
# GRAVITAS

m. (feminine gravitatis) a quality of substance or depth
m. (feminine gravitatis) caractère de ce qui a de l'importance

AFMC
The Association of Faculties of Medicine of Canada
L'Association des facultés de médecine du Canada


## Research, Evidence and Advocacy

*By: Irving Gold, Vice President, Government Relations and External Affairs*

The worlds of advocacy and research are becoming increasingly intertwined and there is bound to be much more discussion about the appropriate relationship between the two.

In the pages of this edition of *Gravitas* you will find a lot of talk of evidence. This is not surprising since the entire medical endeavor, from medical education to research to practise, is squarely about evidence – collecting it, reviewing it, interpreting it, assessing its quality and, ultimately, employing it.

The discourse of evidence in the medical domain has come to be dominated by two concepts: evidence-based medicine and knowledge translation. Evidence-based medicine, often associated with the pioneering work of individuals such as Archie Cochrane, David Sackett and Gordon Guyatt, focuses on the explicit use of current best evidence in clinical decision-making, while knowledge translation is a more general process linking evidence to all kinds of decisions and decision-makers.

A common critique of both of these concepts is that their articulations often underestimate the importance of the normative elements that go into many decision-making processes, elements such as values and preferences. The argument is that evidence becomes somewhat reified, and that there is an implicit (and naïve) idea that armed with the best available evidence, all decision-makers will act 'rationally' and implement that evidence. Much has been written about this topic and I will not get into it further here; my purpose is to touch on a different, but related issue – the relationship between scientific evidence and advocacy.

Advocacy is the act of arguing on behalf of a particular issue, idea or person. For many, the line between science and advocacy ought to be clear and solid; situations involving values, interests, or policy are seen as an anathema to science. Alternatively, and increasingly, others argue that there is an intrinsic link between science and values, interests, and advocacy. *Continued on page 9*


Volume 41 | No.1 |
March/mars 2008

GRAVITAS
The Association of Faculties of Medicine of Canada | L'Association des facultés de médecine du Canada



Editor/Éditeur: Irving Gold
Managing Editor/Coordonnatrice: Natalie Russ
ISSN: 1913-9616

WWW.AFMC.CA

# Reflections

*By: Nick Busing, President & CEO*

Practicing medicine today poses many challenges - large numbers of patients, the explosion of information that an individual physician has to grapple with, limited amounts of time, changing morbidity patterns, new practice environments (frequently with interprofessional teams), and evolving payment structures to name but a few. One of the greatest challenges is practising evidence-based medicine. It requires integrating the best available external clinical evidence into a patient-centered model of practise.

As Dr. Kathryn Stewart, Medical Director for Care Management at Sinai Health System in Chicago has stated, it is not simply about finding evidence of what works, but finding 'evidence that matters'. We have always used evidence in the practice of medicine; today we have better evidence, based on more rigorous research and the utilization of tools such as systematic reviews and meta analyses.

Every day in clinical practice I am faced with challenges to apply the evidence in the context of the patient and his or her reality. That reality includes the patients' beliefs and values, financial circumstances and support systems in their living environment. As well, it includes the patients' risk factors, preferences, and co-morbidities.

Let me give you an example. We know the current evidence regarding the targets for managing lipids – in a low risk, medium risk and high risk patient (albeit the targets are continually being adjusted). There are many new and powerful medications on the market to help lower lipids when needed. Lifestyle modifications, including diet and exercise, can contribute to addressing the problem.

Targets are one thing but realizing them by applying the best evidence is a complex process. It requires explaining them to the patient (negotiating the options), encouraging lifestyle changes, discussing medications with potentially serious side effects and assessing those risks against the risks of living with elevated lipids. As well, we need to understand why the patient may or may not be prepared to accept our advice and understand that the patient may not follow our advice – knowingly or with a lack of full appreciation of the issues.

Even though we may have good evidence, and we develop strategies to implement the evidence, acceptance and implementation is still up to the patient. We can teach our students and residents about what the evidence is, where to find it, how to apply it and how to measure its effectiveness. But we must certainly also teach them to listen to their patients (and their concerns), understand the decisions they take, and be prepared to support them whether they accept evidence-based care or not.

The patient-physician relationship is a powerful tool - one we should never compromise or minimize, but one we should recognize as an essential component of the practise of medicine. It can frequently be used to help our patients understand the evidence for taking particular decisions and support them no matter what their decisions are. *(French version on page 5/ version français à la page 5)*

# Uncovering the Rhetorical Truth: A case for evidence-based medical education

*By: Richard I. Levin, Vice-Principal (Health Affairs) & Dean, Faculty of Medicine, McGill University*

*Rhetoric is the science which refreshes the hungry, renders the mute articulate, makes the blind see, and teaches one to avoid every lingual ineptitude.*
- Anonymous, 1495

Since the creation of the Hippocratic *Corpus* some 2500 years ago, knowledge in medicine has surpassed even the most cunning predictions, if not the most optimistic dreams. The doubling rate for biomedical science is estimated at seven years. Yet, the curriculum is offered over the same period of time as it was when our faculties were founded. With shortened lengths of stay, the human classroom of the hospital is transmogrified. Yet, the common methods of our education, take us back to antiquity, when the great teachers, like Aristotle, developed an earlier art and science, that of rhetoric, which still serves as a vital teaching tool to whet the appetite for learning.

Traditional physician-based education derives its power from the ethos, logos and pathos of rhetoric. Put simply, when making a point, a *rhêtôr* (from Greek meaning "teacher") will appeal to students through authority and reputation (ethos), through scholarship, logic or reasoning (logos), and through emotion (pathos). Graduates of our faculties are accomplished students of medicine, understand the success of our best orators, and emulate their mentors. So, why is there a need for questioning our pedagogical techniques? Why might there be a need for change?

As physicians, we must keep abreast of the latest findings and transfer this to what we teach. Before research can be published, it must be rigorously scrutinized by recognized experts and drained of any doubt about validity. We realize the importance of scientific evidence in allowing us to make informed decisions in diagnosis and therapy. So why do we have such a different attitude towards education? Why do we hold such high regard for medical research based on evidence and derive our teaching methods from intuition and tradition through the use of Aristotelian styles of appeal?

The issue is not that use of traditional teaching methods is poor practise, but whether it can be improved. Educational research, a much younger sister to biology, shares many similarities with biological and health-services research in that the interventions under study are often complex and multifactorial. Applying evidence-based principles to medical education is essential to develop the most effective methods and approaches.

New environments, such as Centres for Medical Education, have developed over the last thirty years to carry out such studies. These Centres allow us to conduct sound medical education research that informs practice in an environment where it can be readily tested. Instead of relying on any current pedagogical trend, faculty members will have increasing access to the evidence and resources to make sound professional judgments in their roles as teachers and educators. Even though what and how we teach are always changing, our educational practises will become based on evidence, just as our research will be informed by practise. This is as it should be in a profession that transformed itself by adopting science as its guide.





Gravitas is the official publication of The Association of Faculties of Medicine of Canada. It is published four times a year. Opinions expressed in this bulletin do not necessarily reflect the views of the Association. Contributions to Gravitas in either English or French are welcomed. Advertisements are also accepted. Gravitas is sent free of charge to members of the Association. The annual subscription fee for non-members is $30.00.

Gravitas est l'organe officiel de L'Association des facultés de médecine du Canada et paraît quatre fois par an. Les opinions exprimées dans ce bulletin ne sont pas nécessairement celles de l'Association. Les contributions à cette publication sont les bienvenues et peuvent être rédigées en français ou en anglais. Les annonces publicitaires sont également acceptées. L'abonnement annuel à Gravitas est de 30,00$ sauf pour les membres de l'Association qui le reçoivent gratuitement.

## Articles of Interest

Visit the AFMC website for links to these journal articles at www.afmc.ca/news-articles-e.php

A healing curriculum J. Donald Boudreau, McGill University; Eric J. Cassell, McGill University and Weill Medical College of Cornell University, New York City; and Abraham Fuks, McGill University Medical Education December 2007

Scripts and clinical reasoning Bernard Charlin, Université de Montréal; Henny P. A. Boshuizen, Open University of the Netherlands; Eugene J. Custers, Utrecht University, The Netherlands; and Paul J. Feltovich, Florida Institute for Human and Machine Cognition Medical Education December 2007

Science is fundamental: the role of biomedical knowledge in clinical reasoning Nicole N. Woods, University of Toronto Medical Education December 2007

Cognitive metaphors of expertise and knowledge: prospects and limitations for medical education Maria Mylopoulos and Glenn Regehr, University of Toronto Medical Education December 2007

Teaching from the clinical reasoning literature: combined reasoning strategies help novice diagnosticians overcome misleading information Kevin W. Eva, McMaster University; Rose M. Hatala, University of British Columbia; Vicki R. LeBlanc, University of Toronto; and Lee R. Brooks, McMaster University Medical Education December 2007

Found in translation: the impact of familiar symptom descriptions on diagnosis in novices Meredith Young, Lee Brooks and Geoff Norman, McMaster University Medical Education December 2007

Non-analytical models of clinical reasoning: the role of experience Geoff Norman, Meredith Young and Lee Brooks, McMaster University Medical Education December 2007

Les implications du phénomène des médecins hospitaliers François Lehmann, Université de Montréal; Yvon Brunelle, Agent de recherche, Ministère de la santé et des services sociaux du Québec; Martin Dawes, l'Université McGill; Richard Boulé, Université de Sherbrooke; and Rénald Bergeron, Université Laval Le Médecin de famille canadien décembre 2007

Medical students reach out for Global health Avita Sooknanan, McMaster University and Nikhil Pai, University of Toronto Canadian Family Physician November 2007

Why would I choose a career in family medicine?: Reflections of medical students at 3 universities Ian Scott, University of British Columbia; Bruce Wright, University of Calgary; Fraser Brenneis, University of Alberta; Pamela Brett-MacLean, University of Alberta and Laurie McCaffrey, Health care consultant, Edmonton Canadian Family Physician November 2007

Faculty Development as an Instrument of Change: A Case Study on Teaching Professionalism. Yvonne Steinert, Richard Cruess, Sylvia Cruess, J Donald Boudreau and Abraham Fuks, McGill University Academic Medicine. November 2007.


# Progress Report on the Return on Investments in Health Research: Defining the best metrics assessment

*By: Paul W. Armstrong, Past-president and Martin T. Schechter, President, Canadian Academy of Health Sciences*

AFMC has joined over twenty provincial and national organizations to sponsor a major assessment concerning health research by the Canadian Academy of Health Sciences (CAHS). Modeled after the U.S. Institute of Medicine, the academy was founded in 2004 and has elected approximately 260 fellows from the academic health science community across Canada through a rigorous peer-review process that recognizes those who have demonstrated leadership, creativity, and distinctive competencies. The fellows span the full breadth of academic health science from fundamental science to social science and population health and represent the full spectrum of health disciplines including nursing, dentistry, veterinary medicine, rehabilitation sciences, pharmaceutical sciences, medicine and related fields such as psychology, health law, ethics and health economics. Not surprisingly, many of the fellows of CAHS hold appointments within the faculties of medicine represented by AFMC.

CAHS and its fellows stand ready to address the pressing issues that continuously emerge in the complex world of health and health care, such as the appropriate limits on stem cell research and the relationship of vaccines to autism. Not an advocacy organization, the academy is well positioned to provide careful and thoughtful analysis of complex topics that is not only expert, but also unbiased and independent of vested interests and agendas.

The CAHS assessment sponsored by AFMC, entitled *The Return on Investments in Health Research: Defining the Best Metrics*, has been commissioned to define the best framework and metrics to assess the return on public and private funding of health research. The topic was chosen based on widespread interest from multiple quarters and a commensurate desire to better comprehend this complex subject in an era of increased public scrutiny and accountability. An independent panel of fourteen experts from Australia, Canada, Great Britain, and the U.S.A. who specialize in a variety of disciplines including law, ethics, medicine, economics, and biomedical research has been struck with Dr. Cyril Frank (Faculty of Medicine, University of Calgary) as its chair.*

The work of the panel is well underway. The assessment was launched with a full-day forum in Montréal on September 18, 2007 that included such speakers as the Honourable John Manley, former Deputy Prime Minister and Finance Minister of Canada, and André Picard of the Globe and Mail (to view this PDF go to: www.cahs-acss.ca/e/pdfs/ROI_ForumSummary2007.pdf).

In early November 2007, the inaugural panel meeting was held in Toronto. The meeting brought together the panel to discuss potential frameworks and metrics that are being further investigated. More meetings and teleconferences are planned throughout 2008 prior to submission of a panel report to the academy's Standing Committee on Assessments (Chair: Dr. Andreas Laupacis, University of Toronto) that will coordinate a thorough external review. Only after it is fully revised and approved by the board of the academy, will the panel report be made available to the sponsoring organizations. The panel is expected to produce a comprehensive report that will better enable the assessment abilities of policy-makers, health research organizations, academia and funding agencies to measure and evaluate the effectiveness of the health research enterprise.

*Assessment Panel Members
Cyril Frank (Chair), University of Calgary
Renaldo Battista, Université de Montréal
Linda Butler, Australian National University
Martin Buxton, Brunel University, UK
Neena Chappell, University of Victoria
Sally C. Davies, Department of Health, UK
Aled Edwards, University of Toronto
Chris Henshall, University of York, UK
Yann Joly, Université de Montréal
Terence Kealey, University of Buckingham, UK
Senator Michael Kirby
Gretchen Jordan, Sandia National Laboratories, US Department of Energy
Michael Wolfson, Statistics Canada
Steven H. Woolf, Virginia Commonwealth University, US

# Réflexions *Par: Nick Busing, Président-directeur général*

De nos jours, pratiquer la médecine comporte de nombreux défis – le nombre élevé de patients, l'explosion de renseignements que nous devons absorber, le peu de temps dont nous disposons, l'évolution des tendances en matière de morbidité, les nouveaux milieux de pratique (souvent au sein d'équipes interprofessionnelles) et les changements relatifs aux structures de paiement pour n'en nommer que quelques-uns. Pratiquer une médecine fondée sur la preuve constitue l'un des principaux défis qui nécessite l'intégration de la meilleure preuve clinique externe existante à un modèle de pratique axé sur le patient.

Comme l'a dit la Dre Kathryn Stewart, directrice médicale de la Gestion des soins au Sinai Health System de Chicago, il ne suffit pas de trouver la preuve de ce qui fonctionne, il faut trouver « une preuve pertinente ». Nous avons toujours utilisé la preuve dans la pratique médicale. De nos jours, nous disposons d'une meilleure preuve, fondée sur une recherche plus rigoureuse et sur l'utilisation d'outils tels que les examens systématiques et les méta-analyses.

Chaque jour dans le cadre de la pratique clinique, je suis confronté à des situations qui m'obligent à mettre la preuve en pratique dans le contexte du patient et de sa réalité. Cette réalité englobe les croyances et les valeurs du patient, les circonstances financières et les systèmes de soutien de son cadre de vie ainsi que les facteurs de risques qui se rapportent à lui, ses préférences et les tendances en matière de comorbidité.

Laissez-moi vous donner un exemple. Nous connaissons la preuve actuelle concernant les cibles relatives à la gestion des lipides – chez un patient présentant un faible risque, un risque moyen et un risque élevé (bien que les cibles soient constamment réajustées). Il existe de nombreux nouveaux médicaments puissants sur le marché pour aider à réduire les lipides, au besoin. Modifier son style de vie en optant pour des choix santé en matière d'alimentation et en faisant de l'exercice peut contribuer à traiter le problème.

Fixer des cibles est une chose, mais les atteindre en mettant en pratique la meilleure preuve est un processus complexe. Vous devrez expliquer ces cibles au patient (négocier les options), l'inciter à modifier son style de vie, discuter des médicaments et de leurs graves effets secondaires et évaluer ces risques en les comparant à ceux qui découlent du fait de vivre avec un taux de lipides élevé. Nous devons également comprendre pourquoi le patient peut être ou non prêt à accepter nos conseils et réaliser qu'il est possible qu'il ne les suive pas – sciemment ou en raison d'une mauvaise compréhension de la question.

Bien que nous puissions avoir entre les mains une preuve probante et que nous élaborions des stratégies pour en faire la démonstration, l'acceptation de la situation et la mise en œuvre des mesures nécessaires relèvent toujours du patient. Nous pouvons enseigner aux étudiants et aux résidents ce qu'est la preuve, où la trouver, comment la mettre en pratique et mesurer son efficacité, mais nous devons également leur apprendre à écouter leurs patients (et leurs préoccupations), à comprendre les décisions qu'ils prennent et à être prêts à les appuyer, qu'ils acceptent ou non les soins axés sur la preuve.

La relation médecin-patient est un outil puissant que nous ne devrions jamais compromettre ou minimiser, mais que nous devrions reconnaître comme une composante essentielle de la pratique de la médecine. On peut fréquemment l'utiliser pour aider nos patients à comprendre les raisons expliquant la prise de décisions précises et les appuyer quelles que soient leur décision.

Read AFMC's response to the 2008 Federal Budget on WWW.AFMC.CA

Lisez la réaction de l'AFMC à l'endroit du budget fédéral de 2008 sur le site Web WWW.AFMC.CA

## Appointments, awards and honours from Canada's faculties of medicine / Nominations, prix et honneurs décernés par les facultés de médecine canadiennes

Memorial University of Newfoundland Two members of the Discipline of Family Medicine have received 2007 awards of excellence from the College of Family Physicians of Canada. Dr. Roger Butler and Dr. Michael Jong, were honoured with these awards. They are designed to recognize and celebrate achievements of family physicians and to support them in continuing professional development, continuing medical education, research and education in family medicine.

Université Laval Simon Patry, professeur de clinique au Département de psychiatrie, est le lauréat de la catégorie Soins en santé mentale parmi les médecins de cœur et d'action 2007.

Université de Sherbrooke Dr Réjean Hébert, médecin gériatre, chercheur et membre de l'Académie canadienne des sciences de la santé, a été renommé au poste de doyen de la Faculté de médecine et des sciences de la santé (FMSS) pour un deuxième mandat.

Université de Montréal M. Yves Joanette, professeur à l'École d'orthophonie et d'audiologie et directeur du Centre de recherche de l'Institut universitaire de gériatrie de Montréal ont reçu un doctorat honoris causa. Il doit sa renommée à ses travaux sur les aspects cognitifs de la maladie d'Alzheimer.

Université de Montréal Dr Rafick-Pierre Sékaly, professeur titulaire en microbiologie et immunologie, ainsi que Dr Yves Joanette, professeur à l'École d'orthophonie et d'audiologie et directeur du Centre de recherche de l'Institut universitaire de gériatrie de Montréal, se sont vus décerner un doctorat Honoris Causa par l'Université de Lyon.

McGill University Dr. Margaret Becklake, Faculty of Medicine, has been inducted as a member of the Order of Canada.

Queen's University at Kingston New appointments to the faculty of health sciences: Shafeesqur R. Salahudeen, Diagnostic Radiology and Michael O'Reilly, Medicine Cardiology.

University of Toronto Professor Michael Cusimano of Surgery is this year's winner of the Provan Outstanding Canadian Surgical Educator Award. Sponsored by the Canadian Association of Surgical Chairmen, the award is given in recognition of outstanding contributions to undergraduate surgical education in Canada.

Guest Editorial

# Do We Practise Evidence-based Education for Evidence-based Healthcare?

*By: Jeremy Grimshaw, Canada Research Chair in Health Knowledge Transfer and Uptake; Director, Canadian Cochrane Network and Centre; Department of Medicine, University of Ottawa and Sharon Straus, Associate Professor, Faculty of Medicine, University of Calgary; and Associate Professor, Associate SGS Member, Toronto General Hospital, Department of Medicine*

Medical education aims to equip future doctors with the knowledge and skills to practice medicine and to develop lifelong learning skills. A fundamental component of medical education focuses on the scientific basis of medicine and in the last two decades the emergence of evidence-based medicine (EBM) has further emphasized the importance of using rigorous evidence to answer clinical questions at the bedside.

Whilst EBM recognizes that different research designs and methods are necessary depending on the type of question, it promotes the use of rigorous quantitative designs (mainly randomised trials) to evaluate clinical innovations. Randomised trials have also been used in the education, criminology and welfare sectors to evaluate a broad range of innovative programs.[1]

We are perplexed that medical education appears to largely eschew randomized trials to evaluate innovative programs. Ironically, our experience is that medical educators will often cite systematic reviews of rigorous evaluations when they are available whilst at other times arguing that randomised trials may not be appropriate for evaluating educational interventions.

Currently, there are many different initiatives happening in academic medicine that should be rigorously evaluated to determine their benefits, harms and costs. An example of this is interprofessional education, which is widely promoted despite relatively little evidence about its benefits and even less evidence about how to do it effectively.[2] Similarly, there is relatively little evidence about whether we should be providing medical training over three or four years.[3]

These and other medical education innovations could be evaluated using rigorous randomised designs. Whilst such studies could be performed at single sites, rigour would be enhanced if they were completed across multiple sites. This endeavour would require collaboration at the highest levels, under leadership of the Deans of medicine and organisations such as the Association of Professors of Medicine and others who are interested in preserving and stimulating academic medicine.

Given that medical faculties and training programs are charged with training healthcare professionals for the future and with advancing clinical care, research and education, they should feel compelled to participate in endeavours to stimulate interest in academic medicine and to mandate evaluation of these efforts. Indeed, why should educational interventions be considered different from other interventions such as drugs or care coordination strategies and not be subjected to the same valid evaluation in a randomised trial? A collaborative network of relevant stakeholders could be created to develop and complete this research agenda.

Our challenge is that we need to subject medical education innovations to more critical scrutiny. Failure to evaluate medical education innovations using robust designs limits our learning from such innovations and does a disservice to present and future students.

### References

(1) Boruch R. Better Evaluation for Evidence-Based Policy: Place Randomized Trials in Education, Criminology, Welfare and Health. The Annals of the American Academy of Political and Social Science 2005; 599:6-17.

(2) Reeves S, Zwarenstein M, Goldman J, Barr H, Freeth D, Hammick M et al. Interprofessional education: effects on professional practice and health care outcomes. Cochrane Database Syst Rev 2008;(1):CD002213.

(3) Flegel KM, Hebert PC, MacDonald N. Is it time for another medical curriculum revolution? CMAJ 2008; 178(1):11, 13.

McMaster University Two FHS professors have been elected to the prestigious Royal Society of Canada (RSC): Brian Haynes, Professor and Chair of the Department of Clinical Epidemiology and Biostatistics and Geoff Norman, Professor and Director of the Program for Educational Research and Development, will receive a citation from the Academy of Social Sciences.

Northern Ontario School of Medicine Dr. Peter Hutten-Czapski has been named "family physician of the year" for the North by the Ontario College of Family Physicians (OCFP). The award recognizes the outstanding dedication of family physicians to their patients, their community, and their profession.

University of Manitoba Dr. Phillip Gardiner, Associate Dean Research, Director of the Health, Leisure and Human Performance Research Institute, and Canada Research Chair in Physical Activity and Health, Faculty of Kinesiology and Recreation Management, was awarded the 2007 Canadian Society for Exercise Physiology (CSEP) Honour Award. Dr. Gardiner was cited as "an outstanding scientist and a pioneer and world leader in studies of the adaptation of the neuromuscular system and spinal cord to physical activity and inactivity. His achievements as an investigator of the highest caliber, coupled with his past and ongoing contributions to CSEP make him a richly deserving recipient of the organization's highest form of recognition".

University of Calgary Dr. Janice L. Pasieka, Faculty of Medicine, has been named one of Canada's 100 most powerful women of 2007 by the Globe and Mail. A former Head of the Division of General Surgery, she developed a novel way of delivering call coverage at the Foothills Hospital and in 1998, helped establish the neuroendocrine clinic at the Tom Baker Cancer Centre.

University of British Columbia Dr. Sharon Salloum has been appointed Associate Dean, MD Undergraduate Program, Student Affairs. She has training and a special interest in communication skills in medicine, and she has worked to develop a communications skills continuum within the UBC curriculum. She has also been the course director of an advanced communications skills course for fourth year medical students called "Doctor-Patient Relationships."

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# The Value of Evidence

*By: Steve Slade, Vice President, Research and Analysis, CAPER-ORIS, AFMC*

Canada's physician resource planning record is, arguably, a bit of a mystery. Consider the data we have on doctors: medical enrolment and graduation numbers; the number of doctors entering and leaving the country; population demand for physician services and physician workload variations, and more. Yet with all this data at hand, Maclean's magazine ran a feature article in January 2008 entitled "The doctor crisis: Why you can't find a doctor and why it's about to get a whole lot worse?"

I don't believe that our poor track record in physician workforce planning negates the value of data, or our efforts to undertake evidence informed planning. In fact, data can be very powerful in providing new insight - insight that may raise flags or prompt important questions that would not have otherwise been asked.

To illustrate, consider the 2004 and 2007 National Physician Survey (NPS) results shown in Figure 1. NPS results show that, in 2007, physicians spent about one hour less per week in direct patient care than they did in 2004. The amount of time spent in all other types of activity has increased. Physicians spent 14% more time on teaching activities, representing the largest percentage increase for any single activity. The amount of time physicians spend on indirect patient care increased 11% between 2004 and 2007. Overall, there was a 2% increase in physicians' average weekly work hours between 2004 and 2007.

The great strength of new evidence is its ability to signal potential issues and prompt new questions. NPS results suggest that, while physicians' total work hours have gone up, time spent face-to-face with patients has gone down. How does this trend factor in to the doctor crisis? And what of the time physicians spend teaching? Increased teaching time is certainly in line with recent growth in medical school enrolment, increased numbers of clinical teachers and the expansion of distributed medical education. The NPS data prompts new questions about how (and if) clinician teachers can add more teaching time to their already busy work weeks.

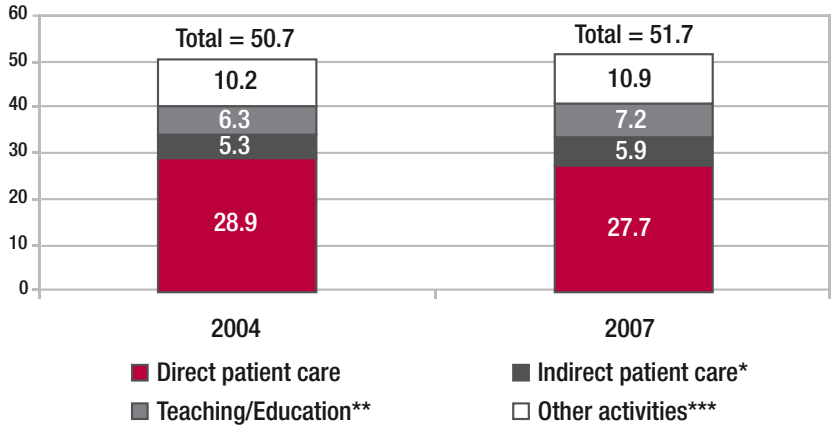
In recognizing the value of evidence, it is equally worthwhile to acknowledge how difficult it can be to act upon it. Physicians can attest to the challenges of inserting evidence-based guidelines into their clinical practices. Similarly, health care policy and decision makers can attest to challenges and constraints within their own domains. Perhaps Barer and Stoddart foresaw exactly these challenges when, only shortly after the release of their 1991 report, they observed,

*One of the great difficulties in developing and implementing a set of strategic policy reforms as extensive as those we have set out is that their success depends so critically on the delicate interweaving of many individual initiatives in areas controlled by many different players. In the end, policy change is developed by individuals, negotiated among individuals and affects individuals.*[1]

As we reflect on the value of evidence, it is important to consider both its strengths and limitations. If we are not always able to put evidence into practise, it doesn't mean that the data-gathering exercise is not worth it. There is value in evidence - I think we're still learning where to find it.

1 Barer ML, Stoddart GL: Toward integrated medical resource policies for Canada: 12. Looking back, looking forward. CMAJ. 1993 January 1; 148(1): 29–32.

Figure 1: Physician Average Weekly Work Hours (excluding on-call), by Type of Activity, 2004 and 2007




*Includes review of chart and lab results, telephone consultation, etc.; **Includes teaching activities in the classroom and in clinical settings; ***Includes activities such as research, administrative, CME and committee work.

Source: 2004 and 2007 National Physician Survey. The College of Family Physicians of Canada, Canadian Medical Association, The Royal College of Physicians and Surgeons of Canada.

## AFMC Resource Group on Institutional Advancement – May 5 & 6 at the 2008 Canadian Conference on Medical Education

Are you on the verge of launching a campaign or in the midst of wrapping one up only to start another? This is the ideal platform for you to learn from your colleagues' experiences in medicine and discuss common challenges and opportunities with a talented group of experts in development.

This year's program includes: Don Taddeo, President of the McGill University Health Centre Foundation, who will discuss best fundraising practises for soliciting grateful patients for both teaching hospitals and medical schools; Russell Williams, President of Rx&D, who will share his knowledge of the pharmaceutical sector and how research and development plans impact medical school advancement; Chantal Thomas from the Université de Montréal and Susan Reid from McGill University, on new planned giving tools to help us fund a Chair by combining planned and major gifts; Royal Govain from Grenzebach Glier & Associates on Capital and Comprehensive Campaign Planning; and KCI Ketchum head-hunter Gillian Morrison, who will offer trade secrets on recruiting senior development officers.

## 2008 CANADIAN CONFERENCE ON MEDICAL EDUCATION
## Montréal May 3-7

*By: Kamal Rungta, Chair, Scientific Planning Committee*

The Association of Faculties of Medicine of Canada, the Canadian Association for Medical Education, the College of Family Physicians of Canada, the Medical Council of Canada and the Royal College of Physicians and Surgeons of Canada have partnered to deliver Canada's premier medical education conference. This year the vibrant city of Montréal plays host and the theme is: *Educating for the Future: Predicting and Managing Change.*

The Scientific Planning Committee has engaged a dynamic schedule of speakers that will enrich your conference experience. The Opening Plenary on Monday will include Mr. Léonard Aucoin, President InfoVeille Santé addressing *The Future of Medicine: Major Changes on the Horizon.* In the same plenary Dr. Dan Hunt, LCME Co-Secretary and Vice President, Division of Medical Education of the Association of American Medical Colleges (AAMC) will speak to *The Future of Medicine: When the Rubber Hits the Blue Sky.*

Details on two other plenaries scheduled for Tuesday afternoon, namely *Competency Based Education: What is the Problem? and Strategies to Change Practice* as well as 36 workshops, 79 oral presentations and 92 posters can be accessed on the conference website: http://www.afmc.ca/annual-conference-2008-conference-program-e.php. The website also provides access to online registration and details regarding accommodation.

At the conference, the AFMC-AMS J. Wendell Mcleod Lecture, which is part of the Sunday Welcoming Ceremony, will be given by Dr. Pierre Jean, Professor Emeritus, Université de Montréal, International Consultant on Education and Evaluation of Health Personnel. His topic is *Fashions in Medical Education: Reflections of a Distant Observer.*

The Scientific Program Committee reflected on feedback from the 2007 delegates and as a result the following changes have been introduced into this year's conference:

:. No pre-registration for the workshops and oral presentations, they are on a first come, first serve basis.

:. Each poster will be part of a facilitated poster session.

:. Simultaneous translation will be available for each plenary session, including the Welcoming Ceremony, and the AFMC-AMS J. Wendell Mcleod Lecture.

As you can see this is not a conference to miss. I look forward to seeing you in Montréal.

# Evidence-based Strategies for Influencing Medical Education

*By: Sue Maskill, Vice President, Education and Special Projects*

In training tomorrow's doctors, medical educators must consider evidence in order to develop and deliver curriculum. AFMC and its seventeen faculties of medicine continue to work together on several national medical education initiatives producing national curriculum frameworks so each faculty does not have to begin from scratch. Often the starting point is to learn from others who have worked in the area of focus. Searches of the peer and grey literature are undertaken and at times, stakeholder interviews are held so we can learn from the experiences and perspectives of others.

Both at the national level and the faculty level, several questions need to be taken into consideration in order to create well-rounded physicians who take such things as life circumstances and community resources into account when thinking of the health of their population and individual clients. Evidence-based strategies that influence medical education are enhanced with the inclusion of the right stakeholders advising the process to be sure we are truly developing an effective and efficient model of medical education. It is also necessary to include the community voice (who know better if our physicians and learners are meeting patient needs and in a caring and respectful manner) as well as student and resident representatives that are able to offer a reality check from the learners' perspective. In order to successfully move forward, we need enough medical educators involved in the development and delivery of curriculum who know the education system and what is reasonable to expect to include in curriculum frameworks as well as other health professionals, governments and health managers who can help ground the discussions. Each has an important contribution to make with regard to process and content for developing and executing curriculum.

However, in moving forward with these guidelines, we are not without our challenges. Some of the important questions to bring to light are:

How do we balance communicating all pertinent knowledge regarding evidence-based strategies for influencing medical education with how it is delivered? This shapes the practicing behaviour of the future physicians.

Have we engaged the faculty in the process of introducing the new curriculum so they can be the role models and mentors the learners need to be responsive to their clients. As we know learners are greatly affected by the attitudes of the faculty, regardless of the curriculum content and process for learning. Are the faculty seen as more than medical experts – respectful collaborators, managers, advocates?

What about evaluation of the new curriculum – what evidence (indicators) will tell us whether the new curriculum content and its method of delivery have been effective? Is it contributing to producing the kind of physician Canadians want?

Developing and introducing new curriculum for training our future physicians is a complex undertaking and there are many kinds of evidence to take into consideration.

## Highlights of the 2008 Canadian Conference on Medical Education

**SUNDAY – MAY 4 16:00 - 17:30**

**WELCOMING CEREMONY AND AFMC - AMS J. WENDELL MACLEOD MEMORIAL LECTURE**

Co-chairs: Richard Levin, Vice-principal, Health Affairs and Dean, Faculty of Medicine, McGill University; Jean Rouleau, Dean, Faculty of Medicine, Université de Montréal

**Greetings from Presidents**
Nick Busing, AFMC
Yvonne Steinert, CAME
Ruth Wilson, CFPC
Rocco Gerace, MCC
Louise Samson, RCPSC

**Fashions in Medical Education: Reflections of a Distant Observer**
Pierre Jean, Professor Emeritus, Université de Montréal, International Consultant on Education and Evaluation of Health Personnel

*Continued from cover article:*

One view of this link co-exists well with the world of evidence-based medicine and knowledge translation. It is a view which sees science and research as being fundamentally different in nature and sequentially distinct from efforts to move it into practise. Friedlaender and Winston (2004), for example, argue that in the medical domain, advocacy "*concludes* a professional obligation to those in our care by translating research to action"[1] (see text box). To illustrate, they point to the critical societal contributions of the advocacy work of medical academics such as Dr. Jonas Salk and Dr. Luther L. Terry, Surgeon General of the United States Public Health Service, the former virtually eliminating polio and the latter dramatically reducing smoking rates in the United States.

### Nine Elements of the Art of Advocacy

1. Choose a position that is grounded in science
2. Determine target audiences
3. Know your audience
4. Choose evidence that is appropriate for your audience
5. Choose action that is realistic for your audience
6. Keep your message clear and succinct
7. Tailor your message to the given forum
8. Acknowledge your limitations and seek collaboration to strengthen your position
9. Evaluate your efforts

Others, however, see the link between advocacy and research residing in elements of the scientific enterprise itself, pointing to the fact that science has always had a side to it that is purposive as opposed to purely exploratory or didactic. Some see advocacy as an increasingly central part of the scientific endeavor itself. The increasing scarcity of research funding has come to mean that all researchers engage in some form of advocacy when they make claims regarding the importance of funding *their* research as opposed to the research of others. Moreover, researchers must often problematize the issues they wish to investigate in order to 'justify' expenditure.

A more abstract perspective leads some to claim that scientists engage in normative assessments when they choose to seek out a particular *type or kind* of knowledge; that what researchers ask is often a value judgment of what they think is important to ask. Their methodologies and theoretical perspectives are also seen as contributing to what they find and the available policy options stemming from their research.

The worlds of advocacy and research are becoming increasingly intertwined and there is bound to be much more discussion about the appropriate relationship between the two. AFMC is integrally involved in both, and in various combinations. We advocate for research, we advocate for evidence-based decisions in the policy arena, and we endeavor to undertake advocacy in an evidence-based way. AFMC will stay tuned into the ongoing discussion to keeps it's advocacy work in step with the times.

1 Inj Prev 2004;10:324

## Highlights of the 2008 Canadian Conference on Medical Education

### MONDAY – MAY 5 08:30 - 11:00

**PLENARY SESSION – EDUCATING FOR THE FUTURE: PREDICTING AND MANAGING CHANGE**

**Learning Objectives:**

- to identify strategies to consider and approach change
- to describe the forces that are likely to produce change in the next decade and beyond
- to provide a common paradigm and or language to discuss change during the rest of the meeting

Co-chairs: Richard Levin, Vice-principal, Health Affairs and Dean, Faculty of Medicine, McGill University; Jean Rouleau, Dean, Faculty of Medicine, Université de Montréal

**The Future of Medicine: Major Changes on the Horizon** Léonard Aucoin, President, InfoVeille Santé

**The Future of Medicine: When the Rubber Hits the Blue Sky** Dan Hunt, LCME Co-secretary; Vice-president, Division of Medical Education, Association of American Medical Colleges

**Discussion and Question Period**

**Concluding Remarks**

## MCC/LMCC/FMRAC Update Session Sunday, May 4 13:00 - 15:00 2008 Canadian Conference on Medical Education (Montréal)

This session is open to all who would like to attend. Updates on the Medical Council of Canada (MCC) activities including examination results (Evaluating Examination, Qualifying Examination Parts I & II), Licentiate requirements, projects, research and development initiatives as they relate to the medical faculties, students, and residents will be presented along with updates from the Federation of Medical Regulatory Authorities of Canada (FMRAC). Those individuals who use the MCC examination results or those individuals who would like to learn more about what the MCC does will find this session useful.

Refreshments will be served.

Proposed speakers:
M. Ian Bowmer, MD, MCC Executive Director
Fleur-Ange Lefebvre, PhD, FMRAC Executive Director
Robert S. Lee, MBA, MCC Director, Examination Bureau
Cindy Streefkerk, MCC Interim Director, Credentials and Registrations
Ramses Wassef, MD, MCC Chair, Central Examination Committee
David E. Blackmore, PhD, MCC Director, Research and Development

## 2008 CFPC Medical Student Scholarship Program

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Each Canadian medical faculty is invited to nominate one outstanding medical student in their second last year of study who has demonstrated an interest in or commitment to family medicine as a career. Sixteen scholarships of $10,000 will be awarded this year to medical students. In addition, students will receive complimentary registration and funding up to $1,000 to cover travel and other expenses to attend Family Medicine Forum (FMF) 2008, in Toronto, November 27 - 29.

The deadline for applications is April 15, 2008.

Application forms are available from the office of the Dean for Undergraduate Medical Education at each Canadian medical faculty and on the CFPC website www.cfpc.ca/awards.

## 2008 AFMC and CAME award winners

### Highlights of the 2008 Canadian Conference on Medical Education

**TUESDAY – MAY 6 14:30 - 16:30**

**PLENARY SESSION (concurrent)**

**STRATEGIES TO CHANGE PRACTICE**

Chair: Ivan Silver, Vice-dean, Continuing Education and Program Development, Faculty of Medicine, University of Toronto

**Learning Objectives:**

- to discuss the enablers and barriers that impact on translating new knowledge and skills into practice
- to describe three practice tools that assist a physician's learning
- to discuss the impact of policy and organizational change on knowledge translation
- to discuss patient factors that influence knowledge translation
- to describe the evidence that education interventions change a physician's practice

**Panel Members:**

- Closing the Clinical Care Gap: The Knowledge Translation Imperative
  Dave Davis, Vice-president, Continuing Health Care Education and Improvement, Association of American Medical Colleges
- Accelerating Knowledge Translation Through Information Technologies: Current and Emerging Opportunities
  *Kendall Ho, Associate Professor, Division of Emergency Medicine, University of British Columbia*
- The Organization and Politics of Practice Change
  Ann Langley, Professor, Department of Management, HEC Montréal
- The Doctor-patient Interface – Communication Issues in Knowledge Translation
  Wendy Levinson, Sir John and Lady Eaton Professor and Chair, Department of Medicine, University of Toronto

**Question Period**

**Concluding Remarks**

The following awards will be presented at the 2008 Canadian Conference on Medical Education (Montréal) Congratulations to the winners!

**2008 AFMC – AstraZeneca Award for Outstanding Contribution to Faculty Development in Canada winner: Dr. Luc Côté**

Luc Côté is a Professor in the Department of Family Medicine at Université Laval. He joined the Faculty of Medicine at Université Laval and the Family Medicine Unit at Saint-François-d'Assise Hospital (UMF-SFA) in 1989. In 1993, he obtained his Ph.D. in education from the l'Université de Montréal and became a Professor at the Bureau de pédagogie des sciences de la santé at Université Laval.

In 2001, he acted as consultant to the Faculty of Medicine at Université de Nantes for the development of a curriculum on the doctor-patient relationship. In 2002, concerned about the training needs in education of professors and clinical teachers, he founded the Faculty of Medicine's Centre de développement pédagogique at Université Laval, which he led as Director until June 2007. He has always been active in medical education research. He was a member of the first Board of Directors of the Société internationale francophone d'éducation médicale (SIFEM). He is presently spending a year studying and doing research at the University of Illinois.

**2008 AFMC – GlaxoSmithKline Young Educators Award co-winner's: Dr. Mark A. Goldszmidt and Dr. Anthony Levinson**

Mark Goldszmidt is a graduate of McGill University, following which he completed his post-graduate work in internal medicine at both Queen's University and the University of Western Ontario. He also holds a Master's degree in Health Professions Education from the University of Chicago at Illinois (Best MHPE Project Awardee). In 2000, he began his career as a general internist and medical educator at the London Health Sciences Centre and the Schulich School of Medicine & Dentistry (SSMD) in London, Ontario.

Dr. Goldszmidt's major academic interest is in education scholarship. He is a founding Co-director of the Group for the Advocacy and Advancement of Medical/Dental Education Scholarship (GAMES). Some of his other current leadership roles include chairing the selection committee for the Canadian Conference on Medical Education (a position which he has held for the past three years), leading a major reform of evaluation practices for SSMD's Department of Medicine, developing an advantage communications program for international residents and participating in various other education-related research projects.

Anthony Levinson, is an Assistant Professor at McMaster University, holds the John R. Evans Chair in Health Sciences Educational Research and Instructional Development, and is Director of e-Learning Innovation for the Michael G. DeGroote School of Medicine. He chairs the e-curriculum sub-group of the Council of Ontario Faculties of Medicine, is a member of the Canadian Healthcare Education Commons (CHEC), a national e-Learning group for the Association of Faculties of Medicine of Canada (CanMedIT), and a member of the e-Learning Advisory Group for the Royal College. Dr. Levinson currently holds research funding and grants from several groups for the development and evaluation of e-Learning. His primary areas of expertise include technology-enabled knowledge translation and he is studying how best to capitalize on multi-media and new technologies to enhance health sciences education. Current areas of interest include knowledge management, information architectures, and instructional design and development, as well as rigorous methodologies for studying the efficacy and effectiveness of instructional interventions.

**2008 AFMC – John Ruedy Award for Innovation in Medical Education winner: Dr. Gerald Fried**

Gerald Fried is a Professor of Surgery and Gastroenterology, and holds the Adair Family Chair of Surgical Education at McGill University. His clinical appointment is at the McGill University Health Centre, where he holds the Steinberg-Bernstein Chair of Minimally Invasive Surgery and Innovation, and is Director of General, Gastrointestinal and Minimally Invasive Surgery at the Montreal General Hospital site.

His clinical interest is in gastrointestinal surgery, and the multidisciplinary application of endoscopic, imaging, and minimally invasive technologies in the care of patients with digestive diseases. Dr. Fried is a recognized authority in surgical education having developed a widely-used simulator for minimally invasive surgery that forms the basis of the Fundamentals of Laparoscopic Surgery (FLS) Program of SAGES and the American College of Surgeons. His group has developed a model for measurement of technical performance in the operating room and the simulator that has met high standards for reliability and validity. Through this work they have established a paradigm to develop and validate simulators to measure technical skills that are highly predictive of clinical performance.

### 2008 AFMC – May Cohen Gender Equity Award winner: Dr. Cara Tannenbaum

Cara Tannenbaum is Assistant Professor of Medicine at Université de Montréal. She brings together a unique combination of medical, research and policy expertise for students and young faculty. With two medical degrees, she practises as a geriatrician and older women's health specialist, overseeing over 70 medical students per year. She is one of the primary mentors of the Canadian Institutes of Health Research Institute's on Aging national SPA program (Summer Program in Aging), where she guides, counsels and mentors graduate and postgraduate students on how to pursue a career in research on aging as a woman, from giving tips on grant writing and publications to discussing when is the best time to get pregnant and start a family.

As an epidemiologist and clinical research scientist, Dr. Tannenbaum holds numerous research grants from the Canadian Institutes of Health Research, and has received recognition from both the American Geriatrics Society and the North American Menopause Society for outstanding research in the field of older women's health. Much of her work serves to empower older women to seek care for their health concerns, and she has had her clinical and research work figure prominently on national television and radio. She recently led the Health Canada Health Policy Research Program on Women's Mental Health Indicators sponsored by the Bureau of Women's Health and Gender Analysis.

### CAME – Ian Hart Award for Distinguished Contribution to Medical Education winner: Dr. Paul Grand'Maison

Paul Grand'Maison has been a member of the Université de Sherbrooke's Department of Family Medicine since 1976 and full professor since 1988. As Vice Dean of Undergraduate Medical Education, he has coordinated the expansion in recent years of more than 100% increase in the number of students in Université de Sherbrooke's MD program.

From 1988 to 1995, he headed the implementation of the Québec OSCE licensing exam on which he completed numerous research projects. He was a member of the Committee on Accreditation of Canadian Medical Schools (CACMS) 1997 to 2005. From 2000 to 2002, he was a founding member of the Canadian Association for Medical Education (CAME) and was President of CAME. Since 2001, he has been the Director of the Sherbrooke World Health Organisation Collaborating Center on the development of responsive health human resources. From 2002 to 2005, he was a member of the international executive committee of The Network: Towards Unity For Health.

He is recognized as an expert in medical education in the domains of faculty development, evaluation of clinical competence, program management, community-based education, distributed medical education and social accountability of medical faculties.

### 2008 CAME – Junior Award for Distinguished Contribution to Medical Education winner: Dr. Liane S. Feldman

Liane Feldman obtained her undergraduate degree from Brown University in Cognitive Science in 1989, and graduated from McGill University in Medicine in 1993. She completed a residency in general surgery and a fellowship in laparoscopic surgery at McGill University. She joined the faculty of McGill University in July 2000. She is currently Associate Professor of Surgery at McGill University, Director of the General Surgery Clinical Teaching Unit at the Montreal General Hospital, and Program Director of the Minimally Invasive Surgery Fellowship at McGill University.

Dr. Feldman's clinical interest is gastrointestinal and laparoscopic surgery, with a focus on solid organ surgery, including donor nephrectomy, splenectomy and adrenalectomy. Her research interests include the use of simulation to teach and assess laparoscopic skills and the assessment and improvement of outcomes of gastrointestinal surgery.

## Highlights of the 2008 Canadian Conference on Medical Education

### TUESDAY – MAY 6 14:30 - 16:30

**PLENARY SESSION (concurrent)**

**COMPETENCY BASED EDUCATION: WHAT IS THE PROBLEM?**

Chair: Dianne Delva, Director, Faculty Development, Faculty of Medicine, Dalhousie University

**Learning Objectives:**

- to understand the issues and definition of competency based education
- to discuss how to provide competency based medical education that integrates competencies and provides learners with the capacity for self-assessment of competence
- to discuss approaches to ensuring continuing competence of physicians
- to understand the challenges and methods for assessing competence

**Panel Members:**

- Pre-certification
  Andrée Boucher, Associate Professor, Department of Medicine, Université de Montréal
- Continuing Competence
  Daniel Klass, Senior Medical Officer, Quality Management Committee, College of Physicians and Surgeons of Ontario
- Evaluation
  Glenn Regehr, Richard and Elizabeth Currie Chair in Health Professions Education Research, Faculty of Medicine, Associate Director, The Wilson Centre, University of Toronto

**Discussion Period**

**Concluding Remarks**

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m. (feminine gravitatis)
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