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INSIDE THIS ISSUE

Health Challenges and Medical Schools

by Charles Boelen, International Consultant in Health Systems and Personnel, Former Coordinator of the WHO Program of Human Resources for Health

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Since the publication of Abraham Flexner's report in 1910 on medical education in the United States and in Canada, medical education has been governed by three main approaches which might be epitomized by following slogans: Medical education is manageable, medical education has a purpose, medical education has an impact [1].

Approach 1: *"**Medical education is manageable!**"* In the fifties, the management by objectives used in industry was progressively introduced in the field of education. Soon after, educational objectives began to be applied to medical education. Medical education can now be planned and assessed using standardized methods. A contract bounds teachers and learners on preset objectives and various didactic processes and material are being experimented and used routinely to attain these objectives in a most efficient and pleasant fashion.

Approach 2: *"**Medical education has a purpose!**"* Capitalizing on experiences gained in the previous approach, this approach puts emphasis on the relevance of the educational system. The final expected outcome is clearly articulated: It should be a doctor possessing a mixture of skills needed to best serve priority health needs of individuals and the community at large. Educational inputs are preceded by an identification of these needs and constantly updated. Particular attention is given to the consistency of educational programs as well as learning sites with the future practice environment of graduates. In this approach, medical schools develop closer relationships with health service organizations expected to employ the newly trained graduates, as well as with representatives of the community where graduates will eventually serve.

Approach 3: *"**Medical education has an impact!**"* This approach is based on the assumption that doctors are more likely to perform the wide range of acquired skills if they find a conducive working environment. Their involvement in curative and preventive medicine, their work in multidisciplinary teams, their contribution to public health programmes can best be ensured if incentives and organizational conditions do exist in the current health system. Medical schools feel responsible for their "products", ie; graduates, research results, health service guidelines, and accountable to society for the capacity of their products to positively impact on the health system and on people's

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Memorial University

Dr. Ian Bowmer, past Dean of the Faculty of Medicine, has been appointed to the new federal Health Council. The establishment of the Health Council, recommended by the Romanow Commission, was a key commitment of the February 2003 First Ministers' Accord on Health Care Renewal as part of their efforts to improve accountability within the health care system. There are 25 councillors on the new Health Council and an independent chair; Dr. Bowmer is one of 13 non-government organization representatives and one of three physicians on the council.

Dalhousie University

Winners of the Aventis/CST Award for Best Research on the Use of Technologies in Health Education were from the CME office at Dalhousie University, and included **Joan Sargeant**, **Greta Rasmussen** and **Dr. Michael Allen** for their work on the facilitation of online CME programs.

University of Toronto

Diana Alli, co-ordinator of the Office of Student Affairs, and **Professor Miriam Rossi** of Pediatrics received a Certificate of Appreciation from the Toronto District School Board. Alli received her certificate for her contribution to the Saturday morning mentoring program and Rossi for her contribution to the summer mentorship program.

Professor Robert Josse of Medicine assumed the presidency of the Canadian Society of Endocrinology & Metabolism for a two-year term at its annual meeting. The Society represents over 300 endocrinologists engaged in basic research or clinical practice in communities, universities and

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industries across Canada with a mandate to represent the interests of its members with respect to clinical practice, academic training, research funding and medical politics.

Professor Peter Liu of Medicine is the winner of the Rick Gallop Research Award of the Heart & Stroke Foundation of Ontario. Named in honour of Rick Gallop who was President of the foundation for 16 years, the award recognizes and cerebrovascular science.research excellence and encourages innovation in the field of cardiovascular science.

Dr. Ross MacKenzie, a Lecturer in the Department of Medicine, was presented with the Distinguished Physician Award at the annual meeting of the American Academy of Insurance Medicine in Scottsdale, Ariz. The award is given every few years to a physician who has made a major contribution to the advancement of the science of insurance medicine and has brought "enlightenment and honour" to the profession. Mackenzie was President of the academy in 2001 and is Associate Editor of its major publication - the *Journal of Insurance Medicine*.

Professor Paul Pencharz of Pediatrics and Nutritional Sciences has been selected as the 2003-2004 recipient of McGill University's Earle W. Crampton Award for Distinguished Service in Nutrition. Established in 1973, the prize is given in honour of Crampton, who founded the first graduate nutrition program in Canada and was responsible for the establishment and promotion of nutrition research and teaching at McGill University.

Professor Val Rachlis of Family and Community Medicine was recognized

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health. Medical schools, therefore; want to be regarded as important stakeholders on the health scene and assume an increasing role in the design and management of the health system.

The three approaches have appeared in a chronological order during the last 50 years. Approach 3, which has been formally articulated in the last decade, streamlines the social accountability of a medical school. It is increasingly considered as an important strategy for the development of medical schools and medical education. The social accountability of medical schools was defined in 1995 by the World Health Organization as *"an obligation to direct 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"* [2].

Social accountability, a rising notion

The notion of social accountability of medical schools is being raised increasingly worldwide by health policy makers, professional associations and medical schools themselves. With the general quest to improve performance in meeting priority health needs of a nation, medical schools, like any other health institutions, are being challenged to provide evidence of their contribution. In addition to the compliance to current educational, research and service standards, a socially accountable medical school must be concerned by ways in which its products are being used and whether they make a real difference on the national health system and people's health status.

This requires that it takes interest in and is willing to play a role on issues such as:

- *Career choices of graduates consistent with identified health needs.*
- *Advocacy for primary health care practices including family medicine.*
- *Fair geographical distribution of medical manpower and incentives to work in underserved areas*
- *Models of services integrating individual care and public health for a target population.*
- *Optimal conditions for the functioning of multi-professional health teams.*
- *Health policies and strategies to create conducive environments to implement the above.*

Social accountability also means that the medical school seeks partnership with other main stakeholders as it realizes that sustainable impact on health systems can only result from alliances with health policy bodies, health service organizations, professional associations and civil society. The creation of a momentum for these stakeholders to share a common vision and action program is the essence of the WHO promoted approach *"Towards Unity for Health"* [3].

Over the last ten years, a number of initiatives have been taken worldwide by several organizations and institutions to promote the notion of social accountability. Hereafter, is a sample of some noteworthy events. In 1995, the World Health Assembly passed a resolution urging countries to reorient their medical education and medical practice towards primary health care[4]. In the same year, WHO published a monograph

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as one of Canada's top 10 physicians, winning a Canada's Family Physician of the Year – Reg. L. Perkin Award of the College of Family Physicians of Canada. Each of the college's provincial chapters selected a Family Physician of the Year. Supported by the college's Research & Education Foundation and Janssen-Ortho Inc., the awards recognize outstanding college family physician members who exemplify the best of what being a family doctor is all about.

Joan Saary, a Clinician Scientist Trainee in Medicine and the Institute of Medical Science, was the winner of the Royal Society of Canada's 2003 Alice Wilson Award. The prize, is given yearly to a woman of outstanding academic qualifications who is entering a career in scholarship or research at the post-doctoral level. In her research, Saary plans to fill the gap between outcome measurement, stakeholder perspectives and delivery of quality health care for occupation diseases.

Professor Emeritus Harald Sonnenberg of Physiology, whose work in the area of sodium handling by the kidney earned him international renown, was the recipient of the 2003 Kidney Foundation of Canada Medal for Research Excellence, honouring a Canadian researcher whose work is recognized by his or her peers to have significantly advanced the treatment of kidney disease and related conditions.

Professor Vladimir Vuksan of Medicine was presented with the Award of Excellence in Health Care Research from the Toronto Institute of Pharmaceutical Technology. Vuksan received the award for his outstanding contribution to nutritional medicine and diabetes research.

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entitled: *"Defining and Measuring the Social Accountability of Medical Schools"* [2]. Also in 1995, the World Organisation of Family Doctors and WHO produced a joint policy document for making medical education and medical practice more relevant to people's needs, which served as a basis for their future collaboration [5]. In 1999, the Educational Commission for Foreign Medical Graduates (USA) and WHO produced a report: *"Improving the Social Responsiveness of Medical Schools"* [6]. In 2001, Health Canada published a white paper on *"Social Accountability. A Vision for Canadian Medical Schools"*[7]. In 2002, French medical schools organized a national conference on the subject and the French Society of Public Health published a special issue of their journal on: *"What Is the Social Responsiveness of Our Medical Schools?"*[8]. Also in 2002, the Association of Philippine Medical Schools decided to survey all their medical schools and assess their level of compliance to a grid measuring social accountability. The same organization plans to introduce elements reflecting social accountability in the criteria for accreditation of medical schools. In 2003, the Association of Canadian Medical Colleges organized their annual meeting with a special focus on: *"Social Accountability. Moving Beyond the Rhetoric"*.

Nowadays, the notion of social accountability or responsiveness of medical schools and medical education is on the agenda of many national and international conferences worldwide. Also, journals specialized in medical education show an increasing interest in the subject. It is not uncommon to read articles advocating for an education taking into account both needs of patients and requirements of a changing health system. Some of the vocabulary used is illustrative of a wider scope of interest when transition is wanted from an "input-based education" to a "results-orientated thinking"[9]. Several medical schools in all continents have begun to accept the notion of social accountability and conduct at their own initiative, formal or informal evaluation exercises to assess and promote it.

New challenges and opportunities

What has motivated this move? Is it a time-limited fashion or is it a sign of a profound transformation in medical schools?

My inclination is to think that it corresponds to a prevailing culture for transparency and evidence for impact. No institution is left immune from public scrutiny and critique. From governmental agencies to citizens, there is curiosity to question whether an institution produces the effects for which it has been set up, and whether it deserves the allocated resources. Regarding medical schools, this movement is still in its infancy but it is likely to grow steadily. There are also early signals that the present system of accreditation of medical schools needs to be profoundly revisited as it is essentially characterized by the use of standards and indicators reflecting compliance with certain processes and procedures within the institution and almost none reflecting outcomes and impact on the health system and people's health.

Some may see in this paradigm shift an additional source of constraints for medical schools, which in certain countries face already a number of challenges for their development and sometimes for their survival. Some others consider it as a unique opportunity

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for medical schools to be recognized as important actors on the health chessboard. They possess indeed an untapped potential for the planning and distribution of a new breed of doctors best fit to serve society, for designing models of comprehensive health services for an entire community, for motivating graduates to serve in under privileged areas, for shaping policies and strategies for a better health system.

Hereafter are some examples of medical schools manifesting their social accountability:

- The medical school at the University of Minas Gerais (Belo Horizonte, Brazil) has a department of paediatrics with a particular interest in genetic disorders of the newborn. They have initiated a project to detect and manage five major diseases within the first week of life for all newborns in the population of the State of Minas Gerais. To do so, they have instructed all primary health settings with a given protocol and created a network involving the ministry of health, professional associations and a dozen voluntary agencies to assist in the implementation of the project.
- The medical school at the Université de Sherbrooke (Québec, Canada) manages a project for a better coverage of the province of New Brunswick with medical services, by ways of decentralization of medical education and retention of new graduates in most underserved areas in the province.
- The medical school at the BP Koirala Institute of Health Sciences in Dahran (Nepal) has initiated a local health insurance scheme for the peasants and so extended coverage of affordable basic health services to thousands of most vulnerable families.
- The medical school at Moi University in Eldoret (Kenya) has established a project for street children, estimated by the World Bank to amount to a million for the whole country. Their goal is to improve the health and nutrition status of street children and give them best chances for their reinsertion in society. For this purpose, they coordinate a group composed of representatives from the medical school, local governmental authorities in the health and education sector, social services and various charitable organizations.
- At Monash University medical school (Melbourne, Australia), the centre for rural health promotes access to a full range of health services for people living in rural and remote areas, by encouraging unity of action among communities, local practicing health staff, and public health services.
- At the medical school of Maastricht (The Netherlands), the department of general practice has developed a comprehensive community cardio-vascular program targeting the entire population of the city. The program consists of health education, prevention measures, identification of high risk individuals, standardization of treatments, rehabilitation of the sick, and is carried out by a consortium made of local public health authorities, cardiologists from the teaching hospital and town, family doctors, a variety of health and social staff and community members.

All cited schools have common features. They are well known for their excellence in medical education. They have a similar desire to ensure that their actions eventually make a difference on people's health. They are concerned by the sustainability of their work and therefore find themselves engaged in a variety of activities well beyond the usual domains of

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CME Congress 2004 News! Student Grants and More!

Through the generosity of Bell University Laboratories at the University of Toronto, the CME Congress 2004 secretariat is able to offer seven grants to support the participation of graduate students in the Congress. The grant will be in the form of waived registration fees. Detailed information can be found on the CME Congress 2004 website (www.cmecongress.org) …go to the Abstracts Page and click on the new link to the Application Instructions for Student Grants.

Back to the Home Page, and under the Welcome from Dave Davis, is a new addition – a Slideshow Presentation of the Congress. Here, again, is a link to the Application Instructions for Student Grants.

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interest of conventional medical schools. They dare to venture into areas relative to health policy and health service organization. They are committed to influence health systems for a better compliance to basic values such as quality, equity, relevance and cost-effectiveness in health care.

In conclusion, improving the social accountability of medical schools is a worthwhile effort leading to a benefit for both medical schools and the health system. Medical schools, by providing evidence for the impact of their activities on people's health, are likely to enjoy a greater credibility from policy-makers and funding agencies in their education, research and service activities. Also, due to their capacity in applying sound research and development methodologies for health system improvement, they will gain recognition of a leadership in the health sector. Finally, medical schools, serving as role models, may encourage other important health partners, such as professional associations and health service organizations, to adhere as well to the principles of social accountability. The impetus they will have initiated towards an alliance of principal stakeholders sharing a common vision and commitment to meet future health challenges will be seen as one of the greatest contributions to a nation's well being. We are aware that the adventure is only beginning and that the journey is not without challenges, but the confidence to be on the right path is high.

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[5]Making Medical Education and Medical Practice More Relevant to People's Needs. The Contribution of the Family Doctor; A Working Paper of the World Health Organization and the World Organization of Family Doctors (Report of a joint WHO/WONCA Conference in Ontario/Canada, Nov.1994), WONCA, 1995.
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[7]Social Accountability: A Vision for Canadian Medical Schools, Health Canada, 2001 (Publications, Health Canada, Ottawa, Ontario K1A 0K9, Canada).
[8]Quelle responsabilité sociale pour les facultés de médecine? Revue de la Société Française de Santé Publique. Numéro Hors série, avril 2003.
[9]Davis, M.H. Harden R.M. Editorial: Competency-based Assessment: Making It a Reality. Medical Teacher, Vol. 25, N° 6, 2003, pp. 565-568.

ACMC-CAME ANNUAL MEETING 2004
April 24 - April 27, 2004
Casino Nova Scotia Hotel
Halifax, Nova Scotia
www.acmc.ca/ann_meetings.htm

The registration desk will be located on the 2nd floor.
Conference Registration Hours:

Friday, April 23	**15:00 - 20:00**
Saturday, April 24	**07:00 - 17:00**
Sunday, April 25	**07:00 - 17:00**
Monday, April 26	**07:00 - 17:00**
Tuesday, April 27	**07:00 - 17:00**

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Professor John Wedge of Surgery is the recipient of the Whittaker Memorial Cerebral Palsy Award for outstanding achievement in rehabilitation, research and development for children with cerebral palsy. The award, is administered through the research department of Bloorview MacMillan Children's Centre and adjudicated jointly with the Ontario Association of Children's Rehabilitation Services.

Professor Michael Wheeler of Physiology, one of Canada's leading young diabetes investigators, received the Young Scientist Award, sponsored by the Canadian Diabetes Association and Great West Life/London Life. The award, given in recognition of outstanding research conducted in Canada in the field of diabetes by a researcher under the age of 45, was presented at the Canadian Diabetes Association/Canadian Society of Endocrinology & Metabolism professional conference.

University of Western Ontario

Medicine Professor Robert Hegele has been awarded the prestigious eighth annual Hellmuth Prize for Achievement in Research. The Hellmuth Prize is named in honour of Bishop Isaac Hellmuth, widely regarded as the founder of the University of Western Ontario.

University of Manitoba

Dr. Brian Hennen was awarded the Dr. Ian McWhinney Family Medicine Education Award. The award is to acknowledge an outstanding family medicine teacher deemed by his or her

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VISIT THE ACMC WEB-SITE (www.acmc.ca) FOR ACCESS TO THE FOLLOWING INFORMATION

- ***MEDICAL EDUCATION, November & December 2003***

  Analytic Global OSCE Ratings Are Sensitive to Level of Training
  Brian Hodges & Jodi Herold McIlroy, University of Toronto

  Variety Show Syndrome: Making a Diagnosis
  Lindsay Davidson, Queen's University

  Technical Skills in Paediatrics: A Qualitative Study of Acquisition, Attitudes and Assumptions in the Neonatal Intensive Care Unit
  Susan L. Bannister, University of Western Ontario; Robert I. Hilliard & Lorelie Lingard, University of Toronto

  OSCE! Variations on a Theme by Harden
  Brian Hodges, University of Toronto

  Martin's Map: A Conceptual Framework for Teaching and Learning the Medical Interview Using a Patient-centred Approach
  Dawn Martin, University of Toronto

- ***ACADEMIC MEDICINE , December 2003-February 2004***

  Role Modeling in Physicians' Professional Formation: Reconsidering an Essential but Untapped Education Strategy
  Nuala P. Kenny; Karen V. Mann & Heather MacLeod, Dalhousie University

  A Workshop for Medical Students on Deafness and Hearing Impairments
  Elizabeth Lock, University of Ottawa

  Effect of an Undergraduate Medical Curriculum on Students' Self-Directed Learning
  Bart, J. Harvey, Arthur I. Rothman and Richard C. Frecker, University of Toronto

  Informed Consent Skills in Internal Medicine Residency: How Are Residents Taught and What Do They Learn?
  Karen L. McClean & Sharon E. Card, University of Saskatchewan

Department of Ophthalmology and Vision Sciences
Annual Research Day, June 4, 2004

The 46th Annual Research Day of the Department of Ophthalmology and Vision Sciences, University of Toronto and the 23rd Clement McCulloch Lecture will take place on Friday, June 4, 2004 in the Koffler Auditorium at the University of Toronto (Room KP108, Main Floor, Koffler Institute for Pharmacy Management, 569 Spadina Avenue, Toronto, Ontario). Presentations by students, residents, fellows and staff will start at 8:00 a.m. This will be followed by the McCulloch Lecture (5:00 p.m.) titled *"A Cause and Cure for Cross-Eyes in Infancy"*, which will be given by Dr. Lawrence Tychsen from the Department of Ophthalmology and Visual Sciences of Washington University in St. Louis, Missouri. This special event entitles participants to earn up to 8 CME credits. Registration at the Koffler Auditorium starts at 7:30 a.m. and there is no charge for registration.

Contact person: Dr. Agnes Wong, Chair of Research Day
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peers to have made a substantial contribution to family medicine education.

University of British Columbia

Dr. Oscar G. Casiro has been appointed Associate Dean, Island Medical Program, at the University of British Columbia and Head, Division of Medical Sciences, at the University of Victoria. Over the past four years as Associate Dean, UGME Program, University of Manitoba, Dr. Casiro's contributions to medical undergraduate education have been impressive including the implementation of changes that resulted in improved student performance, increased student satisfaction and increased faculty participation. He also played a key role in planning and implementing a 20% increase in student enrolment, major changes to clerkships and new rural medical education initiatives such as establishing a "Rural Week" for first year medical students and the creation of new rural clerkship sites.

Cancer Care Ontario

Professor Emeritus John Laidlaw of Medicine was named a member of the Order of Canada. Cited as an exemplary educator and physician, whether as University of Toronto's first Director of the Institute of Medical Science or Dean of Medicine at McMaster University. Laidlaw brought innovative changes to the training of young clinicians and encouraged them to focus on patient-centered health. "Through his leadership roles, notably with Cancer Care Ontario, he has stressed the importance of good communication in providing quality care to patients", the citation states.

CAME Update

by Jean Gray, President, CAME

CAME welcomes you to the annual ACMC/CAME meeting in Halifax in April focusing on the future of health professional education. **"Keeping Up with the Future: Distributed Medical Education for All Learners"** is the theme of the first plenary session. **Dr. Ron Harden** of Dundee will talk about "Just-in-time learning, Just for your learning – An Exciting Future", followed by presentations on the programs at the Northern Ontario Medical School and at the University of British Columbia. The second plenary will involve us all in discussing **"Developing Scholars in the Health Sciences"**, using the recent report developed for CIHR by a team chaired by **Dr. Mel Silverman**, the keynote speaker. CAME will provide 21 workshops, 20 research and development presentations and four facilitated poster discussions. The quality of the submissions this year was extremely high, making final selection a very difficult task.

If all goes according to plan, the look of the 2005 annual meeting in Saskatoon will be quite different. Working in partnership with ACMC, CAME, CFPC, MCC, and RCPSC, a planning committee has been at work developing the plans for a meeting that reflects the input of each of these organizations involved in medical education. We hope to have a preliminary program available for distribution at this year's meeting in Halifax to whet your appetite for attendance at the Saskatoon meeting. Dr. William Albritton, Dean of Medicine at the University of Saskatchewan and the Saskatoon convention planning group have been very helpful in assisting the planning process. Members of the Planning Committee and their affiliations are: William Albritton (ACMC), Meredith Marks (CAME), Danielle Saucier (CFPC), David Blackmore (MCC), Karen McClean (RCPSC) with Jean Gray (Chair) and Sue Maskill (Secretariat).

CAME is delighted to announce that the CAME Senior Award for Distinguished Contribution to Medical Education has been renamed the **CAME-Ian Hart Award for Distinguished Contribution to Medical Education**. This award will now honour not only a senior Canadian medical educator annually but also Dr. Ian Hart, the founder of CAME, in perpetuity. An endowment fund has been established to collect funds to sustain this award. The University of Ottawa's Faculty of Medicine, Dr. Hart's educational home, made the first very generous contribution to this fund, for which we are grateful. Dr. Hart will be present at the CAME meeting in Halifax to make the presentation to this year's winner, **Dr. Peter McLeod** from McGill University.

The other major CAME award is the Junior Award for Contribution to Medical Education. From a very strong set of nominations, the Award Committee selected **Dr. Marcel D'Eon** from the University of Saskatchewan for recognition. The CAME Certificates of Merit will be presented at the annual CAME meeting in Halifax and will recognize those individuals who have made major contributions to the educational efforts in their own medical schools. Our congratulations to all who were nominated and, in particular, to those who will receive the CAME awards.

Keeping Up With the Future: Distributed Medical Education for All Learners

by John Ruedy, former Dean, Faculty of Medicine, Professor Emeritus, Pharmacology, Dalhousie University

Distributed Medical Education is yet another neologism in the glossary of medical educators. It refers to a learning environment that is dispersed across a variety of locales and experiences beyond the traditional confines of the campus-based basic science departments and the tertiary care inpatient wards that have been the dominant venue for undergraduate and postgraduate medical education throughout the twentieth century. The term immediately suggest geographically dispersed locales but includes the concept of novel environments where students can gain the broad competencies expected of the future physician.

This is a timely topic for a variety of reasons. There is general acceptance that the physician needs to gain competencies that are best learned in a broader educational environment than can now be provided on the inpatient units of tertiary care centers, teaching hospitals are being transformed into health authorities responsible for health care of a district providing new opportunities for integrating health education programs into a wider variety of health care functions and electronic learning is maturing with examples of effective methods in undergraduate, postgraduate and continuing medical education. Furthermore there are currently two exciting developments in medical education in Canada, the Northern Ontario Medical School and the expansion of UBC's medical school, both of which are being planned with a focus on distributed learning environments.

Of course, distributed learning is not a new concept. At the beginning of the 20th century, William Osler in inventing clinical clerkships insisted that students gain experience in the general hospital outpatient clinics (at the time an important primary care resource at least for the indigent) before proceeding to the inpatient wards. In the 1950s and 60s those of you beginning your postgraduate training at the Montreal General Hospital had mandatory two-month experiences in such diverse environments as Charlotte, North Carolina, Ste Agathe, PQ, Bermuda and Frobisher Bay! In mid-century, in recognition of the importance of the basic sciences, postgraduate students proceeding to Fellowship in the Royal College of Physicians in Surgeons of Canada spent a year outside of the clinical environment in a basic science (at the time most frequently Pathology). Rotating internship programs were dispersed in a wide variety of institutions including, for example, in British Columbia, community hospitals in North Vancouver, Victoria and New Westminster. As the medical school of the Maritime Provinces, Dalhousie has had decades of experience in the distributed delivery of undergraduate, postgraduate and continuing medical education.

Nevertheless there are many questions and challenges in regard to distributed medical education. What competencies are best learned outside the inpatient units of the tertiary care hospital? Who should comprise the faculty? How can effective faculty development be accessed by the variety of health professionals in a health care team? What infrastructure resources are required? The learning environment of Canadian medical schools has been greatly enhanced by faculty members within the faculty, whose major commitment is not directly medical education (e.g. health research, management of health care services, the education of other health professionals and students in other university or college programs) as well as members of other faculties (e.g. Science, Law, Computer Science). How can comparable university-wide resources be accessed in a distributed learning model? How can equivalent quality standards including student formative evaluation be maintained across diverse sites and experiences? How is student evaluation effected in a continuous manner with effective feedback? How is the student involved in his/her own learning

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objectives in a more complex and varied environment? How can student interaction (senior to junior as well as peer) be maintained? Is it important? How is cohesion maintained in the faculty and in the student body? Is it important?

The Plenary Session at the Annual Meeting "Keeping up with the Future: Distributed Medical Education for All Learners" is designed to address these and other questions. Three exceptional keynote speakers will provide the background. Ron Harden, arguably the international leader in medical education, will address the background and rationale of distributed medical education and lead the discussion group on electronic learning. Roger Strasser will highlight rural medical education from his experience in Australia and more recently as Founding Dean of the Northern Ontario Medical School. Gordon Page will describe the challenges facing the expansion of UBC Medical School to Prince George and Victoria sites. Blye Frank of Dalhousie University will lead the discussion group on one of the most important needs, that of faculty development. We expect a vigorous contribution from the discussion groups that follow the introductory talks.

Social Accountability: Medical Schools Move Forward

by Robert Woollard, Chair, ACMC Working Group on Social Accountability

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HISTORY AND PLANNING

One year ago the Spring issue of the FORUM reported on the ACMC's initiative on *"The Social Accountability of Medical Schools"* and the impending Symposium on that topic in conjunction with the April annual meeting. That meeting[1] and symposium[2] proved a remarkably successful expression of the five way partnership (policy makers, health managers, health professions, communities and academic institutions[3]) envisioned in the international initiative seeking to enhance the ties between the needs of societies and the academic resources represented in medical schools.

The plans that emerged from the symposium were further refined at a broad planning exercise over the summer, and are being translated into action through a number of working groups. This range of activities (the subject of this report to the membership) has moved Canada into the vanguard of this initiative at a time when the Canadian public is contemplating system changes that may be required for the sustainability of our cherished health care system. That academic medicine has much to offer in such an enterprise is obvious. That we have not consistently fulfilled our role in the past should inspire us to do so now.

The framework which follows, and the remarkable people and organizations dedicated to its realization, should provide opportunities for each and all of the medical schools to enhance the focus of their educational, research and service activities on defining and responding to the priority health needs of our respective communities. There is a virtual ferment of existing projects and initiatives, some student driven, some led by faculty, some already engaged in robust partnerships with governments and communities. These range across the country in various regional and provincial structures. What is lacking is an enduring national venue in which lessons can be shared, priorities advanced and substantial social resources focused on complex problems that have so far eluded our best efforts.

We are building towards the inaugural meeting of such an enduring venue—The Partners' Forum on the Social Accountability of Canadian Medical Schools (the "Forum").

FOCUS OF ACTIVITIES

To augment the success of the "Forum" and the overall strategy on social accountability, a number of working groups are coordinating their actions:

- **Inventory Working Group** (Alan Neville, chair) developing a taxonomy, matrix, catalogue and data base of existing relevant projects and programs.
- **Measurement Working Group** (Paul Cappon, chair) developing literature review, methodology for formative evaluations, processes for institutional self-reflection and peer review to enhance feed-back loops in system change.
- **Communications Group** (George Goldsand, chair) developing the mechanisms for internal and external communications to engage everyone from faculty members to institutional partners in joint efforts towards priority needs.

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- **Organizing Committee** for the inaugural meeting of the Partners' Forum (Bob Woollard, chair, representatives of the five partner groups) developing the precise agenda for the inaugural meeting planned for April 27-28, 2004.

These groups will work closely with the:

- **Academic Leadership Group [ALG]** (Bob Woollard, interim chair) consisting of a representative appointed by each dean (four are deans themselves) to be the primary point of contact/focus of activities at each of the seventeen schools. It is clear that each school will give shape to the concept of social accountability in a form relevant to its community needs and circumstances—this group will be a key link in the chain from the deliberations of the Partners' Forum to activities at the "coal face" where education, research and clinical service are integrated.
- **ACMC Working Group on Social Accountability** (Bob Woollard, chair) responsible for the overall strategic approach to Social Accountability—of which the Partners' Forum is a part.

DETAILED PRACTICAL APPLICATION

In addition to the working groups, two other major multi-year inter-university initiatives have been funded (competitively) by the Primary Health Care Transition Fund and form part of the overall strategy. While focusing on primary care, these interdisciplinary projects will provide practical experience in joint action across universities, linking the scale of activities from the national, through provincial and regional to the local level. They may represent the beginning of a number of initiatives that can arise through the priorities and working groups developed by the Partners' Forum. They are:

- **"Issues of Quality and Continuing Professional Development: Maintenance of Competence"** (Kendal Ho, chair) fostering the creation of a national interdisciplinary network of health professionals to support advancement of collaborations in socially accountable CPD. It works from the assumption that Primary Health Care Renewal is motivated by a compelling need to provide health care to those currently underserved.
- **"Des médecins et des soins de qualité pour les communautés francophones minoritaires"** (Paul Grand'Maison, chair) dedicated to the exploration and response to the needs of this particular community but with lessons learned for other minority and/or marginalized communities.

COORDINATION AND COMMITMENT

These eight working groups/committees are accomplishing a great deal in tight time frames. There is broad horizontal membership across the medical schools and vertical membership across the required partnerships at various scales. There has also been judicious use of cross membership to enhance the working coordination of such a complex, multi-dimensional undertaking.

It should not escape our attention that many sincere attempts have been made to address many of the unresolved issues in Canadian health care (the health of aboriginal peoples', the inner citypoor and northerners; the distribution of physicians and other health professionals; effective interprofessional coordination; effective and timely translation of research evidence into practice; etc). Notwithstanding the limited success of these efforts, the lessons we have learned call for a renewed dedication on the part of academic medicine to engage in the kind of broad and collaborative effort that is the foundation for this initiative. If medical schools, grounded in over five centuries of university based and socially supported research, education and service, cannot turn our considerable resources to this daunting task; then who can we reasonably expect might?

For further details on opportunities for further involvement please contact your local member of the ALG or the ACMC Working Group on Social Accountability (smaskill@acmc.ca).

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Members of the Academic Leadership Group

Dean William Albritton, University of Saskatchewan
Dr. Dave Davis, University of Toronto
Dr. George Goldsand, University of Alberta
Dr. Paul Grand'Maison, Université de Sherbrooke
Dean Brian K. E. Hennen, University of Manitoba
Dean Carol Herbert, University of Western Ontario
Ms. Susan Maskill, ACMC
Mrs. Carole Nadeau, Université Laval
Dr. Alan Neville, McMaster University
Dr. Jean Parboosingh, Consultant
Dr. Thomas Scott, Memorial University
Dr. John Seely, University of Ottawa
Douglas Sinclair, Dalhousie University
Dr. Yvonne Steinert, McGill University
Dean Roger Strasser, Laurentian University
Dr. Robert Thivierge, Université de Montréal
Dr. John Toews, University of Calgary
Dr. Sarita Verma, Queen's University
Dr. Robert Woollard, University of British Columbia

[1] Social Accountability: Moving Beyond the Rhetoric, Plenary Proceedings, (www.acmc.ca/issues.htm)
[2] Envisioning Solutions: Creative Partnerships for the Future of Health Care in Canada, Symposium Proceedings, (www.acmc.ca/issues.htm)
[3] Envisioning Solutions: Creative Partnerships for the Future of Health Care in Canada, Symposium Proceedings, see

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Medical Humanities Symposium
2004 ACMC-CAME Annual Meeting
Sunday – April 25, 2004 – 12:30-15:30

Early in the Spring of 2003, a group of medical students at Dalhousie University began discussing the possibility of hosting a medical humanities symposium. Upon learning that the 2004 ACMC-CAME Annual Meeting would be hosted in Halifax, student organizers approached the ACMC planning committee. With the support of the Dalhousie Medical Humanities Program, Alumni Association, Dean's Office, and local planning committee, a proposal was submitted and subsequently accepted by the ACMC organizers.

Dalhousie's Medical Humanities program is now more than a decade old, and through the vigorous support of students, staff and faculty it has become a vital part of the medical school community. Students can participate in several established programs, such as "Music in Medicine", "History of Medicine", the annual Art Show, as well as creative medical writing and narration. Funding is also made available to students for research and humanities projects which fall outside the scope of established programs.

Students at Dalhousie feel that the Humanities Program provides them with a unique perspective on both clinical problems and the patient-physician relationship. *"I find the medical humanities help me to appreciate the issues around illness and healing which fall outside the scope of what can be provided in a textbook."* says Yoko Schreiber, a third year student at Dalhousie. Yoko says that she strongly believes that creating art and writing about experiences on the ward can be a helpful outlet for students to deal with ethical dilemmas and difficult issues such as end-of-life care.

The student organizers at Dalhousie hope to encourage other students who will be attending to initiate or develop humanities programs at their schools. *"This is really intended to be an opportunity for discussion and exchange of information between medical students and faculty"*, says Jan Benedict, who is helping to organize the event. *"We would like to share our experiences, and our strong belief that the medical humanities have a vital role to play in medical education"*.

The symposium will feature Dr. Jock Murray as the keynote speaker and will include student presentations and discussion on selected topics. Organizers are encouraging everyone who is interested in learning more about the medical humanities to attend, particularly other student delegates at the conference. For more information, please contact Jan Benedict at benedict@dal.ca.

Invitation To An Open House - New Directions in Medical Informatics

Sponsored by the ACMC Informatics Resource Group

On **Saturday, April 24th from 10:00 to 11:30** the Informatics Resource Group of the Association of Canadian Medical Colleges cordially invites all annual meeting participants to join us for a **Medical Informatics Open House.**

The Informatics Resource Group of the ACMC was established to facilitate discussion between member schools concerning the growth and development of the field of medical informatics and its potential impact on teaching and learning; to provide a forum for review of issues that surround informatics including the use of new technologies, infrastructure and support; and to address and encourage cooperation and collaboration between schools within a pan-Canadian context.

This year the members of the Resource group will hold an Open House to afford all annual meeting delegates an opportunity to see and discuss the variety of informatics initiatives currently underway in Canadian medical schools.

Please mark your agendas and take advantage of the opportunity to meet the members of the Informatics Resource Group, see presentations and posters on medical informatics in Canada, including current and future directions for e-Curricula, dynamic the use of palm pilots in clinical preparation and practice, the importance of infrastructure, support for faculty and more.

As of February 20th, 18 presentations from the following schools are planned:

Memorial University
Dalhousie University
McGill University
University of Ottawa
University of Toronto
McMaster University
Queens University
Northern Ontario Medical School
University of Calgary
University of British Columbia

More will be added!

New Dean of Medicine at Memorial University

The Board of Regents has announced that Dr. James Rourke will be the new Dean of Medicine at Memorial University effective April 5, 2004. Dr. Rourke is currently the Assistant Dean of Rural Regional Medicine at the University of Western Ontario. He has been an active rural family physician (including obstetrics and emergency work) in Goderich, Ontario for 25 years. He is the Founding Director of the Southwestern Ontario Rural Regional Medical Education, Research and Development Unit (SWORRM), founded in 1997 and funded by the Ontario Ministry of Health to develop, integrate and co-ordinate rural medicine at the University of Western Ontario. Dr. Rourke has worked with the university and 33 communities, family physicians and specialists to build a strong, integrated undergraduate and postgraduate rural and regional medical education network that set the stage for a 40 per cent expansion in the University of Western Ontario medical school.

Dr. Rourke has a long-standing interest in rural medicine and is a recognized leader at provincial, national and international levels. He has received many honours and awards and has had more than 60 journal articles published.

Dr. Rourke brings a management style he describes as collaborative leadership and partnership building and he is comfortable working with a wide variety of people and issues.

New Family Physicians in Rural Practice

by Dianne Thurber, Director, CAPER

The following two tables were prepared from the CAPER database and the CMA Masterfile to give a national view concerning the proportion of Canada's new family physicians who work in rural areas. The physicians included in the tables are the Family Medicine trainees who exited from the 16 Canadian Medical Faculties for the 5 years from 1997 to 2001. For example, exit year 1997 refers to trainees who were registered in a post-M.D. Family Medicine training program on November 1, 1996 but were no longer in training on November 1, 1997. Most of the trainees would have exited training at the end of

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June, 1997. Trainees in all Family Medicine programs were included (F.M. Emergency, Care of the Elderly, etc.). To be included the trainee must have exited at a rank level compatible with completion of training (R-2 or above). IMG residents who were Canadian citizens/permanent residents during training were included in the data along with the M.D. graduates from Canadian faculties. (No Visa trainees were included.)

The designation of "rural" used for these data is the "rural" postal code definition. A '0' in the second digit of the practice location postal code indicates a "rural" postal code. This designation gives us an approximation to the Statistics Canada designation of "rural and small town" areas. These are areas with population centres of less than 10,000 people. The "rural" postal code designation would apply to 80% of the people living in "rural and small town" areas.

Data in *Table 1* show us, that over the last 5 years 13% of new family physicians were in rural practice locations 2 years after exit from training. According to Statistics Canada, the rural population of Canada in 2001 was 20%. Proportions of new family physicians located in rural areas, according to CMA and CAPER data varied from 15% for the 1997 exit group to 11% for the 2000 exit group. The postal code was used to designate rural locations.

Table 2 gives more detailed information concerning the practice location 2 years after exit from training for the family physicians completing training in each province from 1997 to 2001. For this 5-year exit cohort, Newfoundland and Saskatchewan had the highest proportion of their Family Medicine residents locate in rural regions (41% and 23% respectively). According to Statistics Canada (2001 data), 42% of the population in Newfoundland and Labrador lived in rural areas, and 36% of Saskatchewan's population was rural. In Ontario where 15% of the population was rural, 11% of the Family Medicine trainees were working in rural areas 2 years after exit from training.

Table 1
Physicians Exiting From Canadian Family Medicine Training Programs, 1997 - 2001 (Practice Entry Cohort)
YEAR OF EXIT FROM POST-M.D. TRAINING
BY
TYPE OF PRACTICE LOCATION IN CANADA (URBAN VS. RURAL)*
TWO YEARS AFTER EXIT FROM TRAINING

Year of Exit From Post-M.D. Training	Type of Practice Loc.				Total	
	Urban		Rural			
	Count	Row %	Count	Row %	Count	Row %
1997	566	84.9%	101	15.1%	**667**	**100.0%**
1998	600	85.6%	101	14.4%	**701**	**100.0%**
1999	562	85.7%	94	14.3%	**656**	**100.0%**
2000	568	89.0%	70	11.0%	**638**	**100.0%**
2001	555	87.8%	77	12.2%	**632**	**100.0%**
Total	**2851**	**86.6%**	**443**	**13.4%**	**3294**	**100.0%**

Table 2
Physicians Exiting From Canadian Family Medicine Training Programs, 1997 - 2001 (Practice Entry Cohort)
PROVINCE PROVIDING POST-M.D. TRAINING
BY
TYPE OF PRACTICE LOCATION IN CANADA (URBAN VS. RURAL)*
TWO YEARS AFTER EXIT FROM TRAINING

Province Providing Post-M.D. Training	Type of Practice Loc.				Total	
	Urban		Rural			
	Count	Row %	Count	Row %	Count	Row %
NEWFOUNDLAND	60	58.8%	42	41.2%	**102**	**100.0%**
THE MARITIMES	138	88.5%	18	11.5%	**156**	**100.0%**
QUEBEC	945	85.7%	158	14.3%	**1103**	**100.0%**
ONTARIO	1001	89.3%	120	10.7%	**1121**	**100.0%**
MANITOBA	108	81.2%	25	18.8%	**133**	**100.0%**
SASKATCHEWAN	71	77.2%	21	22.8%	**92**	**100.0%**
ALBERTA	332	91.5%	31	8.5%	**363**	**100.0%**
BRITISH COLUMBIA	196	87.5%	28	12.5%	**224**	**100.0%**
Total	**2851**	**86.6%**	**443**	**13.4%**	**3294**	**100.0%**

* Data Sources:
Practice location postal codes from CMA Masterfile.
Exit cohorts from the CAPER database.

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Canadian Medical Education Statistics, 2003

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This publication is available on ACMC's web-site www.acmc.ca.

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