

Results of A Survey of Distributed Medical Education Activities at Canadian Faculties of Medicine



The Association of Faculties
of Medicine of Canada

Survey conducted from February - June 2006

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Introduction

Faculties of medicine across Canada are engaged in distributed educational activities beyond the walls of their institutions. Distributed Medical Education (DME) encompasses a broad definition of activities. In undergraduate, postgraduate and continuing medical education, educational events and activities involve learners and teachers who are outside of the immediate classroom or clinical site. For example, medical students may be assigned to different hospitals for clinical experiences, and to family physicians' offices distant from the university site. They may complete their education at a satellite campus. Residents may undertake all or part of their specialty education at hospitals or in communities outside the university, and practising physicians may participate with their colleagues in their own and other communities in activities conducted by the university.

On May 3rd, 2006, at the request of the AFMC Council of Deans, the AFMC hosted a workshop on DME to provide an opportunity for those interested in and involved in DME to come together to share experiences and address common challenges in developing, implementing and evaluating DME.

In preparation for the workshop, the organizing committee conducted a survey to determine the range and extent of those activities. This information will enable us to learn as much as we can about the use of educational sites and provision of educational experiences outside the "home" Academic Health Sciences Centre.

Thank you again to everyone who took the time to complete this survey.

Method

The survey was designed by the Workshop Organizing Committee. Its purpose was to gather input from all schools regarding the nature and extent of their activities in Distributed Medical Education (DME) across undergraduate, postgraduate and continuing medical education.

We sought information regarding whether schools had distant or partner campuses, as well as the specific activities provided at those campuses at each level of education. Respondents were also asked to indicate whether learners could complete entire educational requirements at distant sites, the extent to which functions such as learner assessment could be conducted at distant sites, arrangements for learners and faculty, successes achieved and challenges encountered. A copy of the survey is found in Appendix 2.

The survey was sent by AFMC to the Dean of each school, to distribute to appropriate respondents for each level of education. The total response rate for all programs was 69%. The survey was distributed a second time to provide non-respondents with another opportunity to participate. This second round brought the response rate to 80%. Previous respondents were also sent a draft of this report for their comments and corrections. Representatives from six programs took the opportunity to provide feedback.

Results

The response rate to the survey was high. Of 17 schools, 15 responses were received from Undergraduate, 16 from Postgraduate and 10 from Continuing Medical Education programs. A list of the respondents and their contact information is found in Appendix 1.

The responses received were very rich, revealing a wide variety of activities at many schools. Perhaps reflecting the state of development of this area, there was considerable variation in the way such terms as “satellite” and “partner” campuses were interpreted. Further, some schools combined their responses across levels, and we have done our best to interpret that accurately. We have attempted to synthesize the information in a way that both gives a picture of the activities underway across the country, and identifies trends or similarities among programs, challenges identified, etc.

In the pages that follow, we present the question asked, and then the combined responses where appropriate, followed by responses separated into Undergraduate, Postgraduate and Continuing Medical Education. In the case of the more detailed information on activities across the schools, we have summarized the main findings. The responses are provided in detail starting on page 14, and the numerical codes for each of the schools are listed below.

	School
1	Memorial University of Newfoundland (UGME)
2	Memorial University of Newfoundland (PGME)
3	Memorial University of Newfoundland (CME)
4	Dalhousie University (UGME)
5	Dalhousie University (PGME)
6	Dalhousie University (CME)
7	Université Laval (UGME, PGME)
8	Université de Sherbrooke (UGME)
9	Université de Sherbrooke (PGME)
10	Université de Montréal (UGME)
11	Université de Montréal (PGME)
12	McGill University (UGME)
13	McGill University (PGME)
14	University of Ottawa (UGME PGME)
15	Queen’s University (All)
16	University of Toronto (UGME, PGME)

	School
17	McMaster University (UGME, PGME)
18	University of Western Ontario (All)
19	Northern Ontario School of Medicine (All)
20	University of Manitoba (CME)
21	University of Saskatchewan (UGME, PGME)
22	University of Saskatchewan (UGME)
23	University of Saskatchewan (PGME)
24	University of Saskatchewan (CME)
25	University of Alberta (PGME)
26	University of Alberta (CME)
27	University of Calgary (PGME)
28	University of Calgary (CME)
29	University of British Columbia (UGME)
30	University of British Columbia (PGME)
31	University of British Columbia (CME)

Satellite and Partner Campuses

Please note:

Several respondents indicated confusion regarding the definition of satellite or partner campuses. The lack of a clear definition in the survey instrument may have influenced survey results. Response rate refers to the proportion of total possible respondents who responded to this question (i.e., all 17 medical faculties or UGME/PGME/CME programs at each of these 17 faculties, depending upon the scope of each question).

To gain a sense of the prevalence of distant learning sites, survey respondents were first asked:

Does your faculty have satellite or partner campuses?

All responses:

65% (11/17) of medical schools have satellite or partner campuses (response rate: 100%).

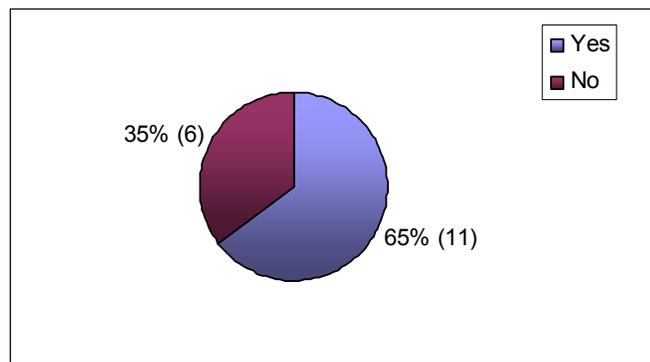


Figure 1. Proportion of Medical Schools with Satellite or Partner Campuses

Partner Campuses by All Educational Levels:

Of the faculties with partner campuses, postgraduate programs have the largest proportion (41%), with 40% of undergraduate and 19% of CME programs making up the remainder (response rate: 88%).

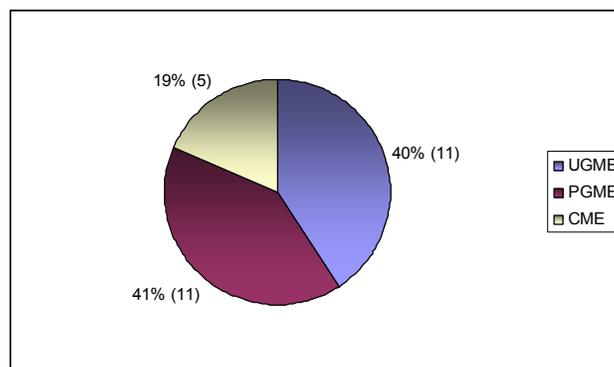


Figure 2. Proportion of Medical Schools with Satellite or Partner Campuses (By Level)

Satellite and Partner Campuses by Individual Educational Levels:

Shown below are the percentages of respondents with satellite and partner campuses at each educational level.

73% of UGME medical programs have satellite or partner campuses (response rate: 88%).

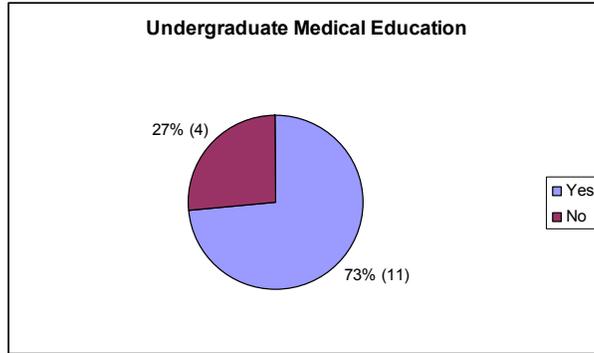


Figure 3. Proportion of Undergraduate Programs with Satellite or Partner Campuses

73% of PGME medical programs have satellite or partner campuses (response rate: 88%).

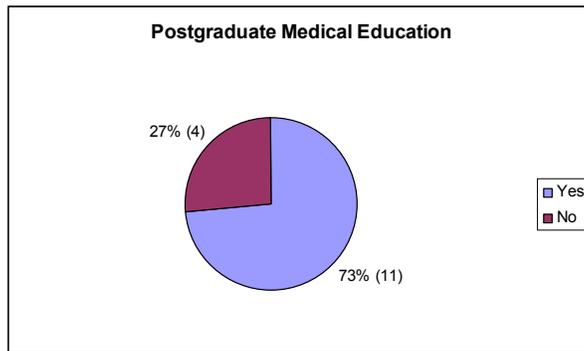


Figure 4. Proportion of Postgraduate Programs with Satellite or Partner Campuses

50% of CME medical programs have satellite or partner campuses (response rate: 58%).

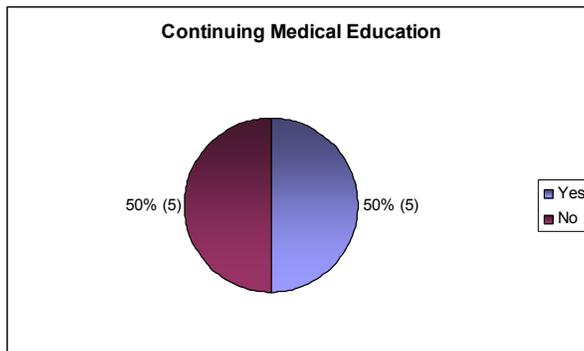


Figure 5. Proportion of Continuing Medical Education Programs with Satellite or Partner Campuses

Summary: Undergraduate Medical Education (UGME)

Virtually every school has some distributed medical education activities at the undergraduate level. While some activities have been ongoing for two or more decades, the majority of DME activities have begun in the last three to four years, meaning a great increase in activity and program development. Respondents included a range of sites in their definitions of partner and satellite campuses. Experience ranged from distant campuses offering full educational programs, to visits to community sites for learning the art and science of medicine.

Perhaps the availability of full educational programs offered at satellite campuses is the most striking development. At the moment, six schools have such an arrangement, with others in development. In addition, more than half of the undergraduate programs have placed students with community physicians, for both learning by observation and learning clinical and communication skills.

At the clerkship level, many schools offer distributed learning opportunities. Almost all schools require that students experience their family medicine rotation in a community setting. These are the longest-standing experiences. Increasingly, students can complete other clerkship experiences at satellite sites, and in five cases, a continuous integrated clerkship is available. Of the schools that responded, 100% reported the ability to conduct performance assessments at the distant sites, allowing the student to have an assessment and feedback in a setting geographically close to the site of learning.

It is striking to note the numbers of rural education opportunities offered. This increasing emphasis reflects the social accountability awareness of the Canadian faculties of medicine, and the attempt to broaden experience and redress health and distribution disparities.

Table 1a
*Distributed Medical Education Activities in Undergraduate Medical Education:
 A Summary of the Pre-Clinical Years**

Activity	Number of schools	Proportion of students	Year initiated
Whole program and years given at different and distant sites	UBC	Victoria + Prince George (starting in January of first year) ~ 20 %	2004
	NOSM	Sudbury/Thunder Bay: 50-50 %	2005
	U de M	Trois-Rivières: ~ 12 %	2004-5
	Toronto	Toronto teaching hospitals	1996
	Ottawa	Sudbury Unknown	Unknown
	Saskatchewan	Regina Unknown	Unknown
	Sherbrooke	Saguenay/Moncton (whole program) ~ 25 %	2006
Variety of rotations (usually 1 to 2 weeks) in community sites (many rural) for clinical exposition and observation	8 (mainly rural sites)	Usually 100 %	1976 (MUN) in the '90s for many schools and 2005 for others
Learning communication skills or the "art of medicine" in community sites (hospitals or physicians' offices)	4	Large proportion	Unknown
Summer electives	Probably many, but information not confirmed	Variable	Unknown

* Thanks to Dr. Paul Grand'Maison for preparing this table.

Table 1b
*Distributed Medical Education Activities in Undergraduate Medical Education:
 A Summary of the Clerkship Years**

Activity	Number of schools	Proportion of students	Year initiated
Comprehensive, continuous (almost 1 year) and integrated clerkship in one community site	UBC MAN NOSM U de M U de S	~ 5 % Unknown 100 % ~ 13 % 25%	2004 or 2005 2006 2007 2007 2008
Core clerkship in Family Medicine in community sites	Most Sherbrooke	100 % 80%	In the '80s for a few, but mostly in the '90s
Core clerkship in specialties in community sites	Most schools, but the number of specialties covered may vary from 1 to 5 as well as the number of sites involved Sherbrooke/all specialties/ > 10 sites	~ 30 %	Mainly after 2000 Progressively since 1999
Clerkship elective	All	Variable	Variable

* Thanks to Dr. Paul Grand'Maison for preparing this table.

Educational Activities

To better understand the nature and range of distributed education activities, respondents were asked:

In your area of responsibility, please describe the educational activities that occur outside of the immediate geographic area of your medical faculty.

Table 2
*Distributed Medical Education Activities at the Undergraduate Level by Year Including Rural Education Opportunities**

	YEAR 1	YEAR 2	YEAR 3	YEAR 4
Memorial University of Newfoundland*	◆	◆		
Dalhousie University			◆	
Université Laval	◆	◆	◆	◆
Université de Sherbrooke	◆			◆
Université de Montréal				
University of Ottawa	◆			
Queen's University	◆			
University of Toronto	◆	◆	◆	◆
McMaster University				
University of Western Ontario				
Northern Ontario School of Medicine	◆	◆	◆	
University of Manitoba				
University of Saskatchewan			◆	◆
University of British Columbia				

* Faculties of Medicine are listed by East to West geographic distribution on this and all tables in this report.

- Indicates Distributed Medical Education opportunities
- ◆ Indicates rural opportunities

The detailed responses from each program are presented below; Undergraduate Medical Education is divided into four years, with one table per year. There are six tables for Postgraduate responses, as there are four years with two educational streams in each of the first two years. Categories with missing information have been left blank in the tables.

Table 3
Distributed Medical Activities in Undergraduate Medical Education (UGME)
Year 1

School*	Type of activity**	Mandatory?***	Length	Proportion of class (%)	When initiated
1	Rural Family Visit	Y	2 wks	100	1976
4	Communication Skills; Skills and Procedures; PBL/Lectures; Interprofessional Modules; Life Cycle; Ethics; Human Sexuality; Clinical Sessions	Y	37 hrs	10	2006
7	1. Immersion week 2. Summer electives including rural	1. Y 2. N	1-8 wks	20-100	1. 1963 2. 2002
8	Clinical immersion rotation/students in community hospitals	Y	3 wks	100	1987-8
10	PBL sessions, lectures, clinical skills	Y	10 mos	12	2004-5
12					
14	Rural Week	Y	1 wk		
15	Rural Week	Y	1 wk	100	2004
16	1. Office of Rural Medical Education (ORME) 2. Rural Week 3. Art and Science of Clinical Medicine: Day of the Doctor 4. The Art and Science of Clinical Medicine: Pediatric Session 5. Determinants of Community Health: Health Promotion	Y/N	2 hrs-7 wks	7 - 100	1993-2005
17					
18	1. Family Medicine Discovery 2. Rural summer electives/research scholarships 3. International electives	Y/N	1-8 wks	5 -100	Years ago
19	Students take first 2 years on 2 different campuses with identical curriculum; live for 1 month in a remote/rural Aboriginal community while curriculum continues as DME	Y	1 mo-1 yr	100	2005
21					
22	Community Experience - observing and participating in "real life" patient care in a variety of communities.	Y	2 wks	100	1997
29	All students in single site for first term; second term entire curriculum at main campus and two partner sites (tutorials, lectures, labs, clinical skills, family practice office visits)	Y	20 wks	50	2004

* For definitions of numerical codes, see page 8.

** Due to the diverse styles of survey responses, many have been edited for clarity and space.

*** In these tables, "Y" indicates that these activities are mandatory, while "N" indicates that they are optional. "Y/N" indicates that some listed activities are mandatory, while others are not.

Table 4
Distributed Medical Activities in Undergraduate Medical Education (UGME)
 Year 2

School*	Type of activity**	Mandatory?***	Length	% of class	When initiated
1	Rural Family Visit	Y	2 wks	100	2003
4	Clinical Session- History/Physicals; Skills and Procedures; Human Sexuality; PBL/Lectures; Interprofessional Modules	Y	37 wks	100	2006
7	Summer electives: Rural International		4-10 wks	10- 40	1970-2002
8	Problem-based learning in community hospitals (more than 30 distributed in Québec and New Brunswick)	Y	2 wks	100	1988-1989
10	PBL sessions, lectures, clinical skills	Y	10 mos	1	2006
12					
14					
15	Critical Enquiry Summer studentships	1. Y 2. N	4-12 wks	10-100	1995-2002
16	1. Office of Rural Medical Education 2. Rural Week 3. Career Exploration in Medicine 4. Determinants of Community Health: Agency Placement (for research project)	Y/N	2.5 days-4 mos	3-160	1993-2002
17	Clinical rotations throughout clerkship	N	4-8 wks	46	2002
18	Rural summer electives/research scholarships International electives		2-8 wks	1- 5	
19	Students take first 2 years on 2 different campuses with identical curriculum; live for 2 months in a remote/rural Aboriginal community while curriculum continues as DME	Y	1 yr	100	2006-7
21	Rural summer extern program Externship in Regina	N	4-10 wks	40	1988
29	Entire curriculum (tutorials, lectures, labs, clinical skills, family practice office visits)	Y	34 wks		2005

* For definitions of numerical codes, see page 8.

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*** In these tables, "Y" indicates that these activities are mandatory, while "N" indicates that they are optional. "Y/N" indicates that some listed activities are mandatory, while others are not.

Table 5
Distributed Medical Activities in Undergraduate Medical Education (UGME)
 Year 3

School*	Type of activity**	Mandatory?***	Length	% of class	When initiated
1	1. Clinical rotations throughout clerkship 2. Family medicine core clerkship rotation 3. Clerkship electives 4. Core clerkship rotations	Y/N	4-24 wks	10-100	1976-2007
4	Clinical Rotations; Didactic Teaching; Interprofessional Modules; Skills and Procedures	Y	24 wks	100	2006
7	1. Introduction to Clerkship 2. Family medicine and specialty electives rural	N	4-5 wks	15	1975-2003
8	Rotations in community sites in intermediate, peripheral or rural regions	Y	Varies	100	1990
10	Clerkships	Y		32	2007
12	Rural family medicine rotation, various locations	Y	4 wks	100	2006
14	1. Family Medicine Clerkship 2. Other clerkships being developed (OB, ER, Surgery)	Y/N	5-6 wks		
15	Clerkships: Core Specialties, Family Medicine, Elective Core and Family	Y/N	6-12 wks	40-95	1980-2003
16	1. Office of Rural Medical Education 2. Clerkship Elective	Y/N	4-6 wks	50-100	1995
17	Clerkship - Clinical Rotations	N	4-8 wks	46	
18	Full & part time clerkships	Y		22	2003
19	Comprehensive community clerkship	Y	30 wks	100	2007-2008
21	Clerkship	Y	6 mos	30	Jan 06
22	1. Clerkship phase in a rural setting in Saskatchewan. 2. Elective time during their clerkship phase	Y/N	4-13 wks	100	1995
29	Entire curriculum – core clerkship program	Y	48 wks		2006

* For definitions of numerical codes, see page 8.

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*** In these tables, “Y” indicates that these activities are mandatory, while “N” indicates that they are optional. “Y/N” indicates that some listed activities are mandatory, while others are not.

Table 6
Distributed Medical Activities in Undergraduate Medical Education (UGME)
 Year 4

School*	Type of activity**	Mandatory?***	Length	% of class	When initiated
1	Clerkship electives & selectives	N	4-8 wks	50-75	1998
4	Clinical rotations	Y	12 wks	100	2006
7	1. Family medicine compulsory rural rotation 2. Family medicine and specialty electives rural 3. International profile (Cuba, Peru)	Y/N	4-12 wks	11-100	1985-2003
8	Rotations in community hospitals in intermediate, peripheral or rural regions.	Y	Varies	100	1990
10	Clerkships	Y		32	2008
12	Electives – can be anywhere within or outside geographic area	N	Max 20 wks	varies	at least 30 yrs
14	1 month elective	Y	4 wks		
15	Clerkships – Core specialties, Family Medicine, Elective Core and Family	Y/N	6-12 wks	40-95	1980-2003
16	1. Ambulatory Community Experience (ACE) Course; 2. Office of Rural Medical Education 3. Clerkship Elective	Y/N	4-12 wks	50-100	1995
17					
18	Electives in all departments				Yrs ago
19	Electives	Y	1 year	100	2008-9
20	TBD; 4-week professional skills course distributed across partner campuses; electives and senior clerkships at all sites	Y	In development		
21	Clerkships	Y	9 mos	30	2006
22	1. Clerkship in Family Medicine, four weeks of which are completed in a rural setting in Saskatchewan. 2. Elective time during clerkship	Y/N	4-13 wks	100	1995
29					

* For definitions of numerical codes, see page 8.

** Due to the diverse styles of survey responses, many have been edited for clarity and space.

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Summary: Postgraduate Medical Education (PGME)

According to the survey responses from postgraduate programs, definitions of distributed medical education are broad. Respondents included ambulatory facilities, community-based facilities and regional hospital facilities in their definitions of both "partner campus" and "distributed medical education." Within these broad definitions, the distributed medical education activity in postgraduate programs appears to be extensive; certain activities involve distance and travel, while other activities appear to take place at a community-based setting closer to home.

Royal College Programs arrange DME experience at two main points in the academic program. Specifically, there are short (4-8 week) DME experiences across a broad array of core rotations to develop generalist skills early in postgraduate Royal College Programs. Then there is a set of upper year DME experiences that seem to be elective or required experiences in the specialty itself in non teaching hospital experiences. These are often labeled community-based, but appear to be in a regional community setting rather than ambulatory; however, the nomenclature may be confused.

Family Medicine Programs appear to structure DME experiences differently. While it appears that all residents experience at least 8 weeks of required DME, a significant number of programs allow residents to experience 50-100% of their program in a distributed setting. Again, this appears often to mean a distributed regional or rural site at some distance from the main academic university; however, in other urban-based programs this may refer to the settings which are primarily ambulatory and community-based.

It seems that virtually every resident, in either Royal College or College of Family Physician programs, will experience some distributed medical education, whether community-based or regional; however, there was little evidence of vertical integration of undergraduate, postgraduate and continuing DME.

The following tables present the distributed medical activities available during each year of postgraduate education. We present the reported activities by year of program. DME activities are reported separately for Royal College of Physicians and Surgeons of Canada (RCPSC) programs and programs of the College of Family Physicians of Canada (CFPC).

Table 7
Distributed Medical Activities in Postgraduate Medical Education (PGME)
Year 1 (RCPSC)

School*	Type of activity**	Mandatory ?***	Length	% of class who participate	When initiated
2	Obstetrics	N	4-8 wks	25	10+ years
5	1. Adult emergency medicine 2. Adult anesthesia 3. Plastics 4. Adolescent pediatrics in high schools, hospital, off-site psychiatry clinics, Phoenix house 5. Pediatrics – QEII, ER/ICU/Obs-Gyn: clinical selective in adult medicine 6. Pediatrics – Psychiatry: off-site clinics 7. Urology – Clinical rotation	Y/N	4-12 wks	15-100	1992-2004
7					
9	Clinical rotations, Internal Medicine; Surgery, Anesthesia, Obs-gyn. Psychiatry, Pediatrics	Y	1-3 mos	Almost 100	1995
11					
13	Clinical rotations	Y	9 mos	All MOH sponsored	1993
14	Pediatrics- Community Urban	Y	4		
15	1. Surgery, Pediatrics 2. Obstetrics and Gynecology 3. Psychiatry 4. Internal Medicine 5. Rehabilitation Medicine 6. Emergency 7. Anesthesia	Y/N	2 mos	10-100	2003-4
16					
17	Clinical rotations	Y/N	1-2 mos	Approx. 24	
18	Clinical rotations: Internal Medicine, Gen. Surgery, Anesthesia, Psychiatry, Pediatrics	Y/N	1-3 mos	30-50	2002
19	Clinical rotations	Y	4-6 mos	100	2000-2
21	PGY-1 in Pathology, Medical Imaging	Y	1-12 mos		2006
23					
25					
27					
30	BCT PGY1	Y	48 wks	30	1992

R
C
P
S
C

* For definitions of numerical codes, see page 8.

** Due to the diverse styles of survey responses, many have been edited for clarity and space.

*** In these tables, “Y” indicates that these activities are mandatory, while “N” indicates that they are optional. “Y/N” indicates that some listed activities are mandatory, while others are not.

Table 8
Distributed Medical Activities in Postgraduate Medical Education (PGME)
Year 1 (CFPC)

CFPC	School*	Type of activity**	Mandatory?***	Length	% of class who participate	When initiated
	2	Medicine Obstetrics Pediatrics Surgery	Y	4-8 wks	90	5+ years
	5	Family medicine- all clinical rotations and academic seminars, specialty rotations	Y	7-12 mos	9-55	1973
	7	Family medicine FPU core rotations Family medicine core specialty rotations	N	12-36 wks	20-25	1984
	9	Family medicine unit Specialty rotations	Y	3-6 mos 1-6 mos	60	1985 1988
	11	Family medicine rotation, including office, hospital, emergency care and obstetrics	Y	2 mos	20	2005
	13	Clinical rotations	Y	8 mos	All MOH sponsored	1993
	14	Rural Month	Y	4 wks		
	15	Pediatrics Obstetrics, Gynecology Psychiatry Internal Medicine Emergency electives General & Orthopedic Surgery	N	2-4 mos	10- 80	
	16					
	17	Clinical rotations	Y/N	2-6 mos	77	
	18	Family Medicine clinical rotation	N	1-12 mos		
	19	Clinical rotations	Y	1 year	100	1991
	21	Family Med Program	Y	12.5 mos	11 positions	Years
	25	Rural rotation (multiple site) Rural Alberta North Family Medicine Program	Y	4 wks- 2yrs	100	2001-2
27	Rural Alberta South Family Med based at two regional sites			20 placements		
30	Placements at Greater Victoria, Vancouver, St Paul's, Chilliwack, rural, Prince George, and Aboriginal	Y	24 mos	100	1992	

* For definitions of numerical codes, see page 8.

** Due to the diverse styles of survey responses, many have been edited for clarity and space.

*** In these tables, "Y" indicates that these activities are mandatory, while "N" indicates that they are optional. "Y/N" indicates that some listed activities are mandatory, while others are not.

Table 9
*Distributed Medical Activities in Postgraduate Medical Education (PGME)
 Year 2 (RCPS C)*

School*	Type of activity**	Mandatory?***	Length	% of class who participate	When initiated
2	Medicine, Pediatrics	Y	1 mo	90	1996-2004
5	1. Clinical rotation in community 2. Neurology – Clinical rotation in a community physicians office 3. Pediatrics – Community pediatrics: clinical rotation in Pediatrician’s office. 4. Pediatrics – Elective: clinical rotation at another university, pediatric center or community/international clinical rotation. 5. Pediatrics – SJRH: clinical in and out patients. 6. Urology – Clinical rotation	Y/N	4-24 wks	100	1986-2005
7	1. General Surgery 2. Internal medicine 3. Pediatrics	Y	4-12 weeks	100	1995
9	Specific clinical rotations	Y		50	
11					
13	Clinical rotations	Y	9 mos	All MOH sponsored	1993
14	Pediatrics - Community North Bay	Unknown	4 wks		
15	1. Surgery, Pediatrics 2. OBS/GYN 3. Psychiatry 4. Internal Medicine 5. Rehabilitation Medicine 6. Emergency 7. Anaesthesiology	Unknown	2 mos	10-100	
16					
17	Clinical rotations	Y/N	1-5 mos	Approx. 5	
18	Clinical rotations : Internal Medicine, General Surgery, Anesthesia, Psychiatry, Peds	Y/N	1-3 mos	30-50	2002
19	Clinical rotations	Y	4-6 mos	100	2001-3
21	1. General Surgery resident rotations 2. Ob/Gyn rotations	Y	2-3 mos	100	1. 2002-3 2. Years
23					
25	1. Internal Medicine Selective 2. Pediatrics Selective	N	8 wks	10-15	1. 2002-3
27					
30	Foundational/Clerkship specialties: 1. Surgery 2. Internal Medicine 3. Psychiatry 4. Ob/Gyn 5. Pediatrics 6. Anaesthesia 7. Lab Medicine 8. Orthopedics	Y	4-48 wks	1 trainee at each site at all times	2004

* For definitions of numerical codes, see page 8.

** Due to the diverse styles of survey responses, many have been edited for clarity and space.

*** In these tables, “Y” indicates that these activities are mandatory, while “N” indicates that they are optional. “Y/N” indicates that some listed activities are mandatory, while others are not.

Table 10
*Distributed Medical Activities in Postgraduate Medical Education (PGME)
 Year 2 (CFPC)*

School*	Type of activity**	Mandatory?***	Length	% of class who participate	When initiated
2	Academic/Rural Family Medicine	Y	4-8 mos	100	5+ years
5	Family medicine –all clinical and academic seminars, etc. Family medicine –community and family medicine rotation	Y	12 wks-12 mos.	45-55	1973
7	1. Family medicine core rotations 2. Family medicine core specialty rotations 3. Family medicine rural	Y/N	8- 24 wks	20-100	1980-4
9	Community-based family medicine units Specialty rotations	Y	3 mos 1-6 mos	100 60	1979 1989
11	1. Family medicine rotation, including office, hospital, emergency care and obstetrics 2. Multiple rotations 3. All rotations	Y	2 -24 mos	10-100	1991-2005
13	Clinical rotations	Y	8 mos	All MOH sponsored	1993
14	Rural Month	Y	4 wks		
15	Family medicine rotation Surgery Paeds OBS/GYN Psychiatry Internal Medicine Emergency Electives: e.g., Anesthesia, Palliative Care	Y	4 mos	100	
16	1. Teaching Practices- 26 rural communities 2. Rural residency program	Y	2-12 mos	100	
17	Clinical rotations	Y	1-4 mos	65	
18	Family Medicine clinical rotation	N	1-12 mos		
19	Clinical rotations	Y	Full Year	100	1991
21	Family Med Program	Y	11.5 mos	11 positions	Years ago
23	1. Three distinct programs with home bases in Saskatoon, Regina and Prince Albert 2. Rural rotation	Y	2 mos	100	
25	Clinical rotation	Y	8 wks	100%	
27					
30	Placements at Greater Victoria, Vancouver, St Paul's, Chilliwack, rural, Prince George, Aboriginal	Y	24 mos	100	1992

* For definitions of numerical codes, see page 8.

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*** In these tables, "Y" indicates that these activities are mandatory, while "N" indicates that they are optional. "Y/N" indicates that some listed activities are mandatory, while others are not.

Table 11
Distributed Medical Activities in Postgraduate Medical Education (PGME)
Year 3 (RCPSC only)

R C P S C	School*	Type of activity**	Mandatory?***	Length	% of class who participate	When initiated
	2	Medicine, Pediatrics, Orthopedics	Y	1-3 mos	90-100	1994-6
	5	Clinical rotations	Y/N	4-12 wks	100	1990-2005
	7	1. Internal medicine 2. Obstetrics and gynecology 3. Pediatrics	Y	4-12 wks	100	1995
	9	Clinical rotations same programs	Y	1 mo	About 10	
	11					
	13	Clinical rotations	Y	9 mos	All MOH sponsored	1993
	14	Pediatrics - Iqaluit		4-8 wks		
	15	1. Pediatric Surgery 2. Obstetrics and Gynecology 3. Psychiatry 4. Internal Medicine 5. Rehabilitation Medicine 6. Emergency 7. Anesthesia			0-10	
	16					
	17	Clinical rotations	N	1-3 mos	16	
	18	Clinical rotations in Internal Medicine, General Surgery, Anesthesia, Psychiatry, Pediatrics	Y/N	1-3 mos	30-50	2002
	19	Clinical rotations	Y	4-6 mos	100	2002-4
	21	Internal Medicine residents	Y	Variable		2006
	23					
	25					
	27					
30	Foundational/Clerkship specialties: Surgery, Internal Medicine, Psychiatry, Obstetrics, Gynecology, Pediatrics, Anesthesia, Lab Medicine, Orthopedics	Y	4-48 wks	1 trainee at each site at all times	2004	

* For definitions of numerical codes, see page 8.

** Due to the diverse styles of survey responses, many have been edited for clarity and space.

*** In these tables, "Y" indicates that these activities are mandatory, while "N" indicates that they are optional. "Y/N" indicates that some listed activities are mandatory, while others are not.

Table 12
Distributed Medical Activities in Postgraduate Medical Education (PGME)
Year 4 (RCPSC only)

R C P S C	School*	Type of activity**	Mandatory?***	Length	Proportion of class who participate	When initiated
	2	Pathology, Surgery	Y	1-3 mos	75-90	2-5 years
	5	1. Electives 2. Adult Emergency Medicine 3. Clinical rotations in community based Pathology 4. Clinical rotations at another university, pediatric center or community/international clinical rotation 5. Clinical rotation in a community physicians office (And more)	Y/N	4-20 wks	50-100	1992-2000
	7	1. Anesthesiology 2. Pediatrics 3. Psychiatry	Y	4-12 wks	100	1995-7
	9					
	11					
	13	Clinical rotations	Y	9 mos	All MOH sponsored	1993
	14					
	15	1. Pediatric Surgery 2. Obstetrics and Gynecology 3. Psychiatry 4. Internal Medicine 5. Rehabilitation Medicine 6. Emergency 7. Anesthesia			0-10	
	16					
	17	Clinical rotations	N	2-4 mos	2	
	18	Clinical rotations	Y/N	1-3 mos	30-50	2002
	19	Clinical rotations	Y	4-6 mos	100	2003-5
	21	1. General Surgery 2. Physical Medicine and Rehabilitation	N	3 mos	1 resident	Years ago-2006
	23					
	25	Surgery – Clinical Rotation	Y	3 mos	100	
27						
30	Foundational/Clerkship specialties: Surgery, Internal Medicine, Psychiatry, Obstetrics/Gynecology, Pediatrics, Anesthesia, Lab Medicine, Orthopedics	Y	4-48 wks	1 trainee at each site at all times	2004	

* For definitions of numerical codes, see page 8.

** Due to the diverse styles of survey responses, many have been edited for clarity and space.

*** In these tables, “Y” indicates that these activities are mandatory, while “N” indicates that they are optional. “Y/N” indicates that some listed activities are mandatory, while others are not.

Summary: Continuing Medical Education (CME)

The following table presents specific distributed medical activities in Continuing Medical Education programs as reported by survey respondents. All CME programs who responded (10/17) reported some distributed medical education activities. Respondents noted that some of these activities have spanned forty years. Most of these activities, however, were begun in the past two decades, with the most recent initiatives begun in 2006.

Respondents' definitions of satellite and partner campuses ranged from online learning sites and videoconferencing to separate university campuses. Two respondents identified distributed learning opportunities occurring in rural communities, while 7 out of 10 (70%) respondents listed online learning as one of their distributed medical sites. Seven survey respondents (70%) included videoconferencing at a satellite or partner campus.

Several listed distributed learning activities involved video and computer technologies, including videoconferencing and online courses and workshops. Learning formats include virtual and distance conferencing, electronic discussion boards, clinical traineeships and faculty development courses. Specific course content included physician remediation and programs addressing congestive heart failure and dyslipidemia. Activities range from small (i.e., one participant at a time) to extensive (i.e., up to 800 participants), and occur over periods ranging from one day to 22 months.

The specific responses from each Continuing Medical Education program are presented below.

Table 13
Distributed Medical Activities in Continuing Medical Education (CME)

School*	Type of Activity**	Length	Average number of participants	When initiated
3	<ol style="list-style-type: none"> 1. Clinical Traineeships 2. Online courses 3. Ask the Consultant web-enabled teleconferencing 4. Onsite programming in province 	1 day-6 mos	10-800	1966-2002
6	<ol style="list-style-type: none"> 1. Community Hospital Program 2. Videoconferenced CME programs 3. Academic Detailing Service 4. Online CME: <ol style="list-style-type: none"> a) Dalhousie CME b) 5 CME modules for family physicians on the MUN website 5. Community interprofessional communication skills workshops 	20 min-1 mo	1-30	1970-2005
15	<ol style="list-style-type: none"> 1. TIPS- 2-day course for all new faculty 2. Faculty Development courses at university 3. Faculty Development courses in communities 	2-12 days	4-16	1995-2005
18	<ol style="list-style-type: none"> 1. Online discussion boards 2. Online courses 3. National Mainpro-C programs 	1-22 mos	12-360	2003-4
19	Online courses/workshops in Northern communities			1990

Table 13 (cont'd)

School*	Type of Activity**	Length	Average number of participants	When initiated
20	<ol style="list-style-type: none"> 1. Live speakers in 7 rural communities with videolinkage to other communities 2. Monthly videoconferenced CME 3. Remediation for practising physicians in difficulty; often in the community 4. CME elective 	up to 2 mos	10-96	1986-2005
24	<ol style="list-style-type: none"> 1. Extended refresher courses 2. Online information (www.usask.ca/cme) 3. Online web CT courses 4. Telehealth video conferences (18 rural sites) 5. District medical society education programs (rural) 	60 min-1 yr	12-30; 80,000 hits per month	1980s-2006
26	<ol style="list-style-type: none"> 1. Clinical Traineeships 2. Videoconferences 3. Regional Conferences 4. Webconferences 5. Conferences Out of Town 	5-60 hrs	7-78	2004-5
28	<ol style="list-style-type: none"> 1. Regional Conference Program 2. Video Conference Program 3. On-Line Courses handled through www.mdCME.ca 4. Emergency Medicine for Rural Hospitals (Banff) 5. Rural Anesthesia for GP Anesthetists 	24 x 2 hrs 6.5-30hrs	168 69-294	1967 1981-95
31	<ol style="list-style-type: none"> 1. Rounds: bi-weekly rounds - rural physicians (Video & Audio); provincial grand rounds for family physicians; rounds for specialists in rural locales (Video) 2. Online programs on selected topics 3. Technology enabled academic detailing 4. Traveling short programs (allergy immunology, head trauma etc.) 5. Certification programs (e.g. APLS, ACLS etc) 6. Technology capacity programs - in person and video 	1 hr-13 wks	15-50 plus	1980s-2005

* For definitions of numerical codes, see page 8.

** Due to the diverse styles of survey responses, many have been edited for clarity and space.

Program Details: Undergraduate and Postgraduate Distributed Medical Education

Respondents were asked to provide some information regarding governance, autonomy, and responsibility at the distant sites. The first question was as follows:

Can learners complete entire rotations at a partner or distant site?

A majority of undergraduate programs reported offering opportunities for completing entire rotations at satellite or partner campuses, whereas about half of postgraduate programs possess this capacity.

62% of undergraduate respondents have satellite or partner campuses where learners can complete entire rotations (response rate: 76%).

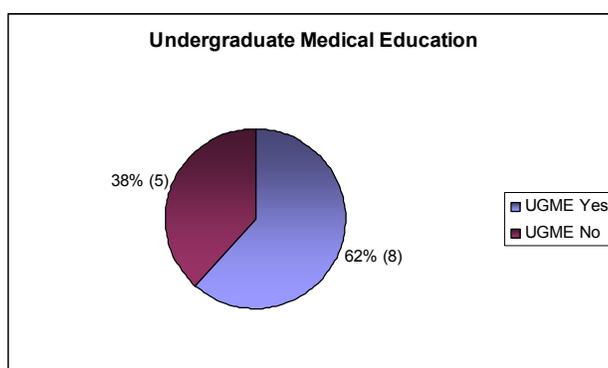


Figure 6. Proportion of Undergraduate Programs with Satellite or Partner Campuses Where Learners Can Complete Entire Rotations

53% of postgraduate respondents have satellite or partner campuses where learners can complete entire rotations (response rate: 88%).

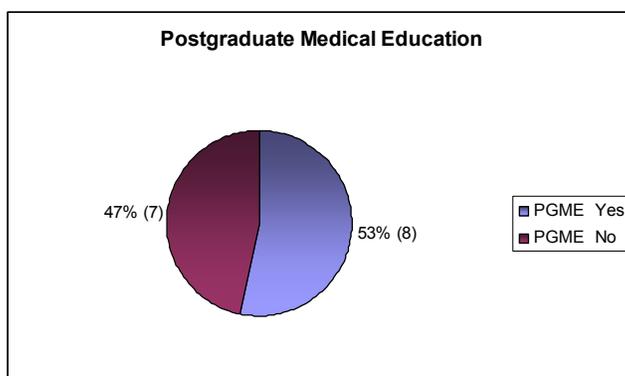


Figure 7. Proportion of Postgraduate Programs with Satellite or Partner Campuses Where Learners Can Complete Entire Rotations

The second question asked about the extent and duration of these distributed medical activities at distant sites; CME respondents did not complete this question.

Can learners complete their entire educational program at the partner or distant site?

Respondents indicated that 43% of undergraduate programs offer complete educational programs to their learners. Similarly, approximately 40% of postgraduate programs with partner and satellite campuses offer entire programs to learners.

Learners can complete entire undergraduate programs at 43% of medical faculties (response rate: 82%).

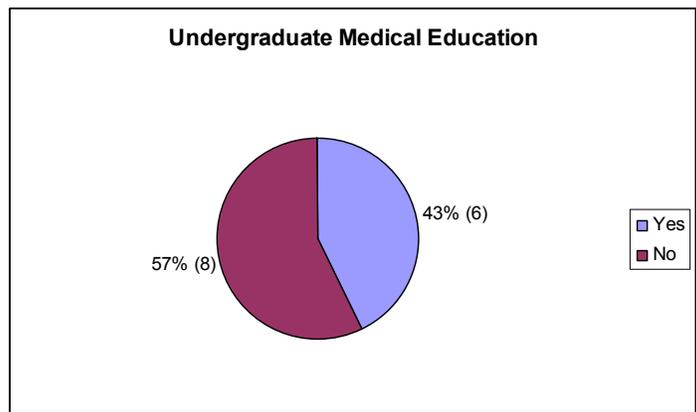


Figure 8. Proportion of Undergraduate Programs with Satellite or Partner Campuses Where Learners Can Complete their Entire Educational Program

Learners can complete entire postgraduate programs at 40% of medical faculties (response rate: 88%).

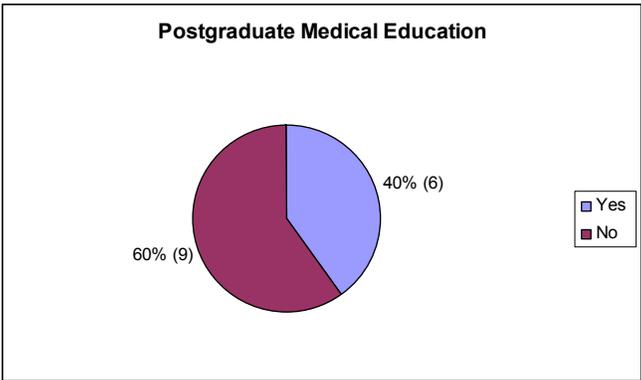


Figure 9. Proportion of Postgraduate Programs with Satellite or Partner Campuses Where Learners Can Complete their Entire Educational Program

Survey respondents were then asked about assessment of learners at these distant sites.

Can performance assessments (written and other) be conducted at the distant sites?

Capacity for conducting assessment of learners at distant sites was reported by all respondents to this question.

100% of distant sites conduct performance assessments on site (response rate: 88%).

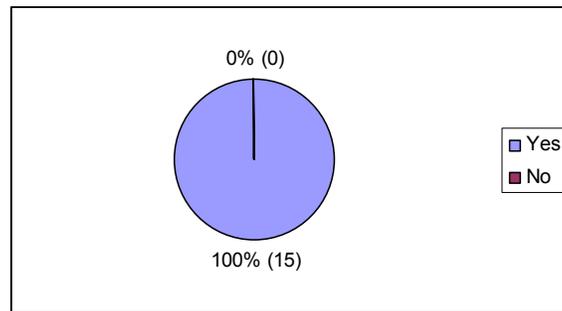


Figure 10. Proportion of Distant Sites that Conduct On-Site Performance Assessments

Institutional Policies

Governance and policy development are key aspects of distributed medical education. We therefore asked the following two questions:

Has your institution developed policies to address financial support for learners at distant sites?

A large majority of medical faculties reported the development of financial policies aimed at addressing learner support. Only three medical schools reported the absence of such policies; however, because only one program at each of these three faculties responded to the survey, it is possible that policies in other programs exist.

88% of faculties have developed policies to address financial support for learners at distant sites (response rate: 94%).

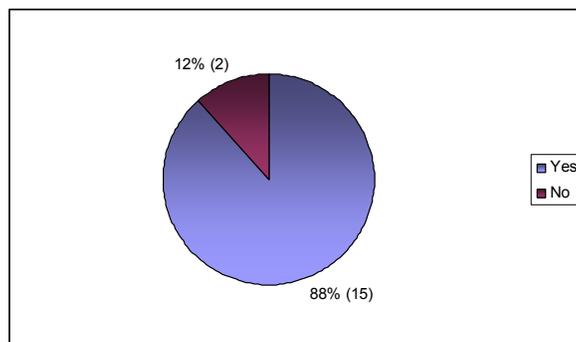


Figure 11. Proportion of Medical Faculties that have Developed Policies to Address Financial Support for Learners

Has your institution developed policies to address issues of appointments and remuneration for faculty at distant sites?

Most medical faculties have addressed appointment and remuneration of distributed medical education faculty by developing policies tailored to these issues. Honoraria and stipends were reported to be two methods of faculty remuneration.

75% of medical faculties reported having developed policies regarding faculty appointments and remuneration (response rate: 100%).

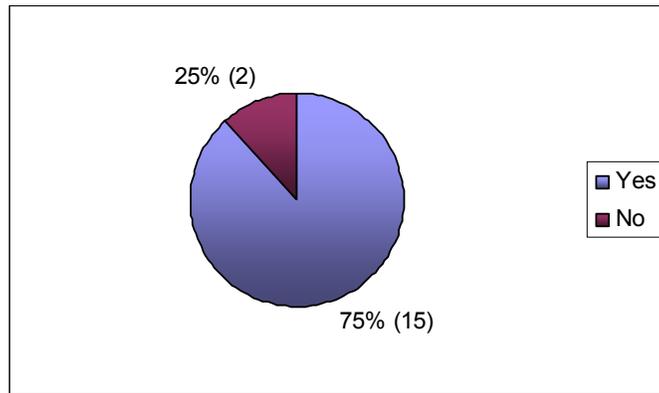


Figure 12. Proportion of Medical Faculties that have Developed Policies to Address Appointments and Remuneration for Faculty at Distant Sites

Summary: Successes, Challenges and Future Goals

What would you describe as your greatest success in DME?

Across the schools, a wide range of successes were reported. Development of rural physicians and increased retention rates were identified as a positive outcome, suggesting an underlying social accountability framework. The development and effective use of technology, and the development of creative online offerings were also noted. A number of schools cited the successful implementation of programs at distant sites, and the extensive development of the infrastructure at those sites. Important successes were seen in the development of key partnerships, and collaborations with distant sites and communities. Faculty enthusiasm and student satisfaction were reported. Critically important were the successful development of new, expanded, high-quality educational programs that will better prepare learners and support physicians in practice. Detailed responses are given below.

Table 14
Successes in Distributed Medical Education (All Survey Responses)

School*	Response
1	Rural Family Medicine 3 rd Year
2	
3	Mdcme.ca
4	Use of Bridget technology for Pediatrics, Surgery and Emergency Medicine teaching session-connect to distant sites throughout Maritimes
5	
6	1. Connections and collaboration with community physicians through distributed learning programs 2. Extensive research and publications on our distributed learning activities
7	1. Students and residents from all disciplines are very keen about their clinical experiences in small community hospitals, very few ask for permission to do their rotation in sites closer to Québec city where they can commute, a 30-45 minute drive 2. Université Laval family medicine and RCPSC graduates establish their practice in rural areas in a larger proportion than any other medical school in Canada
8	The development throughout the years of a comprehensive network of partner health care institutions which can offer complementary experience to medical students in all disciplines at the clerkship level
9	Those sites involving people who were not necessarily quite interested in teaching, now enjoy it very much
10	The idea of a distant medical campus was launched in July 2003 and the creation of the campus was realized in September 2004 with the first 24 students!!! With full faculty, university and government approvals
11	The opening of 3 family medicine units
12	
13	Getting buy-in from physician in remote areas to become teachers

(cont'd overleaf)

Table 14 (cont'd)

School*	Response
14	Hard to answer. New position as of September 2005. Still being developed.
15	Integration of learners from undergrad and postgrad programs in the same community
16	<p>UGME:</p> <ul style="list-style-type: none"> • Students experiencing and gaining appreciation for the quality of health care outside Toronto and limitations / strengths of healthcare providers outside of the academy. • One-on-one learning / mentorship; exceptional collaboration, flexibility to accommodate learning objectives. • Students are able to broaden their horizons and experience health care in under-served areas, and possibly in different cultures. <p>PGME:</p> <ul style="list-style-type: none"> • The development of the PGY-2 year in the Family Medicine Rural Program which provides a continuous 12 month experience in a rural setting. The feedback we have is that it prepares residents well for rural practice. Our retention rate in rural practice is over 70%.
17	Administrative infrastructure – necessary to put program in place; recent Ministry approval for two distributed campuses; support from leadership of community hospitals, universities and colleges
18	1. Enthusiastic reviews from students 2. Recruitment of preceptors at the Windsor Campus 3. Keeness of the preceptor/teachers 4. Strong faculty development
19	<p>UGME: still too early to describe success with learners but it is an accomplishment that we have 29 Aboriginal communities ready to host our students in a month</p> <p>PGME: the numbers of learners choosing to remain in the north is a testament to the strength of the training programs</p>
20	As a CME Office, it would be our ability to focus on the needs of particular communities or groups of physicians. We also have a Rural CME Chairs group that meets twice a year to help us plan our policy for rural CME.
21	Solid educational programs and involved, enthusiastic faculty
22	Achieving a stable mechanism for assignment of clinical clerks to the partner site
23	The increasing strength and success of our Family Medicine programs in Regina and PA
24	The creativity of the on-line offerings by our Continuing Professional Learning group, and the magnitude of access to those resources
25	The increase to the number of residents training in rural family medicine.
26	Video Conference Program. This program has expanded from a teleconference program to a successful collaboration with University of Calgary CME. This year the registration covers 70 individual videoconference sites.
27	Rural Alberta South as noted above
28	Number and variety of course offerings for rural physicians enabled due to infrastructure support provided by Rural Physician Action Plan
29	Successful implementation of first two years of the curriculum; student satisfaction and performance; leadership team; project management approach; program evaluation; quality of educational technology
30	<p>1. Family medicine is a great success and as a template for distribution is very helpful for our RCPSC programs</p> <p>2. Co-ordination of distribution between undergrad and postgrad</p>
31	Our greatest successes have been in the use of technology to reach different rural communities; to develop different communities of learners across different geographical regions

* For definitions of numerical codes, see page 8.

Challenges

What would you describe as your greatest challenge in DME?

The challenges reported mirrored the successes reported. The recruitment, development, and support of faculty and preceptors at distant sites is a continuing challenge. Students and residents have concerns about disruption of their life, and about being isolated from important experiences and career opportunities. Partnerships and good communication are critical, and these take time and effort to develop and maintain. The challenge of developing and maintaining good quality programs was expressed across all levels of education. Evaluation of programs was not specifically cited, but clearly is a challenge that all programs will encounter.

Table 15
Challenges in Distributed Medical Education (All Survey Responses)

School*	Response
1	Ensuring quality of curriculum delivery is maintained
2	Maintaining teaching staff at rural/regional sites; delivery of academic/grand rounds and core contents to trainees at remote sites; costs associated with travel for return
3	Marketing opportunities for DME
4	Full support from faculty for use of IT
5	
6	Securing sustainable funding for programs after the pilot or R&D phase is over.
7	Find new sites with adequate numbers of patients and clinician teachers to increase the percentage of training done outside Québec city. Need new sites to teach the care of children and women outside Québec city.
8	<ol style="list-style-type: none"> 1. Implementation of the whole MD program in two "separate campuses" starting September 2006 2. The consolidation of actual teaching sites at the clerkship level, and the development of new teaching sites in response to increasing enrollment 3. To increase the community orientations of all these rotations 4. Standardization of the learning experiences and meeting LCME criteria ED-8 and ED-2 5. The evaluation of long term impact
9	Maintain what we have and develop new places
10	In 2008-09 we will have approx. 180 students/residents in the separate campus
11	On going in-service training for the teachers; development of research
12	
13	To ensure that the rotations offer good pedagogical value
14	Postgraduate buy-in
15	The burden of undergrad needs relative to postgraduate residency rotations
16	<p>UGME: Time commitment, workload constraints, travel time, costs and the perceptions of students who expect/want transport conveniences; having enough opportunities in competitive fields; travel time to electives just outside GTA; mindset of students who feel the "best" opportunity for matching to their residency is by doing their electives in downtown Toronto hospitals with program directors and "other myths"</p> <p>PGME: Recruiting students into rural training</p>

(cont'd overleaf)

Table 15 (cont'd)

School*	Response
17	Variable uptake amongst internal departments; Need for increased preceptor capacity; internal and external communications – large volume of individuals who need to be kept in the loop
18	<ol style="list-style-type: none"> 1. Concerns regarding preceptor fatigue 2. Development of broad based support in the medical community 3. Concerns of the DME sites about appropriate remuneration of teachers 4. Need for continuing development of relevant faculty development
19	<ol style="list-style-type: none"> 1. Maintaining the communication with the many stakeholders in the distributed communities that are taking our learners, both undergrad and postgrad 2. Maintaining the necessary personal and professional supports necessary for learners on longer rotations in smaller communities
20	<p>In CME: the great variability in our rural physician population. 65% are IMGs, and many only stay for a couple of years, so that educational needs vary widely</p> <p>It is also difficult to provide for CME needs of physicians in small towns with only a couple of physicians – have tried different formats, times of day, etc.</p>
21	Critical mass of students; students at various levels of training to help support each other and the programs
22	RCPSC residents' acceptance of the dislocation involved in rotations away from their home base; helping colleagues and opportunities in Regina become visible to and valued by residents
23	Building successful RCPSC components; ensuring good resident support of clerkship
24	
25	<ol style="list-style-type: none"> 1. The web-conference program. It was offered for two years and was not very successful. There were technical problems and low registration. 2. Getting feedback / evaluations from the rural programs we run
26	Enrolling Royal College physicians as teachers for specialty residents, Family Medicine residents and UGME
27	
28	Geography; size of communities makes it difficult to get a critical mass for regional conference program
29	<p>Developing and sustaining relationships between the partner sites; communication; dealing with the increased complexity and workloads</p> <p>Cultural change at the main campus; trying to streamline and simplify bureaucratic administrative processes</p>
30	Capacity to train at all sites- for numbers of teachers and infrastructure of the distributed sites, in the face of a very rapid expansion
31	<ol style="list-style-type: none"> 1. Funding the technology required; supporting the local sites (e.g. in videoconferencing – providing tech support etc.) 2. Accessing facilities at remote sites

* For definitions of numerical codes, see page 8.

Future Goals

As we look to the future, it is important to understand and clarify the goals of distributed medical education. We began this effort by asking the schools:

What are your future goals for DME in your institution?

Future goals identified by survey respondents included expanding capacity for distributed learning opportunities and for greater integration of technology into DME activities, increasing quality at all sites, developing sustainable infrastructure to support distributed learning at various sites, and integrating DME activities at different levels of medical education. The needs of rural physicians were also acknowledged as priorities.

Table 16
Future Goals in Distributed Medical Education

School*	Response
1	Expand enrolment
2	To improve and continue to work on challenges
3	Blended learning and point of care; integration of CME in EMR/EHR interfaces
4	To explore other IT options in the use of IT in distance learning
5	
6	To make better use of distributed learning for physicians and other health professionals working outside the academic centre. We are considering a pilot project in web-conferencing to provide CME to physicians in their homes over the Internet. This is in response to comments from women family physicians that they could not attend CME in the evening because of family responsibilities.
7	We have to maintain the quality of all our teaching sites and increase the numbers as our class grew from 108 to 210
8	
9	Developing new places
10	Complete the family residency program and the required rotations in specialty residency programs; establish a specific CPD program for physicians in this remote area
11	Increase the number of total rotations in distant sites to 35% for Family Medicine
12	
13	Appoint a central coordinator at the faculty to deal with the logistics and scheduling
14	Increase clerkship options and couple with postgrad; further develop bigger communities
15	UGME: Integration; team based community discipline teaching; regional discipline specific rounds; delivery of effective faculty development; equitable remuneration for community preceptors.
16	<p>To enrich undergraduate and postgraduate medical education by increasing exposure and learning in distributed urban and rural community and hospital settings.</p> <p><u>UGME</u>: 1. Expansion and utilization of preceptors and learning experience potential 2. Promote and enable student diversity and equity through disseminated learning 3. A consolidated, funded, stand-alone learner placement service facilitating elective/selective experiences across the greater Toronto area region such as those established elsewhere</p> <p><u>PGME</u>: 1. Increasing the number of residents in the Family Medicine Rural Residency Program 2. Increasing the number of Family Medicine urban based residents who opt for more than the minimum of 2 months of rural experience 3. Improving coordination in DME between various institutions</p>

Table 16 (cont'd)

School*	Response
17	Development of two satellite campuses, an Aboriginal focus group, and increased number of resident placements
18	<ol style="list-style-type: none"> 1. Development of full 4 year program in Windsor (including pre-clinical teaching) 2. Development of more even flow of trainees to the Windsor site without compromising rural/regional programs 3. Establishing DME sites as training sites for those not wishing positions in Academic Health Sciences Centres
19	Maintain the placements and community involvement for our students without displacing the learners, both undergrad and postgrad, that come to the North from other schools for electives
20	Our Dean speaks of "Campus Manitoba" and is actively involved in increasing the number of rural GFTs. For the CME Office, our goal is to be responsive to the varied and evolving needs of our rural physicians.
21	Solid number of students at various levels of training; yearly budget; increased involvement of premed students from the University of Regina and FNUC; enhanced interdisciplinary education and research with other health professionals in the RHA
22	
23	<ol style="list-style-type: none"> 1. Seamless integration of clerkship and RCPSC programs between Saskatoon and Regina, and into smaller communities thereafter 2. Continued success of FM programs at partner sites 3. Sustainable, non-industry resources to build on the successes in CPL
24	<ol style="list-style-type: none"> 1. Increased accredited web-based learning 2. Increased centrally supported rural small group learning
25	Master Clinician GIM program in Grande Prairie; 2 positions will be allocated for the 2007 CaRMS Match
26	
27	We are attempting to implement a third year clerkship in rural areas for all core rotations
28	Expand programs as the needs develop
29	Implementation of distributed clinical education; ensuring sustainability
30	Overall goal is recruitment and retention in the distributed sites. To support this, we anticipate more robust distribution in most disciplines.
31	Develop a more comprehensive strategy for CPD for the entire province; provide active engagement for non-Vancouver based specialists; develop regional communities of learners; strengthen our presence in our partner community sites

* For definitions of numerical codes, see page 8.

Summary

Survey responses indicate that differences exist among distributed medical education across all three programs (Undergraduate, Postgraduate, and Continuing Medical Education). Within these levels, there was a range of definitions for satellite and partner campuses, as well as for distributed medical education itself. Partner sites ranged to include ambulatory facilities, community-based facilities, and regional hospital facilities. Within the broad category of DME itself, activities spanned from online learning, teleconferencing, to sites involving short and long-distance travel.

All undergraduate respondents identified distributed learning opportunities at some point over a four year program. Six schools (35%) reported the capacity to offer entire educational programs at satellite campuses, while more than half offer student placements with community physicians. Distributed learning opportunities also exist at the clerkship level, with almost all schools requiring community-based family medicine rotations; these rotations are the longest-standing experiences. Increasingly, however, other clinical rotations may be experienced at distant sites.

As with undergraduate learners, survey results indicate that all residents will experience some form of distributed medical education. Half of residents are able to complete entire rotations at a partner or distant site. Within postgraduate programs, differences emerged between Royal College Programs (RCPSC) and Family Medicine Programs (CFPC) regarding the timing of DME opportunities. RCPSC programs generally offer short (4-8 week) experiences in diverse rotations for the early development of generalist skills, and in later phases, offer electives as well as requisite courses in specialty areas. CFPC programs offer at least eight weeks of required DME, many programs provide the opportunity to experience from half to all of their educational experiences in a distributed setting.

At the CME level, all programs appear to offer at least some form of distributed medical education experience. While most of these experiences were established over the past two decades, specific opportunities have existed for four decades. More than two-thirds of CME programs listed online learning as one of their distributed activities, while half of respondents included videoconferencing as a vehicle for DME. Online courses and discussion boards accompanied clinical traineeships and faculty development courses as DME program formats. At this level, distributed learning opportunities may last from one day to almost two years.

Across the schools, a wide range of successes were reported. Development of rural physicians and retention rates was identified as a positive outcome. The development and effective use of technology, and the development of creative online offerings were also noted. A number of schools cited the successful implementation of programs at distant sites, and the extensive development of the infrastructure at those sites. Important successes were seen in the development of key partnerships, and collaborations with distant sites and communities. Faculty enthusiasm and student satisfaction were also reported. Critically important was the successful development of new, expanded, high-quality educational programs that will better prepare learners and support physicians in practice.

The challenges reported mirrored the successes reported earlier in the survey. The recruitment, development, and support of faculty and preceptors at distant sites are a continuing challenge. Students and residents have concerns about disruption of their life, and about being isolated from important experiences and career opportunities. The challenge of developing and maintaining good quality programs was expressed across all levels of education.

Future goals identified by survey respondents included expanding capacity for distributed learning opportunities and for greater integration of technology into DME activities, increasing quality at all sites, developing sustainable infrastructure to support distributed learning at various sites, and integrating DME activities at different levels of medical education. The needs of rural physicians were also acknowledged as priorities.

In all, the picture of DME in Canada is one of movement: growth of existing activities, and rapid development of many innovative opportunities. As most energies are focused currently on development, few respondents identified the evaluation of effectiveness of DME activities as a challenge. Clearly, this is a future challenge for all DME programs at all educational levels.

Appendix 1: List of Respondents

ID *	School	Role	Name
1	Memorial University (UGME)	Chair of Undergraduate Medical Studies	Dr. Vernon Curran
2	Memorial University (PGME)	Dean for PGME	Dr. Asoka Samarasena
3	Memorial University (CME)	Director, Professional Development & Conferencing Solutions	Ms. Fran Kirby
4	Dalhousie University (UGME)	Associate Dean UGME	Dr. Richard Rowe
5	Dalhousie University (PGME)	Associate Dean PGME	Dr. Martin Gardner
6	Dalhousie University (CME)	Director Special Projects	Dr. Michael Allen
7	Université Laval (UGME, PGME)	Assistant Dean Development of Clinical Teaching in Regions	Dr. Jacques Frenette
8	Université de Sherbrooke (UGME)	Dean for UGME	Dr. Paul Grand'Maison
9	Université de Sherbrooke (PGME)	Dean for PGME	Dr. François Lajoie
10	Université de Montréal (UGME)	UGME, President of the Faculty Teaching Council	Dr. Raymond Lalonde
11	Université de Montréal (PGME)	Directeur, Département de médecine familiale	Dr. François Lehmann
12	McGill University (UGME)	Associate Dean, UGME	Dr. Joyce Pickering
13	McGill University (PGME)	Associate Dean, PGME	Dr. Jean-Pierre Farmer
14	University of Ottawa (UGME, PGME)	Director of DME	Dr. Michael Hirsh
15	Queen's University (All)	Director Regional Education	Dr. Gene Dagnone
16	University of Toronto (UGME, PGME)	Coordinator, Council of Education Deans	Dr. Allison Hardisty
17	McMaster University (UGME, PGME)	Director—MacCARE Program for Distributed Medical Education	Dr. Karl Stobbe
18	University of Western Ontario (All)		Dr. Kenneth A. Harris
19	Northern Ontario School of Medicine (All)	Vice Dean, Academic Affairs, Associate Dean Postgraduate Planning	Dr. Dan Hunt, Dr. Maureen Topps
20	University of Manitoba (CME)	Associate Dean CME	Dr. Gisèle Bourgeois-Law
21	University of Saskatchewan (UGME, PGME)	Associate Dean Regina	Dr. Gill White (with Dr. Sheila Harding)

Appendix 1: List of Respondents (continued)

ID*	School	Role	Name
22	University of Saskatchewan (UGME)	Assistant Dean, UGME	Dr. Lou Qualtiere (with Dr. Sheila Harding)
23	University of Saskatchewan (PGME)	Assistant Dean, PGME	Dr. Karen McClean (with Dr. Sheila Harding)
24	University of Saskatchewan (CME)	Director of CME	Dr. Penny Davis (with Dr. Sheila Harding)
25	University of Alberta (PGME)	Associate Dean, PGME	Dr MG Elleker
26	University of Alberta (CME)	Dean for Continuous Professional Learning	Dr. Chris J de Gara
27	University of Calgary (PGME)	Associate Dean Rural /Regional Affairs	Dr. Doug Myhre
28	University of Calgary (CME)	Director, CME	Dr. Jocelyn Lockyer
29	University of British Columbia (UGME)	Dean for UGME	Dr. Angela Towle
30	University of British Columbia (PGME)	Associate Dean, PGME	Dr. K. Rungta
31	University of British Columbia (CME)	Director, Knowledge Translation and Continuing Professional Development	Dr. Luke Ferdinands

* **Please note:** These IDs are used in the report tables.

Appendix 2: Sample Survey

Survey of Distributed Medical Education (DME) Activities at Canadian Faculties of Medicine

Please provide the following information:

Medical Faculty: _____

Your role or position (e.g. Dean for CME, UGME or PGME): _____

Name: _____

Telephone #: _____

E-mail address: _____

1. Does your Faculty have satellite or partner campuses? Yes____ No____

If Yes, how many? ____

2. **N.B. Please complete this question for your area of responsibility only (e.g. Undergraduate, Postgraduate or Continuing Medical Education).** In your area of responsibility, please describe the educational activities that occur outside of the immediate geographic area of your medical Faculty. Please use the following Table to provide your response. **If you wish to add more rows, please do so.**

Appendix 2: Sample Survey (continued)

2a. Undergraduate Medical Education

Level of experience	Type of activity (e.g. Clinical rotation(s))	Mandatory Y/N	Length of experience (number of weeks or months)	Proportion of class who participate	When initiated
First year UGME					
Second year UGME					
Third Year UGME					
Fourth year UGME					

Comments:

Appendix 2: Sample Survey (continued)

GO TO QUESTION 3

2b. Postgraduate Medical Education

Level of experience		Type of activity (e.g. Clinical rotation)	Mandatory Y/N	Length of experience (number of weeks or months)	Proportion of class/learners who participate	When initiated
RCPS Programs	First year PGME					
	Second year PGME					
	Third year PGME					
	Fourth year or higher PGME					
CFPC Programs	First year PGME					
	Second year PGME					

Comments: _____

Appendix 2: Sample Survey (continued)

GO TO QUESTION 3

2c. Continuing Medical Education

Type of activity (e.g. Clinical traineeship, online course)	Length of experience (number of weeks or months)	Average Numbers who participate	When initiated

Comments: _____

3. For undergraduate or postgraduate medical education, please answer the following two questions:

a) Generally, can your learners complete their entire educational program at the partner or distant site? Yes ____ No ____

b) Can performance assessments (written and other) be conducted at the distant sites? Yes ____ No ____

Appendix 2: Sample Survey (continued)

Questions 4-9 are for all respondents

4. Has your institution developed policies to address financial support for learners at distant sites? Yes____ No____

5. Has your institution developed policies to address issues of appointments and remuneration for faculty at distant sites? Yes____ No____

6. What would you describe as your greatest success in DME?

7. What would you describe as your greatest challenge in DME?

8. What are your future goals for DME in your institution?

9. What would be useful to you to focus on at the May 3rd workshop, which will be helpful with your program?
