Welcome to our faculties  Irving Gold
A Day in My Life Carol Herbert
Accreditation 101 or everything you wanted to know about accreditation but were afraid to ask! Linda N. Peterson
Célébrations : Une année dans la vie d’un doyen du niveau prédoctoral Geneviève Monneau
What Does a Postgraduate Dean Really Do? J. Mark Walton
Continuing Professional Development: Where does it belong? Penny Davis
The Role of Research in Canadian Faculties of Medicine Penny Moody-Corbett
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Editor/Éditeur: Irving Gold
Managing Editor/Coordonnatrice: Natalie Russ
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Président-directeur général
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Vice-président, Relations gouvernementales et affaires externes
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VP, Research and Analysis CAPER-ORIS/
Vice-président, Recherche et analyse CAPER-ORI
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Reflections
Nick Busing, President & CEO

The following President’s Address entitled “Academic Medicine – What more can we do?” was presented by Dr. Nick Busing at the 2010 Canadian Conference on Medical Education in St. John’s, NL.

Those of you who know me will know that I am often satisfied with a job well done but seldom content that we have done enough. It is in this context that I offer some reflections today.

There are many areas in which the Canadian academic medical community excels – first class undergraduate, postgraduate, and graduate education; world-class research and a brain-gain to our credit; many worlds’ firsts in research innovation and clinical care; and community, national, and international recognition for many of our faculties.

But, there is more we can do. I want to address a few issues that, in my opinion, need our attention.

Firstly, let’s talk about the diversity of Canada’s future physicians. A recent national medical student survey suggests that current Canadian medical students are different from the doctors that they will replace; but do they reflect Canada’s diversity? They will be older, more frequently married, making different career choices than many of us did.

But they are primarily from higher income families, parents with professional training. Twenty-nine percent of medical students come from families with an annual income of greater than $120,000. Only 4.9% of the population have incomes of that level. While 22.4% of the Canadian population is of rural origin, only 10.8% are medical students. There are still only relatively small numbers from a rural background; in addition, blacks and Aboriginals are under-represented in our medical schools, not to say anything about many other important minorities in Canada. Couple this with, as CFMS has pointed out, admissions requirements that tend to favour students of urban origin and higher income background, and the trend is accentuated. There is still too much emphasis on academic achievement, extra-curricular activities, and an interview. These criteria can disadvantage applicants from lower income and rural backgrounds. Our Future of Medical Education in Canada project has clearly highlighted this challenge with its recommendation to enhance admission processes.

There is some emerging data that suggest that tuition to medical schools is an important determinant of who applies or gets in. From a 2007 national medical school survey that demonstrates the household income quintiles of our students we can see a more even distribution among the different FSA levels in Quebec versus the other provinces. Tuition fees in Quebec have gone up 21% versus 74% outside Quebec since 2000.

One lesson to be taken away is that Quebec, with the lowest tuition fees, has students from a more diverse background in terms of family income. There is relentless pressure to increase tuition fees. I believe that will accentuate trends seen here - we need a new model to support our medical students that does not disadvantage those we want to apply.

A second challenge, as has been aptly put by so many, is to maintain and nurture excellence during a time of growth. First-year enrolment is up 56% since 2000, first-year PGY-1s are up 77% for the same period. Part-time faculty growth has outstripped full-time
CHEC Launches a New Interactive Website

The Association of Faculties of Medicine of Canada (AFMC) is pleased to announce the launch of a new interactive version of the Canadian Healthcare Education Commons (www.CHEC-CESC.ca) web portal to help educators and learners work collaboratively, share pedagogical resources, and network.

The new user-driven site was launched in St. John’s, NL, at the Canadian Conference on Medical Education in May 2010. In the new version, members can upload and share learning objects, maintain virtual libraries and comment on material contributed by their peers. Members can also establish and moderate virtual communities for online collaboration. Each virtual community includes a suite of project management tools including a discussion forum, wiki, blog, file storage, and an event calendar.

The site features a collection of more than 70 virtual patients in the CHEC-CESC Virtual Patient Gallery, 20 active communities and over 500 resources in its shared library.

CHEC is a uniquely Canadian initiative created by AFMC and the 17 Canadian faculties of medicine it represents. CHEC is designed to help increase national and interprofessional collaboration, build capacity for change, improve the use of technology and enhance faculty development and will be a strategic implementation tool to support the recommendations contained in the report: The Future of Medical Education in Canada (FMEC): A Collective Vision for MD Education.

faculty growth and has grown 55% since 1998. Graduate degrees also demonstrate major increases. The increases have been truly dramatic and we cannot but appreciate how they are putting a tremendous pressure on all our resources. Perhaps our largest schools can accommodate these increases. That may not be the case across the entire country, without very careful planning and possibly making choices with regard to priorities, in order to maintain excellence and ensure quality.

One priority may be to look at the number of visa residents that faculties accept and contrast that to the need for capacity in educational space and faculty for our growing number of Canadian graduates, and possibly to accommodate an increased number of IMGs, in particular Canadians studying abroad. We are still taking in more than 100 visa PGY-1s a year, and have more than 700 in all residency training. Fellows, though not a similar potential demand on the system, continue to increase in numbers as well.

Our UGME and PGME programs are distributed more and more into the communities; clinical teachers are increasing in numbers, putting a strain on faculty development, finances, and governance issues. This distribution to the community is, in my opinion, a very appropriate step, but it comes with significant costs.

In the research domain we have expanded revenues at all of our medical schools. However, we need 4 key deliverables for a successful research enterprise – people, infrastructure or buildings and labs, grants from agencies such as CIHR and others, and the support for indirect costs. There are challenges in all these areas – the stability of support and the amount of support are not necessarily assured. We have grown our own talent and have imported talent – how will we nurture them if we don’t have a large enough grant pool they can access? Indirect costs, often at 40% to cover expenses are reimbursed up to 26% and often less. We need to support new infrastructure and refurbish existing infrastructure. How can we assure growth in this environment, all the while maintaining excellence?

A third area I want to discuss with you is that of social accountability. According to the BlueRidge Academic Health Group,

“Academic health centers can address the social determinants of health in five major ways. We can assure that: 1) future health professionals are taught to understand the importance of social determinants of health; 2) through advocacy and public forums, policymakers and the public are fully cognizant of this crucial issue; 3) the social determinants of health become a research priority with academic health centers and their parent universities; 4) patient care is organized by taking in to account how social factors affect health outcomes; and 5) silos are transformed into multi-sector, multi-disciplinary systems wherein teams can help address those regional social problems that impact health.”

It applies to faculties and the broader academic health science centres we have in Canada. It emphasizes the importance of the social determinants of health not only for education, research and clinical care sectors.

Though we have an active, important and highly relevant social accountability movement in Canada that we should be proud of, are we meeting some of these goals? The first FMEC recommendation to Address Individual and Community Needs lays down the challenge clearly.

We have to consider linking social accountability objectives to measurable healthcare and health human resource outcomes and develop a national strategy to articulate roles to achieve these outcomes. We need to encourage students and faculty to work in community advocacy; to listen to and respond to local and regional communities. Even though many of our schools address some of these issues, there is still a perception of
Three new deans to serve on AFMC Board of Directors

Dr. Richard Reznick is Queen’s new dean of Health Sciences and director of the School of Medicine. His five-year term commences July 1, 2010.

He will be appointed full professor with tenure in the Department of Surgery and will serve as the chief executive officer of the Southeastern Ontario Academic Medical Organization (SEAMO).

Dr. Reznick is currently the R.S. McLaughlin professor and chair of the Department of Surgery at the University of Toronto and vice-president, Education, at University Health Network.

He is considered one of the pre-eminent surgical educators in North America and abroad. An accomplished general and colorectal surgeon, his principal academic focus is research in medical education.

Dr. Brian Postl has been appointed as professor and dean, Faculty of Medicine at the University of Manitoba for a five-year term beginning July 1, 2010.

Dr. Postl is a graduate of the University of Manitoba. He received his doctor of medicine degree in 1976 and the Royal College Fellowship in Community Medicine and in Pediatrics in 1981 and 1982, respectively. He is the founding president and CEO of the Winnipeg Regional Health Authority (WRHA), a position he has held since 1999.

Dr. Postl has served as head of pediatrics and child health and as head of community health sciences at the University of Manitoba. He has also served as director of the J.S. Hindes Northern Medical Unit and division of community and northern medicine and as director of the Faculty of Medicine’s community medical residency program.

Dr. Postl’s research, published works and professional involvement focus on Aboriginal child health, circumpolar health and human resource planning. His contributions in these areas, combined with his experience as a visiting pediatrician to communities in northern Manitoba and Nunavut, contributed to him earning the Canadian Association of Pediatric Health Centres’ Child Health Award of Distinction in 2006 and the Inter-Professional Association of Pediatric Health Centre’s Child Health Award in 2007.

Le Dr Rénald Bergeron est nouveau doyen de la Faculté de médecine à l’Université Laval pour un mandat de quatre ans. Ce mandat débutea le 1er juillet 2010.

Rénald Bergeron a passé les 30 dernières années de sa carrière dans le réseau de l’Université Laval à cumuler différentes fonctions en clinique, en enseignement, en recherche et en gestion.


AFMC says goodbye to 5 deans of medicine

In 2010, AFMC will say goodbye to five of its Board of Director members. Pierre Durand, Carol Herbert, David Walker, Dean Sandham and Réjean Hébert will all be stepping down from their positions as deans of their faculty of medicine in June and September 2010. AFMC would like to extend our sincerest thanks to all outgoing deans, their role on AFMC’s board of directors has been critical to the success of the organization and their contributions will be sorely missed. AFMC wishes all five deans all the best in their future endeavours.

L’AFMC dit au revoir à cinq doyens de médecine

En 2010, l’AFMC fera ses adieux à cinq membres de son conseil d’administration : Pierre Durand, Carol Herbert, David Walker, Dean Sandham et Réjean Hébert quittent tous leurs fonctions de doyens de leur faculté de médecine en juin et septembre 2010. L’AFMC tient à remercier sincèrement tous les doyens sortants, leur rôle au sein du conseil d’administration de l’AFMC s’est révélé essentiel dans la réussite de l’organisation et leurs précieuses contributions nous manqueront certainement. L’AFMC souhaite à ces cinq doyens la meilleure des réussites dans leurs projets futurs.
Réflexions
Nick Busing, président-directeur général

L'allocation suivante intitulée « La médecine universitaire - Que pouvons-nous faire de plus? » a été présentée par le Dr Nick Busing dans le cadre de la Conférence canadienne de 2010 sur l'éducation médicale qui s'est tenue à St. John's, T.-N.-L.

Ceux d’entre vous qui me connaissent le savent, j’apprécie le travail bien fait. Cependant, je trouve rarement que nous en fissions assez. Ma réflexion d’aujourd’hui s’inscrit donc dans ce sens.

La communauté médicale universitaire canadienne excelle dans plusieurs domaines –éducation prédoctorale et postdoctorale de qualité exceptionnelle, recherche de calibre mondial, recrutement de cerveaux, plusieurs premières mondiales en matière d’innovations sur le plan de la recherche et de soins cliniques et reconnaissance de plusieurs représentants du corps enseignant au niveau communautaire, national et international.

Nous pouvons cependant faire davantage. Laissez-moi aborder quelques problèmes qui méritent selon moi que nous nous y attaquions.

Parlons tout d’abord de la diversité qui caractérise le bassin des futurs médecins canadiens. Une récente étude menée à l’échelle nationale auprès des étudiants en médecine suggère que ces derniers diffèrent des médecins qu’ils remplaceront. Sont-ils le reflet de la diversité canadienne? Ils seront plus vieux, plus fréquemment mariés et leurs choix de carrière différeront de ceux faits par plusieurs d’entre nous.

Ils proviennent principalement de familles à revenus élevés et leurs parents ont reçu une formation professionnelle. Au total, 29 % des étudiants en médecine proviennent de familles dont le revenu annuel est supérieur à 120 000 $. Seulement 4,9 % de la population affiche des revenus d’un tel niveau. Bien que 22,4 % de la population canadienne soit d’origine rurale, seulement 10,8 % des étudiants en médecine proviennent d’un tel milieu, ce qui demeure un pourcentage relativement faible. En outre, les Noirs et les Autochtones sont sous-représentés dans nos facultés de médecine, sans parler de plusieurs autres importantes minorités au Canada. Si on ajoute à cela, comme le faisait remarquer le SSFC, des exigences d’admission qui ont tendance à favoriser les étudiants d’origine urbaine et provenant de milieux mieux nantis, la tendance s’accentue. On met encore trop l’accent sur la réussite académique, les activités parascolaires et l’entrevue. Ces critères peuvent désavantager les candidats affichant un revenu moindre et provenant d’un milieu rural.


Certaines nouvelles données suggèrent que les droits de scolarité exigés par les facultés de médecine constituent un déterminant important quant à la nature des candidats ou des postulants choisis. Selon les données d’une étude nationale menée en 2007 dans les facultés de médecine du pays et démontrant les quintiles de revenu du ménage de nos étudiants, on peut constater une distribution plus équitable entre les divers niveaux de RTA au Québec par rapport aux autres provinces. Depuis 2000, les droits de scolarité au Québec ont augmenté de 21 % comparativement à 74 % à l’extérieur du Québec.

Une des leçons que l’on doit en tirer est que le Québec, qui affiche les droits de scolarité les moins élevés, accueille des étudiants provenant de milieux plus diversifiés en ce qui a trait au revenu familial. On constate une pression constante pour augmenter les droits de scolarité. Je crois que cette situation accentuera les tendances constatées ici – nous avons besoin d’un nouveau modèle qui, tout en appuyant les étudiants en médecine, ne désavantage pas ceux qui désirent postuler.
Comme plusieurs l’ont si bien dit, le deuxième défi consiste à préserver et à encourager l'excellence en période de croissance. Les inscriptions en première année ont augmenté de 56 % depuis 2000, le nombre d’étudiants en première année d’études postdoctorales a augmenté de 77 % pour la même période. La croissance du corps professoral à temps partiel a dépassé la croissance du corps professoral à temps plein, augmentant de 55 % depuis 1998. On constate aussi d’importantes augmentations quant aux diplômes d’études supérieures décernés. Les augmentations ont été véritablement marquées et force est de constater que cette situation exerce une incroyable pression sur toutes nos ressources. Les facultés les plus grandes sont peut-être en mesure de composer avec ces augmentations. Ce n’est peut-être pas le cas dans l’ensemble du pays où il conviendra de procéder à une planification très conscienceuse et peut-être faire des choix relativement aux priorités, afin de préserver l’excellence et d’assurer la qualité.

Parmi les priorités, il faudra peut-être étudier le nombre de résidents détenteurs d’un visa qui sont acceptés par les facultés et comparer cette donnée au besoin relatif à la capacité liée à l’espace pédagogique et au nombre d’enseignants relativement au nombre grandissant de diplômés canadiens, et possiblement tenir compte d’un nombre accru de DHCEU, en particulier des Canadiens étudiant à l’étranger. Nous acceptons toujours plus de 100 stagiaires de première année d’EMPô détenteurs d’un visa par année et on en compte plus de 700 dans l’ensemble du programme de résidence. Le nombre de boursiers, bien qu’ils n’exercent pas une demande potentielle similaire sur le système, continue également à augmenter.

Nos programmes d’EMPô et d’EMPo sont de plus en plus décentralisés afin d’être offerts au sein des collectivités. Le nombre d’enseignants cliniques augmente, ce qui exerce une pression sur la formation professorale, les finances et les questions de gouvernance. Bien qu’elle constitue selon moi une mesure très appropriée, cette distribution dans la collectivité s’accompagne de coûts importants.


Je tiens maintenant à aborder la question de l'imputabilité sociale. Selon le Blueridge Academic Health Group, « il existe cinq manières pour les centres de santé universitaires de traiter des déterminants sociaux de la santé : 1) On enseigne aux futurs professionnels de la santé à comprendre l’importance des déterminants sociaux de la santé. 2) Grâce à des initiatives de défense des droits et intérêts et de forums publics, les décideurs et le public sont totalement conscients de cette question cruciale. 3) Les déterminants sociaux de la santé deviennent une priorité de recherche des centres de santé universitaires et des universités mères. 4) Les soins aux patients sont organisés en tenant compte de la façon dont les facteurs sociaux influent sur les résultats en matière de santé. 5) Les structures traditionnelles sont transformées en systèmes multi-sectoriels et multi-disciplinaires au sein desquels des équipes peuvent se pencher sur les problèmes sociaux régionaux ayant une incidence sur la santé. »

Cela s’applique aux facultés et aux centres de santé universitaires canadiens dans leur ensemble et met l’accent sur l’importance des déterminants sociaux de la santé, non seulement pour les secteurs de l’éducation, mais également pour ceux de la recherche et des soins cliniques.
Bien qu’il existe au Canada un important mouvement d’imputabilité sociale actif et hautement pertinent dont nous devons être fiers, réussissons-nous à atteindre certains de ces objectifs ? La première recommandation du projet sur l’AEMC qui nous encourage à répondre aux besoins individuels et communautaires pose clairement les bases de ce défi.

Nous devons songer à lier les objectifs en matière d’imputabilité sociale à des résultats mesurables en matière de soins de santé et de ressources humaines en santé et à élaborer une stratégie nationale visant à articuler les rôles qui nous permettront d’atteindre ces objectifs. Nous devons encourager les étudiants et les enseignants à œuvrer dans le domaine de la défense des droits et intérêts communautaires, à être à l’écoute des collectivités locales et régionales et à répondre à leurs besoins. Même si plusieurs de nos facultés traitent de ces questions, la perception voulant que les facultés de médecine exercent leurs activités dans une tour d’ivoire perdure. On croit aussi volontiers que seuls les jeunes étudiants en médecine idéalistes font preuve d’engagement envers la collectivité locale. Les principaux membres de notre corps enseignant doivent prendre part à ce processus.

En terminant, je tiens à mentionner une question qui semble de plus en plus importante aux États-Unis et qui mérite que nous nous y attardions au Canada. Comme le faisait remarquer mon prédécesseur, le Dr David Hawkins, dans le JAMC en 2005, « les 17 facultés de médecine canadiennes possèdent toutes des politiques sur les conflits d’intérêt pour leurs membres qui dictent ce qui est acceptable et ce qui ne l’est pas en ce qui a trait aux relations avec l’industrie. Cependant, il n’existe aucune norme nationale de déclaration des conflits d’intérêt au niveau de l’éducation médicale prédoctorale. En notre qualité d’organisme national, on ne nous a pas demandé de traiter de la question. En l’absence de normes nationales, les politiques varient de façon marquée. »

Nous devons nous pencher sur les questions de conflits d’intérêt. Peut-être dans un sens plus large pouvons-nous parler de l’aspect moral de notre milieu, que ce soit en ce qui a trait à l’éducation, à la recherche ou aux soins cliniques. Les conflits d’intérêt peuvent exister dans toutes les sphères de nos activités et dans tous les milieux – scéne d’apprentissage en petit groupe, hôpital universitaire, laboratoire de recherche, activités de formation professionnelle continue et ainsi de suite. Luttons-nous contre ces questions potentielles de conflits d’intérêt ? Quel rôle de leadership la médecine universitaire joue-t-elle ? Agissons-nous toujours d’une manière moralement au-dessus de tout reproche, et créons-nous un milieu d’apprentissage pour les étudiants en médecine et les chercheurs qui représente une relation positive et saine avec l’industrie, une relation qui reflète des valeurs partagées, du respect et de la collaboration, sans influence ou pression indue (subtile ou non) ?

Durant l’année qui vient de s’écouler, l’AFMC a adopté les directives de l’AAMC relatives au traitement des conflits d’intérêt dans les facultés de médecine. Ces directives doivent être interprétées et mises en pratique, et c’est ce qui commence à se produire dans l’ensemble du Canada. Comment les hôpitaux universitaires traitent-ils la question, ou s’y attendent-ils vraiment ? Comment le milieu de la FPC et les bureaux de FMC de nos universités pourront-ils survivre si nous réduisons de façon marquée l’appui fourni par l’industrie ? Nous devons nous pencher sur ces questions et sur ces relations.

Donc, en résumé, je pense que parmi la liste des défis qui s’offrent à nous, nous devons nous concentrer sur 1) l’élargissement de la diversité au sein du bassin d’étudiants en médecine, 2) la poursuite de l’excellence en période d’expansion rapide, 3) l’atteinte de la véritable imputabilité sociale et 4) le fait de nous attaquer à des questions sérieuses comme le comportement éthique au sein des communautés de recherche, d’éducation et de pratique. En réalisant des progrès relativement à ces enjeux, nous accroîtrons la transparence, le degré de coopération et, avec de la chance, le caractère mesurable de l’engagement de la médecine universitaire envers nos collectivités.

Vous trouverez cette présentation, ainsi que les diapositives qui l’accompagnent, à l’adresse suivante : http://www.afmc.ca/about-ceo-f.php
Welcome to our faculties

Irving Gold, Vice President, Government Relations and External Affairs

This is an edition of Gravitas I have wanted to produce for a long time. Ever since I began at AFMC, about three and a half years ago, I have been amazed at the incredible complexity and the breadth of activities conducted in, and by, our faculties of medicine. I have also become convinced that relatively few people have a true understanding of how faculties of medicine function and the numerous areas in which they contribute to Canadian society.

In my advocacy role at AFMC, I have frequent discussions with members of parliament, senators, senior bureaucrats, policy development staff, and others. These discussions revolve around medical education, our social accountability activities and vision, health human resources, science and technology and the importance of investments in health and biomedical research in this country.

Over the years, I have come to realize that virtually everyone has some form of preconceived notion of what a faculty of medicine is about, and these notions are almost always incomplete. One of the prevailing visions is of faculties of medicine as simple academic departments in universities charged with training physicians. This vision ignores the important role faculties of medicine play in health and biomedical research, innovation, clinical care, and other areas.

I did not come from the world of medicine, and I, like so many others, had such an incomplete understanding of our faculties when I began my work here. I also did not quite appreciate the fact that when you’ve seen one faculty of medicine, you’ve seen one faculty of medicine. I have visited most of our faculties, and have become convinced that in order to really bring our collective voice to bear on public policy issues, one of our greatest challenges remains educating those we wish to influence about who we are and what we do.

This special issue of Gravitas, therefore, is a first step in this process. To provide an accurate glimpse inside our faculties of medicine, we would need to write a very long book. Still, it is our hope that the submissions in this issue will give readers a sense, if you don’t already have one, of the myriad of activities our faculties are involved in. We hope you enjoy this special issue of Gravitas, and would be happy to receive any feedback you may care to offer. As always, I can be emailed at: igold@afmc.ca.
The Deanery  Carol P. Herbert, Dean, Schulich School of Medicine & Dentistry, University of Western Ontario

A Day in My Life

Today has been a fairly typical day. It began with a 7:00 am meeting with surgical colleagues, so they could get to the OR for their first case, followed by a weekly meeting with one of my associate deans. Then, there were three annual probationary faculty reviews, mandated by the Collective Agreement to ensure tenure-track faculty are progressing appropriately – there are more than 40 such interviews this time of year, split between myself and the associate dean of basic science academic affairs. An annual career development meeting held by the integrated hospital vice president of medical affairs and I, with one of the chair/chiefs took the next hour, followed by a noon-hour video-conference meeting between our regional assistant deans and the education decanal group in London. One small comfort: there are sandwiches at the London site!
Between these meetings I reviewed e-mail messages, dealing with as many as possible on the spot and retaining those that required more deliberate response. I get about 150 e-mail messages daily, many of them “for information” only, but all needing at least a quick look.

In the afternoon, time for a meeting with my executive assistant to review my upcoming schedule, another with the associate directors of finance and human resources to sort out some hiring issues and deal with the usual budgetary challenges, then travel to an academic hospital site for a board meeting. After the board meeting, I went back to the dean’s office to deal with snail mail and e-mail, then home at 7:00 pm with a brief case full of materials to read for tomorrow’s meetings.

My very supportive husband had gone to the grocery store, so dinner didn’t take long to prepare. At least we have no children living at home, so we don’t have that additional pressure. Some nights we just go out to a restaurant, so we can visit while someone else does the cooking and clean-up. Of course, once or twice a week there is an evening social event related to work; sometimes partners are invited, sometimes not.

Tonight, I fit in 30 minutes on the stationary bike, before doing my homework (exercise tends to be the activity that gets ‘bumped’ during week days, so I am proud of myself). I finish left-over e-mail and my prep for tomorrow, and then skim the current issues of New England Journal, CMAJ, and Academic Medicine. I manage to read a few pages in my current novel before turning out the light.

Some days, I have more meetings on campus, with the provost, vice president of research, or dean of another faculty. Other days there are more hospital or research centre or institute meetings – my exercise regimen includes walking briskly to get to meetings on time, and using the stairs as much as possible. And other days, there is lunch with a potential donor or a named lecture to attend. I haven’t mentioned the days on the road, with some six weeks of work-related travel annually. Luckily, I like traveling and sleep easily on a plane, though I relish the time to read and reflect when no one can ‘get’ to me.

My best days include time with students, teaching a small group or reviewing a graduate student’s work, and sometimes I get to spend time wrestling with my own data, but mostly that’s at night or on weekends. I look forward also to those strategic days when I work with my colleagues to vision and plan how to build our research, educational, and clinical capacity as an academic health sciences network.

My best days include time with students, teaching a small group or reviewing a graduate student's work.

Overall, with the help of outstanding colleagues and staff, I have been successful in experiencing each day as a challenge to enjoy, rather than as a chore to endure.

Carol Herbert is dean of the Schulich School of Medicine & Dentistry at the University of Western Ontario and professor in the departments of family medicine and pathology. She was formerly head of the UBC Department of Family Practice, founding head of the Division of Behavioural Medicine, and a founder of the UBC Institute of Health Promotion Research. She was a pioneer in developing services for sexually abused children and co-founded the Sexual Assault Service for Vancouver. She has conducted participatory action research with Aboriginal communities, focused on diabetes and on environmental effects on human health. Other research interests include interprofessional education and patient and physician decision-making. She is a recognized leader in women's health and mentorship of academic women. She is a Fellow of the Canadian Academy of Health Sciences and foreign associate member of the Institute of Medicine.
or everything you wanted to know about accreditation but were afraid to ask!

Linda N. Peterson, Senior Evaluation Associate, Faculty of Medicine, University of British Columbia Assistant Secretary, Committee on Accreditation of Canadian Medical Schools

Depending on whom you ask, accreditation has been described as being as pleasant as a root canal or as a significant force in maintaining and improving the quality of our Canadian medical education programs. Read on if you would like to know more about the history and process and why it is important to you.

The first review of 155 North American medical schools was conducted by Flexner in 1910 and included the eight existing Canadian medical schools. The report was glaringly candid and lead to major improvements in the quality of medical education.
Of the five schools that Flexner rated as excellent, two of them were Canadian i.e., McGill and the University of Toronto! The main outcome of the Flexner report was the establishment of the fundamental importance of the scientific basis of medical practice. There was an increase in admissions and graduation requirements and a move toward the affiliation of medical education programs with university degree granting programs. By 1920, all Canadian medical schools had a “Class A” rating which was earned by affiliation with a university. However, accreditation as we know it today did not exist.

In 1943, in response to the request of the government to increase the number of physicians to meet the demands of the war effort, the Canadian deans formed the Association of Canadian Medical Colleges (ACMC), now known as the Association of Faculties of Medicine of Canada (AFMC). The major concern was the potential decline in the quality of the medical education programs due to the acceleration of training to produce more physicians. Similar problems were facing medical schools in the United States. Within months of the bombing of Pearl Harbor, a joint board for conducting medical school surveys was created by its two parent organizations i.e. the American Medical Association and the Association of American Medical Colleges to avoid duplication of efforts. Subsequently, the joint survey board was named the Liaison Committee on Medical Education (LCME) and its membership was later expanded to include one ACMC member. Canadian medical schools were reviewed by the LCME but not regularly until 1952. At this time, concern was voiced that the ACMC should assume more responsibility in determining the standards which apply in Canada. However, Canadian schools continued to be accredited only by the LCME until 1979 when the Committee on Accreditation of Canadian Medical Schools (CACMS) was created. CACMS was established by its two parent organizations, the Canadian Medical Association (CMA) and the ACMC.

The creation of CACMS by the ACMC deans was seen as necessary given the recent introduction of our universal healthcare system. Even at that time, the linkage between the societal needs and the medical education programs in Canada was seen as significantly different compared to the situation in the United States. From 1979 until the present, Canadian schools have been accredited by both the LCME and CACMS using a joint process (http://www.afmc.ca/education-cacms-e.php and www.lcme.org).

Currently, the voting membership of CACMS is similar to that of the LCME in having individuals appointed by the two parent organizations: 4 AFMC and 4 CMA, 4 students (2 Canadian Federation of Medical Students and 2 Federation of Medical Students of Quebec), 1 member of the LCME (co-chair) and 2 public members. The chair of the CACMS is a voting member of the LCME. The CACMS and the LCME meet three times per year about one week apart and make independent decisions regarding the accreditation status of the medical education programs. The members of the accreditation committees can not consult on matters of accreditation. Each of the accreditation committees has a secretariat staff that provides survey team training, develops educational materials for schools, students and surveyors, organizes and implements survey visits, conducts fact-finding visits, and mandated and requested consultation visits and communicates the decisions of the committees. The secretariat does not participate in the decision-making process and can provide consultation support to the medical schools on all matters related to accreditation.

Accreditation is the responsibility of a self-regulating profession. CACMS and LCME accreditation is a standards-based, peer review process of continuous quality assurance/improvement of the function, structure and performance of a medical education program. In order for a medical education program to achieve and/or maintain their status as a CACMS and LCME accredited program,
the faculty must provide evidence that the requirements of 128 standards are met. The standards describe the requirements for the institutional setting such as

**Institutional Standards:** strategic planning, residency and graduate degree programs, and the relation between the faculty of medicine and the university;

**Education Standards:** the educational objectives, design, content and management of the curriculum, and evaluation of the educational program;

**Medical Student Standards:** the requirements for admission of medical students and their support;

**Faculty Standards:** the faculty; types and numbers, appointments and support; and

**Educational Resources Standards:** the required educational resources: physical space, clinical facilities, libraries and newly added standards related to IT and Informatics.

The standards are jointly embraced by both countries and collaboratively revised. The standards continue to evolve reflecting changes in healthcare delivery, societal needs, population demographics, and the findings of educational research. The most recent version of the standards will be found on the website of the LCME in mid-June and is entitled: *Functions and Structure of a Medical School* (LCME 2010). In order to pursue residency training in Canada, students must be graduates of accredited medical education programs in Canada or the US. There are important reasons for Canadian faculties of medicine to be diligent in maintaining their accreditation status.

Canadian schools are now accredited for an eight-year cycle. Approximately 1.5 years before the scheduled onsite full survey visit, the school begins its formal preparation for the visit. This is referred to as the Institutional Self Study (ISS). The faculty reviews the program for compliance with accreditation standards. Normally over 100 faculty members and a large number of administrative personnel and several medical students participate in the ISS. The faculty also completes the Educational Database which is a mirror image of the standards. The database can be viewed as a translation of the standards and provides the evidence that is analyzed by the external survey team that reviews the program’s compliance with the standards. At the same, there is a parallel self-study conducted by the medical students. The Independent Student Analysis is a comprehensive report written by students based on the results of an extensive survey conducted about 12 months before the survey visit. Students identify what they value most about the school and evaluate topics ranging from the format and quality of teaching, examinations and marking systems, demands of clinical training, quality of classrooms, study and relaxation space, lockers, counseling support (personal, academic, financial), financial aid, and mistreatment. The faculty normally receives the Independent Student Analysis and considers the findings of the students in formulating the ISS report. The school reviews itself to gauge compliance with the standards, and identifies areas of strength. The faculty outlines its plans to address the noted deficiencies and resolves as many as possible before the onsite survey visit. The ISS Report is usually widely shared with faculty, administrative personnel and medical students prior to the survey visit.

The credibility of the accreditation process depends on the quality and composition of the peer-review survey team. The team must collectively possess the content and contextual expertise to review all of the standards and have expertise in the accreditation process. Each Canadian medical school is reviewed by a survey team normally consisting of at least 1 member appointed by the LCME, 1 member of CACMS, 1 student member of CACMS, and 2-3 faculty members from the AFMC. The chair of the survey team is normally a current/former dean, or vice dean of education. The other team members hold faculty positions of significant responsibility in a MD educational program in another Canadian faculty of medicine. Surveyors are trained and receive graded responsibility based on their experience. The survey team is recruited 12 months before the survey visit date. Before the onsite visit, each team member reviews the school’s past accreditation history to note previously identified areas of partial and non-compliance and all the follow-up reports and limited visits meant to address them. The reviewers study the ISS and the Independent Student Analysis, and the accompanying Educational Database. The secretary of the survey team assigns portions of the final report to individual members.
of the team. The team member then assumes responsibility to review the school with respect to the related standards in great detail including drilling down into the database for an evidence-based approach to the analysis. The team writes one survey report that will be reviewed independently by CACMS and the LCME.

The purpose of the 3.5 day onsite visit is for the survey team to answer questions regarding compliance with standards raised by the ISS, the Independent Student Analysis and the Medical Education Database. The survey team follows a report writing guide and ensures that the report contains all the information needed by the accreditation committees to determine if the program meets all of the requirements of the standards. The team meets with the dean, university, hospital and faculty leadership, course and clerkship directors, students, department heads, junior faculty, library and educational resource administrators. The team verifies information and impressions present in the documentation provided by the school. At the end of each day of meetings, the team works for several hours to construct the exit document “Summary of the Survey Team Findings”. This document lists the strengths of the school which should be recognizable at the national and international level. These are not just “apple pie and motherhood” statements but would be practices or processes related to the achievement of compliance with standards that are worthy of emulation. The summary also includes the areas of partial or non-compliance (standards where the requirements are not fully met), and areas in transition. Areas in transition are changes that are occurring in the program, the faculty of medicine or externally that may affect the school’s ability to remain in compliance with the standards. An example would be a change in admission requirements (may admit students who are unable to meet the performance standards), or an expansion in the number of students (may exceed classroom space, clinical training capacity, etc). On the last day of the onsite visit, the survey team meets with the dean and the university vice president or provost and reads the Summary of Findings. The dean is informed that the CACMS or the LCME may not agree with the team findings. The team report of the survey visit will be sent to the dean in about 6 weeks which the school can review for factual content and tone.

After the visit the survey team writes the Survey Report which is sent to the Secretariats of CACMS and the LCME (very experienced in accreditation matters) for feedback. Over the years, the CACMS and the LCME have moved to better define the standards, and provide clearer directions to the surveyors to ensure the process is evidence-based. Each area identified by the survey team must be linked to a standard (explicitly in the summary of the Survey Team Findings) and the report must provide documentation that an objective reviewer would judge as sufficient to support the claim of partial or substantial non-compliance. The draft is revised and sent to the dean of the medical school to note corrections and any concerns s/he may have about the tone of the report. The team considers the revisions and then sends a final report to the dean and the LCME and CACMS. The dean is informed that she/he should communicate in writing to the secretariats of the CACMS and LCME any remaining concerns about the tone or factual content of the report. This letter is appended to the survey report and considered in the review by both accreditation committees.

The reports and any correspondence from the dean are considered by both the CACMS and the LCME. Two members of each committee receive the survey report and review the team findings and the documentation of evidence. They can add/remove items from any part of the summary. It is not uncommon that some of the strengths noted by the team are not retained by the accreditation committee. The reviewers may find other areas of non-compliance and areas in transition not identified by the survey team. Items can be removed from these lists too,
but that is less common (most of that is addressed by the pre-review by the secretariats). The reviewers recommend whether and for what term, accreditation status should be continued, and the nature of any follow-up reports or visits.

Each accreditation committee can also recommend the addition or removal of strengths, areas of partial or substantial noncompliance and areas in transition. After full discussion of the report and the reviewers' recommendations, each committee votes on the accreditation decision and necessary follow-up.

In the past, the separate decisions of the CACMS and the LCME were communicated to the dean of the school. It was confusing for Canadian schools to receive separate decisions and requests for follow-up which frequently addressed different issues. As of 2007, the CACMS and the LCME developed a reconciliation process such that each Canadian school now receives only one accreditation decision and required follow-up. The independent recommendations of both committees are considered and reconciled by the secretariats using a process agreed upon by both committees. The reconciled decision includes the areas of noncompliance identified by each committee and reflects the most conservative action and most comprehensive follow-up which is communicated in a single consolidated letter of accreditation. It should be mentioned that every medical school accredited by the CACMS and the LCME is cited for areas of partial or non-compliance i.e. there is no “perfect” medical school. Deans, especially new deans, and the faculty need to be reassured of this and the message that accreditation is a quality improvement process.

The CACMS and LCME accreditation process is summative in nature i.e., like a final exam constitutes a pass/fail decision. Although the school receives valuable feedback on the program, the areas of noncompliance must be resolved within 2 years. Failure to achieve compliance results in a more adverse decision by the accreditation committees. The deans were concerned about the number of standards that our schools are being cited for noncompliance and the type and frequency of follow-up by the accreditation committees. The AFMC Council of Deans Advisory Committee struck a Working Group on Accreditation which over the last 2 years created a new formative process called the AFMC Interim Accreditation Review Process. The information obtained through the formative process is entirely for the benefit of the school and no information is provided to either accreditation committee. Each dean has chosen a faculty member to serve as the Interim Review Coordinator (IRC). The IRC will be a permanent member of the curriculum oversight committee and will report to the most senior education dean. The IRC will be kept current with changes in standards and the accreditation process and organize a systematic ongoing review of the standards using newly developed checklists. Another hallmark of the new process is an Interim Accreditation Survey which will be held at the four-year mid-point between the CACMS and LCME survey. The new Interim Accreditation Review Process is easier for the school to implement and will help prepare the school for formal CACMS/LCME surveys. The IRC were introduced to their new role in a workshop held at the CCME. Further training organized by the secretariat of CACMS is planned.

As noted in several previous articles in Gravitas, accreditation has been identified as leverage to help schools move ahead in meeting the recommendations of the Future of Medical Education in Canada. It is likely that an informal process will be used at first followed by a more formal process linked to accreditation in the near future.

Linda Peterson, PhD serves as the Assistant Secretary to the Committee on Accreditation of Canadian Medical Schools. She is also an adjunct professor in the Department of Cellular Physiological Sciences, and a senior evaluation advisor of the Evaluation Studies Unit in the Faculty of Medicine at the University of British Columbia (UBC).

Prior to taking on these positions, she was a full professor in the Faculty of Medicine at the University of Ottawa for 23 years and was undergraduate dean of education from 1997-2005. In addition to participating in the Harvard Macy Scholar Course for Leaders in Medical Education, she recently fulfilled the requirements of a Masters of Education in Adult Education in the UBC Faculty of Education. Dr. Peterson completed her PhD in Renal Physiology at Yale in 1975; postdoctoral training in the Renal Division at the University of Colorado in Denver; and a sabbatical in the Renal Division at Harvard University in 1995. She has had a productive 25 year career in biomedical research while developing her career in medical education. She has been active in the accreditation of medical schools since 2003 and served on the CACMS committee for 6 years.
Célébrations : Une année dans la vie d’un doyen du niveau prédoctoral

Geneviève Moineau, doyenne associée, Éducation médicale de premier cycle, Faculté de médecine, Université d’Ottawa
Membre, Comité permanent de l’AFMC sur l’enseignement médical prédoctoral

Le degré d’exhaltation est palpable et l’attente est à son paroxysme en ce premier jour d’école. « Nous vous souhaitons la bienvenue à la faculté de médecine! » À mesure que les étudiants sont présentés au reste de la classe, je croise les doigts en espérant que notre processus d’admissions a permis de correctement identifier les candidats possédant un solide profil cognitif et les attributs non cognitifs nécessaires à leur succès, tant sur le plan de la formation que de la pratique. Car laissez-moi vous le dire, une fois qu’ils sont acceptés, il est difficile de leur demander de partir. Je le sais, j’ai essayé.

Vient ensuite la cérémonie de la blouse blanche, lorsque le doyen accueille chaque étudiant comme membre junior de la profession. Plusieurs facultés misent sur de tels événements pour insister sur l’attention croissante qui est accordée au professionnalisme dans toutes nos facultés de médecine.

Passons maintenant au programme d’études, un élément « mineur » devant faire l’objet d’un examen majeur, ce que plusieurs d’entre nous viennent de faire, sont en train de faire ou se préparent à faire. Nous sommes heureux de pouvoir maintenant bénéficier d’un ensemble de recommandations découlant du projet sur l’Avenir de l’éducation médicale au Canada qui nous permettent d’orienter notre travail. La planification constitue le volet agréable de l’entreprise, mais nous devons aussi gérer le travail d’élaboration des politiques et le travail du comité relativement aux modifications et à leur mise en œuvre. Pour vous donner une idée de la tâche, avez-vous déjà effectué des rénovations majeures à votre domicile pendant que vous y viviez avec de jeunes enfants?


À mesure que nous guidons nos étudiants dans le cadre de leur apprentissage, nous collaborons également avec nos collègues des Affaires étudiantes afin de fournir aux étudiants des services d’orientation professionnelle et de les
Nous sommes heureux de pouvoir maintenant bénéficier d'un ensemble de recommandations découlant du projet sur l'Avenir de l'éducation médicale au Canada qui nous permettent d'orienter notre travail.

aider à se préparer au processus du Service canadien de jumelage des résidents (CARMS). Nous appuyons ceux qui ne réussissent pas dans la première ronde et les aidons très rapidement à se redéfinir.

Chaque année, nous passons, pour la plupart d'entre nous, un temps incroyable à tenter de satisfaire aux quelques 130 normes d'agrément établies par le LCME/CAFMC, à soumettre des rapports écrits et à accueillir des équipes d'évaluateurs dans le cadre de visites complètes ou abrégées. Si jamais vous cherchez le doyen des études prédoctorales pendant quelques jours et que vous n'arrivez pas à le trouver, c'est qu'il s'est enfermé dans une pièce pour se préparer à l'échéancier relatif au processus d'agrément... L'établissement de relations avec tous les principaux membres de la faculté, y compris les présidents des divers départements, est le seul moyen d'accomplir le travail.

Ensemble, avec nos doyens respectifs, nous sommes en communication constante avec nos gouvernements provinciaux concernant divers enjeux comme le nombre d'étudiants et le financement de nos programmes d'études médicales prédoctorales. L'augmentation du nombre d'étudiants, qui nécessite la création de nouvelles installations d'apprentissage, notamment de campus satellites, est devenue l'une des principales préoccupations de plusieurs facultés.

La possibilité de rencontrer deux fois l'an nos homologues de l'ensemble du pays, de partager nos connaissances et d'apprendre les uns des autres constitue l'un des aspects les plus agréables de notre travail. Nous formons un groupe collégial et amical au sein duquel la collaboration est excelente relativement aux questions les plus difficiles.

Et avant même que nous nous en rendions compte, c'est le temps de la célébration finale de l'année, la remise des diplômes. Même si j'ai assisté à plusieurs de ces cérémonies, je suis toujours émue d'entendre le nom de chaque diplômé précédé du titre de docteur. C'est pourquoi nous faisons ce métier. Pour avoir le privilège d'exercer une influence sur les étudiants à qui nous enseignons, sur ce qu'ils apprennent et sur qui ils deviennent. C'est ainsi que nous contribuons à la société et à la profession.

Et le jeu en vaut totalement la chandelle. 

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Geneviève Moineau a obtenu son Baccalauréat ès sciences en biologie et son doctorat en médecine de l'Université d'Ottawa. Elle s'est formée en pédiatrie à l'Université de Toronto. Elle est titulaire d'un certificat et est Associée du Collège royal des médecins et chirurgiens du Canada en pédiatrie, ainsi que de l'American Board of Pediatrics en médecine d'urgence pédiatrique. Elle a travaillé en médecine d'urgence pédiatrique à l'hôpital des enfants de Toronto (the Hospital for Sick Children), puis au Mott Children's Hospital à Ann Arbor, au Michigan, et travaille présentement au Centre hospitalier pour enfants de l'est de l'Ontario à Ottawa. En 2005, elle a été nommée doyenne associée, Études médicales de premier cycle à la Faculté de médecine de l'Université d'Ottawa. Ce nouveau rôle lui a permis de devenir une agente de changement pour les étudiants et les professeurs cliniques. Cette année, elle a été présidente du comité du programme scientifique de la Conférence canadienne sur l'éducation médicale.
The assistant or associate dean (titles vary between universities) of postgraduate medical education (or the PG dean) is responsible for all activities related to postgraduate medical education in the faculty of medicine. This includes training programs for both residents and fellows. It may appear to most that PG deans attend many meetings and spend most of their time dealing with challenging issues faced by programs, residents and faculty. This is certainly true but not the complete picture.

The PG dean is in a unique position to interact with many different groups including their own deanery, the two accrediting colleges (Royal College of Physicians and Surgeons of Canada and College of Family Physicians of Canada), the Association of Faculties of Medicine of Canada and provincial ministries of health as well as the provincial regulatory bodies. The position interacts widely within the university as well as the health care facilities that help train residents and fellows. PG deans are often asked to assist chairs of departments to understand the licensing requirements for our provincial colleges (regulatory bodies). Both the Academic Health Sciences Centers (AHSC) and the non-AHSC’s are critical to postgraduate training.

Ensuring that accreditation standards are met within these environments can be challenging and time consuming. Although a PG dean deals with the systems that train residents and fellows, they also have an instrumental role in meeting societal needs for the delivery of health care. Planning the appropriate mix of specialties often spans 15 years in the future.

As medical education becomes more and more distributed and moves out of the traditional training settings, preceptor development and institutional awareness are critical. These regional sites have historically been used for elective experiences but now are contributing to core rotations. Adherence to accreditation standards as well as the resident association’s collective agreements is critical. Educating our provincial ministries concerning the front line activity within the healthcare system is an important but challenging facet of the PG dean position.

The PG environment lacks flexibility at times and has evolved to be a multilayered and tortuous environment. The postgraduate language (and its abbreviations) is complex with many nuances. PG deans’ strive to streamline the present system.

So, why do this job? Well, what a PG dean really does is assist people – whether they be hospital administrators, residents, medical students, or deans of medicine. It is gratifying and rewarding to see new programs develop; well established programs overcome challenges and overall, improve the training environment for residents. Interactions with exceptional people such as our residents and program directors make the position exciting and stimulating – and this is perhaps the most important reason why the postgraduate deans’ role is the best job in the faculty of medicine within a university.

Mark Walton has been involved in medical education since 1993 when he became part of the faculty at McMaster University as a pediatric general surgeon. He is a professor of surgery and the assistant dean of postgraduate medical education since 2004. Prior to this he was the general surgery program director, from 1999 to 2004, at McMaster University. He is presently the chair of both the Postgraduate Management Committee for the Council of Ontario Faculties of Medicine (PGM:COFM) and the AFMC Standing Committee on Postgraduate Medical Education. He is a member of the accreditation committee (and its steering committee) of the Royal College of Physicians and Surgeons of Canada and has participated in numerous accreditation visits as both a surveyor and deputy chair. Dr. Walton’s professional interests include mentoring medical educators and residents, developing systems for health human resource planning and the costing of PG education. In addition, he has an active clinical practice in pediatric general surgery.
Continuing Professional Development: Where does it belong?

For years the words “Continuing Medical Education (CPD)” have conjured up a room full of physicians taking time from their practices to hear lectures on the latest exciting discoveries in medicine, and then returning to their practice to put one or two “pearls” of information into action.

Over the last twenty years the focus, and identity, of these activities has widened, stressing CPD as a professional responsibility to meet the needs of patients and to provide a feedback loop into the physician training programs in order to better prepare graduating physicians for the needs of current practice.

It may have been true in the days before the blossoming of the information age to believe that “All I will ever need to know I learned in medical school” but in the current climate of continuing research, new treatment options, and widespread community education, this is no longer a tenable belief. That echoes of this belief may still persist may be due to this persisting stereotype, but a review of the true range of CPD should lay this to rest.

CPD concentrates on continually building upon the skills acquired in medical school, the translation of new knowledge into changed actions, and assisting physicians to learn how to learn. The role of group learning in conferences or workshops persists in that it draws physicians together to learn with, and from, each other and forms the support network which is essential to maintaining competence. However, societal and technological changes have made possible wonderful new opportunities.

As the pace of practice life becomes more hectic, physicians turn to home- or office-based self-directed learning by way of reading or on-line programming. It is estimated that in 10 years 50% of CPD will be accessed on-line, asynchronously, and in very small bites, even fractions of hours. The knowledge of where to seek information will in part replace the skill of remembering facts which will rapidly change. The concept which may not be fully appreciated as yet is that of ongoing self-assessment, an expansion of the peer assessment available in some settings, into the use of validated tools to review individual practice, identify educational needs and accept responsibility to seek needed knowledge.

The critical truth to remember in all of these CPD opportunities is the source from which the education springs. It must be valid, reputable, guided by learning principles related to the style of learning it uses, as well as have clinical relevance, amenable to evaluation in terms of outcomes in change of care delivery as well as satisfaction with the learning process, and above all, congruent with the learning process begun in undergraduate and postgraduate life, with all the cross pollination of ideas which this facilitates.

CPD is indeed a critical ongoing part of medical education, and universities abandon it at our peril.

Penny Davis is currently the assistant dean of continuing professional learning in the College of Medicine at the University of Saskatchewan. She received her undergraduate training from the University of Birmingham in England and she graduated in medicine 1971. She received her postgraduate diplomas in paediatrics and obstetrics and gynaecology in 1972-3. Her academic appointments include clinical assistant professor for the Department of Academic Family Medicine; clinical lecturer for the Department of Obstetrics, Gynecology and Reproductive Sciences; and director of Continuing Professional Learning in the College of Medicine at the University of Saskatchewan.
The Role of Research in Canadian Faculties of Medicine

Penny Moody-Corbett, Associate Dean, Research and Graduate Studies, Faculty of Medicine, Memorial University of Newfoundland
Chair, AFMC Standing Committee on Research and Graduate Studies

Canada is home to 17 faculties of medicine recognized for training world-class medical doctors. These faculties play a major role in the research activities of our universities and contribute not only to the global expansion of the knowledge in health and biomedical sciences, but are also the drivers behind the application of this knowledge to improve clinical care and healthcare delivery. An example of this research energy is the recent report on a potential therapy for glioblastoma brain cancers from a group of medical researchers, lead by Dr. Evangelos Michelakis, in the Faculty of Medicine and Dentistry, at the University of Alberta (Science Translational Medicine, 2, 31-34, 2010). The work demonstrates the importance of fundamental discovery research from animal models to application in a clinical population. Although still early stage, the results have the potential to alter the course of one of the deadliest human cancers. Every faculty of medicine in Canada can report remarkable examples of research making critical differences in our understanding of health, medicine and disease and providing major contributions world-wide for more appropriate treatments and therapies.

The goal of research in our faculties is to generate new knowledge in all areas of health; disseminate this information through scientific and academic publications and translate the information to application in healthcare delivery and health policy. The traditional fields of biomedical discovery research and clinical trials are now integrated in the broader field of health, healthcare delivery, health policy and community and population health. Researchers in Canadian faculties of medicine are not only leaders in fundamental discovery research such as the groundbreaking work on neural stem cells or the sequencing of the SARS virus but are also involved in unique large-scale Pan-Canadian research programs of interdisciplinary teams such as the Canadian Cardiovascular Outcomes Research Team or the Canadian Longitudinal Study on Aging. These research endeavours require infrastructure, state-of-the-art resources and highly-skilled health research staff, all of which requires financial investment. In 2008-09 over $2B from public and private sources and provincial and federal governments was invested to support research in the faculties of medicine.

The research programs in our faculties rely on a dedicated group of faculty members who engage in research; supervise and train undergraduate and graduate students in research; mentor post-PhD and post-MD trainees in research programs; and teach basic principles of health and disease in the medical curriculum. Faculties work in partnership with healthcare organizations and teaching hospitals and other health-related academic units at the universities. Recently we have participated in a survey which estimates that Canadian universities with faculties of medicine have over 12,500 faculty members engaged in health research. Within the faculties of medicine there are over 11,000 graduate students (Masters and PhD) training to become research scientists and another 2,300 post-doctoral scholars working in research programs with a small proportion of students pursuing combined research and clinical degrees (MD-PhD).

It is interesting to note that faculties of medicine train about as many graduate students as undergraduate medical students. The result is an overall environment that encourages and supports health research in the medical curriculum with the goal of training “research knowledgeable and research-friendly physicians”.}

Penny Moody-Corbett is a professor of Neuroscience and Physiology and is the associate dean for Research and Graduate Studies in the Faculty of Medicine at Memorial University of Newfoundland. Her research focus has been on the development of membrane excitability relative to synapse formation in the nervous system and the expression of ion channels (K+, Na+ and Ca++) during early stages of development. Dr. Moody-Corbett is chair of the Research and Graduate Studies Committee of the Association of Faculties of Medicine of Canada (AFMC). She is a member of a number of committees on research ethics and integrity including chair of the Ethics Committee of the International Union of Physiological Sciences, AFMC representative on the Canadian General Standards Board Committee on Research Ethics Boards Reviewing Clinical Trials and the AFMC representative to the Canadian Research Integrity Committee.
To be a resident physician in a country with the unparalleled reputation of having one of the highest standards of healthcare in the world, grounded by a fundamental belief that universal access to care is a right and not a privilege, and where medical education is considered to be the best and most cutting edge, is nothing short of a dream come true.

Being born and raised in Canada, but pursuing my undergraduate medical education in the Netherlands-Antilles and United States, I was always told that coming back home to undertake my residency would be quite a challenge. During my clerkships in the United States including Johns Hopkins and Cornell-affiliated hospitals, I often engaged in discussions with faculty, residents, students and non-medical friends about how our systems differed and developed a reputation of the “proud Canuck”. Although I was welcomed with open arms into a highly competitive American residency program in family medicine, my love and desire to return to Canada and serve this country compelled me to apply to Canadian residencies. I was successful in obtaining a position at my first choice residency – family medicine at the University of Manitoba.

I felt very privileged to be home and wanted to become engaged with and share my perspectives with other residents across the country. I joined my provincial resident association and was elected to be the representative to the Canadian Association of Internes and Residents (CAIR), the sole national representative body for over 7500 resident physicians across Canada. CAIR works on many issues in medical education such as professionalism, accreditation, capacity, transition to practise and other issues that are identified collaboratively with residents which advance quality medical education, resident well-being and patient care. Being a member of CAIR has given me the opportunity to contribute meaningfully to the ongoing improvement and development of our medical education system. My professional interests are fueled by the deep personal satisfaction I receive from clinical work and the relationship with patients who I truly believe are at the centre of our highly advanced medical education and healthcare system.

As I come towards the end of my family medicine residency and prepare to begin my fellowship in sport and exercise medicine at the University of Toronto, I am thrilled to be involved with the new and exciting projects that CAIR is undertaking. Most especially, I am delighted to finally be back home in Canada after a seven-year journey that has broadened my horizons and given me a universal perspective on healthcare and an appreciation for my community that I can integrate into my residency training and eventual practice environment.

Dr. Noor Amin is the 2009-2010 President of the Canadian Association of Internes and Residents (CAIR). Dr. Amin graduated from the Saba University (Netherlands-Antilles) School of Medicine in 2007. He is currently a second-year resident in family medicine at the University of Manitoba, and will be training in Sport and Exercise Medicine at the University of Toronto in 2010-2011. Dr. Amin has actively represented residents interests, particularly at the College of Family Physicians of Canada, in a number of capacities. Dr. Amin recently presented a poster entitled Safety, Ethical, and Communications Considerations for Medical Resident Placements in Global Health at the 2010 International Medical Workforce Collaborative Conference in New York City.
A Word from CIHR...

Alain Beaudet, President, Canadian Institutes of Health Research

I’m very pleased to have the opportunity to continue my dialogue with members of the AFMC community. Since the theme of the current AFMC newsletter is - what you need to know about medical education - I wanted to use this space to address what I perceive to be a gap in the medical education system, and that is the lack of attention given to primary healthcare.

As many of you know, earlier this year the Canadian Institutes of Health Research held a major summit examining the underdeveloped state of primary healthcare in Canada. There are a number of causes for this but, as concerns the medical education system, one vexing issue is that most students are making specialty medicine their first choice. Primary care is too often perceived as a second-rate, even career-limiting choice. What follows are a few thoughts about how to alter this state of opinion and achieve improvements in primary healthcare.

Research should play a key role in this process. In previous columns I have underlined the need to include research as a core competency in any medical training program. In the field of primary healthcare, this is particularly true. To advance improvements to Canada’s primary healthcare system, we need to develop and pursue probing, pertinent research questions – questions that can achieve left-of-decimal impact in healthcare and health outcomes. I believe that, with the right capacity, key fields such as health economics, healthcare policy and intervention research will produce many rich and exciting avenues of inquiry. We can and must increase our scholarship in these research areas.

To support this kind of work, we also need to develop an innovative primary healthcare research structure. As such we need universities and healthcare institutions to step up efforts to recruit and retain high level research talent. But, to reach success, such efforts will be demand greater openness to the practice of integrating broad teams of healthcare professionals. As there is more than one path to health and wellness, students need to see role models across the healthcare spectrum. With this kind of capacity, we can truly move from disease research to health research, a transformation that will have tremendous benefits for the medical education system in Canada.

Dr. Alain Beaudet, MD, PhD, is the President of the Canadian Institutes of Health Research (CIHR). As President, Dr. Beaudet acts both as Chair of the Governing Council and Chief Executive Officer of CIHR. Before joining CIHR in July 2008, Dr. Beaudet was the President and Chief Executive Officer of the Fonds de la recherche en santé du Québec (FRSQ), a position held since 2004.

Un message des IRSC...

Alain Beaudet, Président, Instituts de recherche en santé du Canada

Je suis très heureux d’avoir l’occasion de poursuivre mon dialogue avec les membres de la collectivité de l’AFMC. Comme le thème du présent bulletin de l’AFMC est « ce que vous devez savoir au sujet de l’éducation médicale », je voulais en profiter pour parler de ce que je considère comme une lacune dans le système d’éducation médicale, soit le manque d’attention accordée aux soins de santé primaires.

Comme vous êtes nombreux à le savoir, les Instituts de recherche en santé du Canada ont tenu plus tôt cette année un important sommet pour examiner l’état de sous-développement des soins de santé primaires au Canada. Cette situation tient à un certain nombre de causes, mais dans le contexte du système d’éducation médicale, un problème ennuyeux est que la plupart des étudiants font de la médecine spécialisée leur premier choix. Les soins primaires sont trop souvent perçus comme un choix de deuxième ordre, voire contraignant pour la carrière. Suivent quelques réflexions pour aider à modifier cette façon de penser et à améliorer la situation des soins de santé primaires.

La recherche devrait jouer un rôle clé dans ce processus. Dans des chroniques précédentes, j’ai insisté sur le besoin d’inclure la recherche comme compétence de base dans tout programme de formation médicale. Cela s’applique particulièrement au domaine des soins de santé primaires. Pour réussir à améliorer le système de soins de santé primaires du Canada, nous devons poser et étudier des questions de recherche pertinentes et poussées, des questions auxquelles les réponses pourront avoir un effet non négligeable sur les soins de santé et les résultats cliniques. Je crois que la bonne capacité aidant, des domaines clés comme l’économie de la santé, la politique des soins de santé et la recherche interventionnelle débouchent sur de nombreuses solutions de recherche riches et intéressantes. Nous pouvons et devons augmenter nos bourses d’études dans ces domaines de recherche.

Pour appuyer ce type de travail, nous devons également établir une structure de recherche novatrice en soins de santé primaires. Il faut donc que les universités et les établissements de soins de santé intensifient les efforts pour recruter et conserver des chercheurs de haut niveau. Pour être fructueux, toutefois, ces efforts exigeront une ouverture accrue à la pratique consistant à intégrer de vastes équipes de professionnels des soins de santé. Comme plus d’une voie mène à la santé et au bien-être, les étudiants ont besoin de voir des modèles de rôle dans tout le spectre des soins de santé. Avec ce genre de capacité, nous pouvons vraiment passer de la recherche sur les maladies à la recherche en santé, un virage qui profitera immensément au système d’éducation médicale au Canada.

Le Dr Alain Beaudet, M.D., Ph.D., est le président des Instituts de recherche en santé du Canada (IRSC). À ce titre, le Dr Beaudet assume les fonctions de président du conseil d’administration et de premier dirigeant responsable des IRSC. Avant d’entrer en fonction aux IRSC en juillet 2008, le Dr Beaudet occupait le poste de président-directeur général du Fonds de la recherche en santé du Québec (FRSQ) depuis 2004.
Susan Maskill, Vice President, Education and Special Projects

Social Accountability: Linking faculties to communities they serve

It is with mixed feelings that I write this, my last article for *Gravitas*, before I retire from AFMC. It has been a wonderful journey for me – allowing me the opportunity to work with so many fine, forward-thinking colleagues from across our 17 faculties, within our communities, and with our national and regional partners.

My proudest moments have been when we, through a shared vision of a better way of working, have moved the social accountability “yardstick” along within our faculties, and in our national collaborations. After all, isn’t it our responsibility, whether at the faculty level or national level, to partner with our communities when recruiting and training the next generation of physicians, advancing medical research or building a better system of community-centred healthcare for all?

The definition of social accountability of medical schools is the obligation to direct their education, research and service activities towards addressing the priority health concerns of the community, region, and/or nation they have a mandate to serve. The priority health concerns are to be identified jointly by governments, health care organizations, health professionals and the public.

- WHO, 1995

We can be proud of our many national efforts since 2002 which have been guided by this lens of community relevance and accountability — to better serve in a more effective and efficient manner both now and in the future. This agenda, approved by the deans (2002), led to early initiatives which included meeting the needs of our francophone minorities outside Quebec by placing non-Quebec francophone students to more appropriately serve these communities while gaining clinical training, collectively developing regional/local Continuing Professional Development (CPD) initiatives to meet communities’ needs while gaining CPD opportunities for our healthcare professionals; spreading innovative curriculum development as a basis for further system change through collaboratively building an end-of-life/palliative care curriculum framework for MD programs (which also formed the basis for residency curriculum in this area) and working with the Indigenous Physicians Association of Canada (IPAC), and other indigenous partners to develop a First Nations, Métis, Inuit undergraduate health curriculum framework which also became the platform for the Royal College of Physicians and Surgeons of Canada and IPAC to build a residency curriculum for certain general specialties. The 17 faculties and AFMC, with representation from the AFMC Resource Group on Admissions and Student Affairs, have also collaborated with IPAC and other Aboriginal stakeholders to develop tools and resources for the recruitment into and support of Aboriginal students in medicine. This partnership has been extended to include an annual session with the admissions and student affairs resource group, to support further advancements in this area and gain a broader representation of indigenous students within faculties of medicine.

Presently, an AFMC Public Health Educators’ Network (PHEN), with representation from each of the 17 faculties, and supported by the Public Health Agency of Canada, is proudly developing a comprehensive, bilingual on-line interactive public health “primer” for medical students which will also
be relevant to other health students or those working in the public health sector. This valuable, engaging resource is sure to capture the attention of our international colleagues as the “cadillac” for healthcare student engagement in public health, just as the bilingual AFMC Faculty Development Program for Teachers of Internationally-educated Medical Graduates, was branded (http://www.afmc.ca/img/default.htm).

Additionally, interprofessional public health student interest groups have been formed and supported within our faculties to raise awareness of the importance of population and public health in all areas of practice and to promote community medicine as a career.

The social accountability agenda continues its influence on AFMC’s most recent initiatives – The Future of Medical Education in Canada (FMEC): A Collective Vision for MD Education and the Accreditation of Interprofessional Health Education (AIPHE), which is beginning its implementation phase. AIPHE involves the eight accrediting bodies for six health disciplines – nursing, occupational therapy, pharmacy, physiotherapy, social work and medicine. These two initiatives promote immersing our students in diverse community settings and with other health students during training so they are better prepared for collaborative patient-centred practice in any environment. In this work, our communities must be active partners. In fact, I am more convinced than ever, to keep our publicly funded healthcare system accessible, accountable and efficient. Our health faculties, governments, health managers, community representatives, and national health organizations need to collaborate and share their expertise for the good of all Canadians. This framework for partnership has guided and enhanced AFMC’s efforts. The Partnership Pentagram below is a graphic representation of the partnership model used. I urge all striving to meet their community(ies)’s needs, whether at the local, regional, provincial or national level, to use this partnership model. Through this new way of working, aligned through a shared vision and desire for better outcomes for all, our planning, engagement and the very success of the initiative is improved. Many of our faculties are using this collaborative lens to drive their efforts. Saskatchewan’s College of Medicine, the University of British Columbia and University of Toronto’s faculties of medicine come quickly to mind but there are others, and it is through sharing all our successes, lessons learned and best practices that we all will make innovative leaps forward that we could not make in isolation from one another.

The above summary is a snapshot of some of our tremendous national work together to address the changing health needs of Canadians. Much of this work has been financially supported by Health Canada whom we have also involved on many occasions as ex-officio on the steering committees. Thank you Health Canada and a special thank you to the many colleagues I have had the privilege to work with and learn from. I wish you well as you continue to build upon the collaborative efforts to date and make those important leaps towards a system that provides and supports healthy communities and improved care for all.
Steve Slade, Vice President, Research and Analysis, CAPER-ORIS, AFMC

Canada’s Faculties of Medicine by the Numbers

I’ve recently taken up listening to “Stuff You Should Know” podcasts during evening walks with the family dog. It’s a popular science program covering topics as varied as the manufacturing of Lego playing blocks to the particle science of the large hadron collider. The podcasts are peppered with interesting facts and provide a quick overview of things you may have wondered about. For instance, did you know that the plastic Lego blocks manufactured twenty years ago fit with those that come off the production line today? Whether the topic is hiccups or urban planning, the program offers quick facts you can file away for future use.

In a similar vein, there are dozens of facts about Canada’s faculties of medicine that are well worth knowing. They may not cover as broad a spectrum as the SYSK podcasts, but they’re every bit as fascinating. Here are some examples:
Canada’s first faculty of medicine was established in 1829 at McGill University. Two more faculties of medicine (at Queen’s University and Université Laval) were established prior to the birth of the Dominion of Canada in 1867.

Today, Canada’s 17 faculties of medicine operate out of 18 universities and 8 satellite campuses.

In 1968, 1,377 students entered the first year of their MD degree programs; 243 (18%) were women.

In 2009, 2,742 students entered the first year of their MD degree programs; 1,572 (57%) were women.

In 2009, first year MD program tuition fees for Canadian citizens/permanent residents ranged from about $3,000 to $19,000 across Canadian universities.

A total of 10,518 undergraduate students were enrolled in MD programs in 2009/10, the largest number on record.

In 1968/69, there was a total of 2,406 full-time medical faculty members – 1.95 per MD student in that year.

In 2007/08, there was a total of 11,265 full-time medical faculty members – 1.17 per MD student in that year.

The number of part-time medical faculty members increased 55% between 1998/99 and 2007/08, going from 13,957 to 21,687.

Faculty of Medicine research revenues increased 141% between 1998/99 and 2007/08, going from $1.08 billion to $2.61 billion.

In 2009, 2,740 Canadians started medical residency training – 39% in family medicine, 45% in medical/laboratory specialties and 16% in surgical specialties.

In 2009, 2,140 Canadians completed residency training for the first time – 43% in family medicine, 41% in medical/laboratory specialties and 16% in surgical specialties.

As you know, Canada’s faculties of medicine are the backbone of our physician workforce. They are the very upstream point at which both the numbers and types of physicians serving Canadians is decided. Moreover, they represent a cornerstone of biomedical and health research in this country. They are defined by the cadre of students, trainees and faculty members that teach, learn, provide care and undertake scholarship within their academic communities.

The example statistics quoted above typify what’s available through the Office of Research and Information Services (ORIS) and the Canadian Post-M.D. Education Registry (CAPER). I welcome you to visit www.afmc.ca and www.caper.ca. Peruse our online statistics. Definitely take a look at our two annual flagship reports Canadian Medical Education Statistics and the Annual Census of Post-M.D. Trainees. These reports offer incredible data on academic medicine in Canada. I hope you will feel it is “stuff you should know”.

Canada’s first faculty of medicine was established in 1829 at McGill University.