for this in central and distributed sites.
- Enhance the use of technology.
- Provide access to computers and Netcare from call rooms.
- Improve the scope and opportunities within teaching and training. Residents wish to see more technology-based training, such as funded courses in ultrasound/FAST/ATLS/AIM/PALS for all interested residents.
- Increase exposure to surgical and medical procedures while in training and more tele-education at distributed education sites would work to diversify exposure and opportunities.
- Improve use of technology for teaching and assessment of all other CanMEDS roles (e.g., simulation, videotaping of consults, delivering bad news).
- Give every learner a national training card that has a barcode to record their presence at each location for all learning activities.

**Competency-based Education**
- Develop a national competency based medical education (CMBE) curriculum that aligns with Royal College certification. Consider changes to the Royal College exam structure as has already changed in some American programs (i.e., delay exams to at least a year after training so the already limited training program is not affected by residents only concerned about passing exams).
- Use competency based learning.
- Assess competencies objectively with a toolbox of validated assessment devices so that a resident has objective measures of competence for all important aspects of that specialty before they commence independent practice.
- Move towards a more outcome-based medical education system (along continuum from purely time-based towards more CBME) for all residents (with use of appropriate assessment tools based on competence).
- Incorporate competency-based objectives.
- Develop competency-based training: variable length training depending on trainee ability to achieve competency in different knowledge, skills, and attitudes (impossible to achieve in today’s structure).
- Include a broad trial of competency-based residency programs. A large cohort of residents including representation from all programs and regions would be needed. If there was demonstrated to be no change in the quality of care delivered from these graduates (or an increase in the quality of care), phase competency-based residencies to all programs across Canada.
• Exploit the tremendous opportunity to explore competency-based education, although it may take some time to implement fully.
• Explore competency-based education.
• Reduce the duration and increase the concentration of training, through more learner-centered, competency-based training. This will require a new human resources plan for large academic institutions to meet service delivery obligations.
• Pursue a competency-based model of training and evaluation, much like the Montessori model, where you have flexibility in what you do and how long you do it, as long as you are competent at the end of the training. Length of training could be variable.

Cross-Canada Collaboration/ Sharing of Best Practices in Delivery of PGME
• Adopt a collaborative approach between universities for residency programs to allow access across the country for components of training where they are easily available.
• Develop national curricula, with common assessments and based on best practice.
• Create cross-country chat rooms to discuss cases.
• Improve the use of information technology with model units to pilot new methods of information transfer, quicker translation of research findings and virtual library of presentations or self-learning modules for the entire country.
• Do more globally to address capacity building and share educational resources.
• Create/maintain national networks for residents in the same discipline to share resources.
• The didactic teaching for each specialty could be standardized nationally, reducing duplication of work for program directors and ensuring consistency across the country.
• Allow opportunities for cross fertilization of ideas, for example allowing both residents and educators to move between specialty specific programs nationally.
• Create standardized training standards/guidelines across North America that takes the best of what each country has to offer.
• As not all provinces have the population base to support training in certain specialties, explore intra-provincial collaboratives at the PGME level to ensure that residents from all jurisdictions can access the range of skills necessary for their home province.
• Establish more national and international joint programs such as MD/PhD, MD/MBA, etc. across nations and jurisdictions. Create international residents’ fellowship exchange programs with uniform requirements and standards.
• Allow for inter-university training, not limited to electives. Residents should be able to access excellent training resources from across the country. Residents could be funded to go to other universities for some training and/or leaders could be funded to take clinical sabbaticals in other universities to enhance and improve local programs.

Educational Experience

General
• Look at a “co-op” model of training in which periods of work in a variety of settings are interspersed with intensive periods of education ensuring exposure to settings more representative of Canada’s needs.
• Provide all residents, regardless of program, city or university, access to the same opportunities and resources.
• Expand family residency programs to allow for further training opportunities.
• Incorporate more community based electives into PGME training.
• Provide opportunities to have final-year rotations to be credited toward fellowships.
• Extend the residency training a little to make it more pleasant for the residents and to provide ample opportunity for inter-professional, collaborative experiences. Physicians need to understand rehabilitation from the patient’s perspective - what the patient goes through post surgery. The surgeon should not be so isolated from the consequences of his/her treatment decisions. The residency requirements could include shadowing other health care professionals for a period of time.

• Bright, passionate people become cynical and lose their compassion during their medical training. Reduce the strain on these physicians of a health care system that is driven by fee-for-service.

• Provide contact with patients as early as possible

• Provide early involvement of a mentor with each student

• Increased clinical time spent with senior staff clinicians.

International Experience

• Introduce rotating internships (e.g., allow residents to complete a rotation outside of their home medical school and/or outside of the country).

• Institute additional requirements for health training or volunteering abroad to encourage the following outcomes: enhancement of the reputation of Canadian health professionals abroad; emphasis on need for and opportunities associated with general practice; placement of our health system in an international (including developing world) context for residents; broadening of medical perspectives.

• Create better opportunities for exchanges between countries in order to improve residents’ experience.

• Include international medicine opportunities in the curriculum of all residency programs (ex with organized faculty/resident clinical trips abroad), promoting awareness of the positives/negatives of our current medical system and challenging residents to learn to be resourceful.

Encouragement for Research

• Encourage residents to at least look at a research career. In practice, the ‘scholar’ role is not working to increase understanding of research by the majority of residents.

• Enhance research opportunities (i.e. Clinician Investigator Programs).

• Ensure opportunities to undertake research training, for example dedicated blocks of training.

• Support resident research

• Leverage research institutions to create a scholarly program in postgraduate medical education.

Transitions

UG to PG

• Create a stronger link between UG and PG education.

• Redesign clinical education to a 4 year clinical curriculum after 2 years of pre-clinical medical school. This curriculum could include continuity rotations and experience in different specialties and contexts. After the 6 years (2 + 4) graduates would be eligible to enter family practice. Some (arguably fewer) residents could go on to specialist training for an additional 3 – 4 years.

• Connect PGME and UME in a way that would permit better collaboration between the two levels of training. One thought would be to ensure there is a Associate Dean that is involved in the transition between UME to PGME that could liaise with these groups on shared concerns (e.g. CaRMS)

• Consider the development of ‘final year clinics’ where a clinical teacher supervises a group of final year residents, who ‘work’.

• Reintroduce an apprenticeship model.
Entry to Practice

- Establish a system whereby residents transition through a stage of ‘junior colleague’ before they become full staff to smooth the transition from learner to practitioner.
- Consider a system where entry to practice is more graduated.
- Make the training 6 years (instead of 5) and make the 6th year elective and funded.
- Improve the transition into a Canadian practice to ensure job opportunities for Canadian trained physicians (i.e. hire more Canadian educated doctors).

Re-entry

- Build flexibility within the system to allow physicians to move in and out of formal training as desired for specific upgrading, remediation, career change and/or enhanced professional satisfaction.
- Provide more career development and opportunities for flexibility and retraining.
- Provide more retraining opportunities for specialists (to facilitate switching careers).
- Allow for a greater number of re-entry residency position.
- Create both re-entry opportunities and short term “mini-sabbaticals” for physicians in practice (this would include the establishment of a locum pool to allow these physicians to comfortably leave their practices).

Life-long Learning

- Teach residents to take charge of their own learning through a critical reflection process: making residents responsible for their learning continuum for the remainder of their careers.
- Make education a continual process, not only during medical education but also after individuals have finished their degrees; clinical and inter-personal skills should be assessed regularly and upgrading be provided when necessary.
- Develop a Canadian Institute of Medical Professional Development – to develop programs for physicians in practice. Also allow all physicians 1 year sabbatical after every 10 years of practice.
- Once physicians are practicing, make it mandatory to take a sabbatical with full pay during which they can retrain and improve whatever skills they want. These sabbaticals should occur throughout the physician’s career, so that learning and change become a life-long continuum.
- Make medical education programs take responsibility for learners after they graduate. For example, if you graduated from the University of Toronto in anaesthesia, you would also go back to the U of T for your continuing medical education specific to anaesthesia. Alternatively, a more rigorous CPD framework would not necessarily need to be based at individual school and could be a collective responsibility.
- Deliver postdoctoral education based in the community not solely at the university. Obviously, that presupposes providing both financial and educational support to community-based practices and integrating community-based medical offices into the delivery of the medical curriculum.
- Consider shortening training time (competency may do this?) and linking further skills to CPD/life-long-learning.
- Build additional training and academic supports for new grads in Family Medicine. There needs to be a structure that supports lifelong learning, including CQI and knowledge translation.
- Create surgical continuing education following residency training with 3-5 year options for 2-3 month updates for technique or technology with subspecialty educators but having enough redundancy that service coverage is available as backfill for those being updated.
Consider the PG phase of this project as part of the full continuum of education, including continuing education and professional development (CEPD). Competencies are important. At graduation, you have the basic competencies, but expecting everyone to have all competencies at graduation is not realistic. Physicians need to learn how to learn, and how to identify what they do not know and need to learn.

Change the model of education to bring more of a focus to post-licensure learning.

**Human and Financial Resources**

**Teaching Infrastructure**
- Properly resource faculties of medicine to maintain and support the infrastructure needed for distributed education (i.e., bricks and mortar” as well as academic support for clinical teachers).
- Provide adequate resources to community preceptors, including space, other infrastructure and financial incentives.
- Develop a governance model for the clinical academic community that integrates medical education, clinical service and research and provides adequate resources for clinical teachers, to support best practice (e.g., patient-centered team care).
- Provide more resources to support the enhanced expectations of accreditation. Dedicated time and money to support faculty development and support for CanMEDS for program leadership within (for example to support a masters degree in education for a faculty member) and for clinical faculty to upgrade assessment skills (protected time for clinical fee-for-service faculty members)
- Provide additional funding for faculty engaged in remedial education for struggling residents, allowing more personal contact.
- Provide resource support for the implementation of CanMEDS.
- Allow programs to use training dollars as best needed locally.
- Make the programs self sustaining without need for university budget
- Improve funding for programs (such as the clinical investigator programs).
- Establish financial programs for academic training that provide long-term support for specialized clinical and research fellowship training. Reduce the reliance on residents as service providers.
- Provide more teachers: high quality and improved infra-structure.
- Provide sufficient faculty to meet the educational and research mandates through development of alternative funding plans.
- Ensure consistency amongst programs for funding of ancillary programs ATLS, ACLS and or research/advocacy project allowing for opportunities to be accessed by all residents.
- Provide more educational research support along with clinical /translational research support.
- Provide more capacity (e.g., ORs) and more redundancy (e.g., HR) in the system.
- Train and fund to competency regardless of duration
- Consider establishing centres of excellence so that we do not necessarily have all specialty programs in all universities.

**Remuneration**
- Increase teaching capacity by providing incentives that encourage fee for service physicians to teach. This may mean direct payment, deferred payment (participation in a pension scheme), and/or increased, improved or subsidized access to clinical teaching facilities.
- Provide incentives and opportunities for community physicians to become more involved in teaching and translational research, for example a shared locum pool to provide release from service duties.
- Pay doctors to be teachers and limit their other work-related activities
• Provide funding for more clinicians for teaching and research.
• Provide funding to allow for more teaching by clinicians
• Eliminate fee-for-service and institute a salary for everyone in a teaching setting
• Fund preceptors at University teaching hospitals for remediation (not only IMGs) and fund community preceptors.
• Remunerate Program Directors.
• Create the opportunity for physicians to take more time for clinical teaching and still be able to treat more patients because of the increasing demand. To do that, we would need the government to increase the number of specialists in university programs without having money issues.
• Get rid of the fee for service model. MDs cannot think altruistically at the same time as they are thinking monetarily.
• Examine the remuneration of physician services with a focus on reducing the pay discrepancy between family physicians and specialists through advocacy.
• Improve compensation for rural teachers.
• Reform the fee guide to reward specialty care that reflects specialties of need (e.g., internal medicine, general pediatrics, psychiatry)
• Create new funding models such as alternate relationship plan, salary based for clinical and educator / teaching faculty possibly researchers as well.
• Withdraw medical staffing plans.
• Figure out how to pay clinicians for non-clinical work.

Other Ideas

Specialty-specific Recommendations
• Create hybrid positions to pilot a decentralized PG path for medical imaging with more clinical, surgical, imaging as a group. Make the program more clinically oriented and relevant and educate clinicians about imaging.
• Develop a genuine commitment to self-analysis in Family Medicine education, so that we routinely assess what we do and how we do it.
• Examine surgical residents actually doing surgery.

Health Care Delivery System
• Make the hospitals about 20% of their current size and push health care delivery out to the community. Hospitals should be for those who need machines.
• Eliminate non-MD administrators and ensure that MDs are running our hospitals
• Hospitals should strive to be resident-independent for delivery of healthcare thus allowing residents to concentrate on their education without the pull of service.
• Improve the healthiness and quality of hospital cafeteria food.
• Share the on-call workload with other professions.
• Improve patient flow through the system; increase patient access to long-term care beds.
• Increase the speed of knowledge transfer to improve network efficiency.
• Introduce electronic medical records to create efficiencies that will leave more time for education and direct patient care and less for paperwork and logistics.
• Create a system that rewards collaboration and willingness to consult with other disciplines.
• Find a way to encourage physicians to be more concerned with patient care than with a hospital bed report card or shortening the length of stay.
• Create standalone facilities for provision of outpatient surgical care for common surgical problems.
• Increase the level of health literacy; making information more accessible to the average patient.
• Prepare patients to be empowered about their health and disease.

Other
• Recognize that in order to meet the needs of society we must free up resources and not continue to pump money into the curative system.
• Link all or a large proportion of overall medical and health care education responsibilities, including budgets, to Health Ministries with dedicated Associate and Assistant Deputy Ministers responsible for physician, nursing and other health professional career-long education processes. Ensure effective liaison in the field of assessment with CCFP, RCPSC and Quebec bodies. Residents/PG trainees play an important part as both teachers and role models in undergraduate clinical education.
• Lobby provincial governments to attend to the advancement of medical education. This may include the ability to fund additional training positions or research initiatives.
• Ask the federal government to give the College of Family Physicians of Canada (CFPC) $1 million to hire researchers to study the educational system of training family physicians in Canada.
• Improve communication between PGME and government.
• Remove health care planning and delivery from the political and move it to a corporate structure where innovation and improvements in service delivery would be important. This would allow rapid standardization of EMR and other standards that would facilitate communication and improve care.
• Build public trust in the profession.
• Shape what a medical practitioner is using CANMEDs roles
• Create more public exposure about what postgraduate education is, highlighting successful careers in academic and clinical medicine through good media coverage, mini med schools, etc.
• Without a longer and more thoughtful process, the best we can do is merely identify blockages and means to remove them, rather than building something better from the ground up.
• Improve evidence-based treatment and testing models and make best-practices information readily available.
• Place greater emphasis on and ensure additional funding for public health, community medicine, and preventive care initiatives.
• Encourage transparency among health-care professionals and patients to improve understanding of the real costs of tests and procedures.
• Identify trainees early who have demonstrated abilities in research and offer them something earlier in their training to nurture these abilities. Brenda Zimmerman at Schulich (York University) could help us understand complexity theory as it applies to PGME.
• Achieve interjurisdictional harmonization to allow movement across the country, and also interjurisdictional to allow a less restricted flow of physicians across international borders. This may require the regulatory colleges to accredit those foreign institutions where both UG and PG training can be considered equivalent to Canadian training. It was noted that in Europe, despite the varied programs and standards, physicians face few restrictions in practising in jurisdictions other than where they were trained.
Appendix E: Summary of Themes, November 15, 2010
Liaison and Engagement
Consultant Progress Report

Dr. Sarita Verma
November 16, 2010
Presentation to the
FMEC PG Steering Committee

Status of Consultations (Nov 12/2010)

<table>
<thead>
<tr>
<th>Stakeholders</th>
<th>Completed</th>
<th>Confirmed</th>
<th>Tentative</th>
<th>To be scheduled</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educators *</td>
<td>23</td>
<td>9</td>
<td>1</td>
<td>0</td>
<td>33</td>
</tr>
<tr>
<td>Academic Chairs</td>
<td>11</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>15</td>
</tr>
<tr>
<td>Students/Residents</td>
<td>5</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>Government</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Allied Health</td>
<td>5</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Hospital Authorities</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td>Medical Associations</td>
<td>5</td>
<td>4</td>
<td>0</td>
<td>4</td>
<td>13</td>
</tr>
<tr>
<td>Colleges</td>
<td>7</td>
<td>6</td>
<td>0</td>
<td>5</td>
<td>18</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>62</strong></td>
<td><strong>33</strong></td>
<td><strong>5</strong></td>
<td><strong>21</strong></td>
<td><strong>121</strong></td>
</tr>
</tbody>
</table>

* Deans, PG Deans, UG Deans, Program Directors, Education Councils, etc.
Status of Consultations (cont’d)

<table>
<thead>
<tr>
<th>Stakeholders</th>
<th>National</th>
<th>West</th>
<th>ON/MN</th>
<th>PQ/Atlantic</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educators</td>
<td>9/4</td>
<td>6/3</td>
<td>4/1</td>
<td>4/2</td>
<td>23/10</td>
</tr>
<tr>
<td>Academic Chairs</td>
<td>10/2</td>
<td>1/0</td>
<td>0/2</td>
<td>-/-</td>
<td>11/4</td>
</tr>
<tr>
<td>Students/Residents</td>
<td>2/0</td>
<td>3/1</td>
<td>0/2</td>
<td>0/4</td>
<td>5/7</td>
</tr>
<tr>
<td>Government</td>
<td>1/0</td>
<td>0/2</td>
<td>-/-</td>
<td>1/0</td>
<td>2/2</td>
</tr>
<tr>
<td>Allied Health</td>
<td>5/3</td>
<td>-/-</td>
<td>-/-</td>
<td>-/-</td>
<td>5/3</td>
</tr>
<tr>
<td>Hospital Authorities</td>
<td>1/1</td>
<td>0/3</td>
<td>0/2</td>
<td>0/5</td>
<td>1/11</td>
</tr>
<tr>
<td>Medical Associations</td>
<td>2/0</td>
<td>1/1</td>
<td>0/2</td>
<td>2/5</td>
<td>5/8</td>
</tr>
<tr>
<td>Colleges</td>
<td>4/5</td>
<td>2/1</td>
<td>0/2</td>
<td>1/3</td>
<td>7/11</td>
</tr>
<tr>
<td>Other</td>
<td>1/1</td>
<td>2/2</td>
<td>-/-</td>
<td>-/-</td>
<td>3/3</td>
</tr>
<tr>
<td>Total</td>
<td>35/16</td>
<td>15/13</td>
<td>4/11</td>
<td>8/19</td>
<td>62/59</td>
</tr>
</tbody>
</table>

Completed/Pending

FMEC Postgraduate Project 3 Liaison and Engagement

1. Strengths

- University based
- National accreditation standards and peer review process
- Common standards for certification exams
- Clinical exposure (quantity and variety)
- CanMEDS framework
- Canadian brand and quality of product
- CaRMS
- Well prepared Canadian MDs coming into PG system
2. Weaknesses/Vulnerabilities

- Early streaming into a specialty and lack of flexibility to change course
- Major disconnect between who we ‘admit’, what they choose to specialize in, the availability of jobs and societal needs
- Too much focus on input and none on output
- Accreditation standards become redundant and long time between site surveys
- Challenged to effectively teach and evaluate the non medical expert CanMEDS roles e.g., lack of training in inter-professional care

2. Weaknesses/Vulnerabilities (cont’d)

- Residents not prepared/ comfortable/ willing to leave training/ tertiary centre
- Inadequate and inconsistent funding for University PGME, hospitals and clinical teachers
- Shortage of clinical faculty and supervisors
- Challenged to dismiss students/ residents once they get in
- Inadequate faculty development
3. Risks

• Reduced work week (e.g., from 70 to 40-50 hours) will require fundamental change in structure of residency - Perception that sometimes “union mentality” supersedes learning

• New technologies and emerging health care professions will take over MD market share (not enough integration of IPE and IPC)

• Disconnect between health human resource planning and capacity for PG specialties. No national “stock and flow” model

3. Risks (cont’d)

• If we cannot manage the HHR output, the control will be lost and we will be micromanaged

• Loss of the public’s trust in MDs

• Challenged to be nimble - update/innovate teaching methods (e.g., simulation, distance education, technology)
4. Opportunities

- Harmonize the role of resident as Employee, Regulated HCP and Student
- Reduce bureaucracy at the institutional levels - more self evaluation and professional accreditors
- Introduce new models of training that address the hidden curriculum, IPE and simulation and reinforce generalism
- Have evaluation throughout residency count rather than one high-stakes exam

4. Opportunities

- Conduct HHR planning at national level across all healthcare professionals for the right balance of generalists, specialists, sub specialists, fellows and research scientists
- Make better use of potential resources (e.g., IMGs, DME sites, IPE opportunities, programs for underserviced areas)
- Pan-Canadian sharing of training resources - reduce interprovincial barriers to practice and training.
5. “Blue Sky” Ideas

- Base PG as UG, entirely at universities with full funding
- Have a small number of key paths that complete UG and PG directly into practice without the ‘match’
- Issue restricted licence after 2 years and make practice a requirement for subsequent PG training
- Redesign system to introduce flexibility in training path and reduce the number of PGY 1 entry programs e.g., eliminate 4th year of UG and bring back the rotating internship
- Mandate community based practice and learning of social determinants of health in all residency programs
- Reduce the number of colleges to one with one integrated mandate to over see the universities’ programs
- Graduated entry to practice: Make practice “Education”

Round 2 Consultations

- **Purpose:**
  To discuss the FMEC PG Steering Committee’s draft recommendations as they emerge (Feb to July 2011)

- **Considerations for approach to Round 2:**
  Draft Recommendations
  Portal Feedback
  Townhalls (Feb- March 2011)
  CCME national forum (May 2011)
Appendix F: Standard Feedback Form for Round 2 Consultations

**Future of Medical Education In Canada - Postgraduate Project**

*Feedback on Recommendations*

Please complete in Microsoft Word and return to fmec.pg@utoronto.ca

<table>
<thead>
<tr>
<th>Stakeholder information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
</tr>
<tr>
<td>Title:</td>
</tr>
<tr>
<td>Organization:</td>
</tr>
<tr>
<td>Email:</td>
</tr>
<tr>
<td>Description of stakeholders represented:</td>
</tr>
</tbody>
</table>

1. What is your overall impression of the content and direction of the draft recommendations?

2. What barriers do you anticipate in the implementation of these recommendations?

3. What suggestions do you have for the FMEC PG Steering Committee to refine or improve the individual recommendations?

4. In your opinion, are there any significant omissions in the draft recommendations?

5. Other comments

Thank you for your contribution!

For further information, go to: http://www.afmc.ca/future-of-medical-education-in-canada/