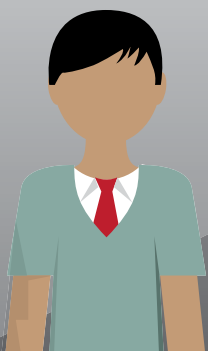


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POSITION PAPER

Principles on Entry Disciplines and Framework for Medical Education Reform

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Resident Doctors of Canada (RDoC) represents over 10,000 resident doctors across Canada. Established in 1972, we are a not-for-profit organization providing a unified, national voice for our membership. RDoC collaborates with other national health organizations to foster excellence in training, wellness, and patient care.

Principles on Entry Disciplines and Framework for Medical Education Reform

When the Royal College of Physicians and Surgeons of Canada (Royal College) was created by an Act of Parliament in 1929 to oversee postgraduate medical education in Canada, only two specialty streams were created: General Medicine and General Surgery. In 1954, the College of General Practice of Canada (*which became the College of Family Physicians of Canada [CFPC] in 1967*) was created with the mandate to establish a postgraduate training program leading to certification in Family Medicine.

Over time the number of residency training disciplines certified by the Royal College and the CFPC has grown substantially. The number of disciplines and subspecialties now available to postgraduate trainees includes 29 Royal College specialties, 36 subspecialties, and 16 diploma areas, as well as 19 areas of enhanced skills in Family Medicine.¹

According to the Maudsley Report (1996), the process by which entry disciplines in postgraduate medical education (PGME) are created is guided by an overarching premise:

“The primary objective of specialist postgraduate medical education is to prepare an appropriate number and mix of consultant physicians and surgeons, with the requisite knowledge, skills and attitudes to meet the needs of Canadian society.”²

Entry disciplines – the training programs that medical students enter at the start of residency – have long been a subject of interest and debate. This document offers background on the current state of entry disciplines in the Canadian PGME system, and suggests principles for their assessment at the national level.

Societal Needs

Entry disciplines have a profound societal impact within health care, where resident doctors serve a dual role as both postgraduate trainees and health care providers:

“...medical educational institutions serve dual purposes – as an education institution it services the education and training of its students; and as part of the health care system it has the responsibility for understanding and meeting the health care needs of the population.”³

As the basic scaffolding of postgraduate medical education, the mix of entry disciplines ultimately guides the supply of physicians in different specialties and locations across the country. Since medical education in Canada is significantly subsidized by government, all citizen-taxpayers are invested in medical training and expect the mix of physicians to meet their needs, wherever they live.

1 The Royal College of Physicians and Surgeons of Canada. Directions for Residency Education, 2009. A Final Report of the Core Competency Project. February 2009, Ottawa.

2 The Royal College of Physicians and Surgeons of Canada. Final Report of the Task Force to Review Fundamental Issues in Specialty Education (Maudsley Report). Ottawa, 1996. p. 1.

3 White, Kerr L. and Julia E. Connelly. Redefining the Mission of the Medical School in “The Medical School’s Mission and the Population’s Health”, Foreword p. v.

4 Carraccio, Carol. Shifting Paradigms: From Flexner to Competencies. Academic Medicine. 2002; 77: 361-7.

Decision-Making in Entry Disciplines

The medical education system is currently in a period of significant change. As competency-based medical education is implemented and demographic pressures increasingly strain the health care system, all aspects of the education system have come under scrutiny.⁴ Most entry disciplines (with the exception of Family Medicine and CFPC areas of enhanced skills) are ultimately set by the Royal College Committee on Specialties.⁵ This committee regularly reviews entry disciplines and subspecialties and considers the right mix and type of specialists to serve the needs of Canadian patients. Although definitions for each entry discipline have evolved or adapted over time, very few have ever been removed.⁶ And neither government nor other national medical organizations provide input into decisions concerning entry disciplines.⁷

In contrast, health human resource (HHR) planning is rooted in the principle that the distribution of specialists should serve and be accountable to the Canadian population. HHR planning perennially captures the attention of governments and medical education stakeholders. The Canadian Post-MD Education Registry (CAPER) was established in 1986, through a partnership of federal/provincial/territorial governments and national medical organizations, with the mandate to track demographic and training information on postgraduate trainees.⁸ CAPER publishes annual data on the demographics, specialties, and locations of all postgraduate resident doctors, and this data has informed many other groups interested in HHR planning.

In 1992 the Conference of Deputy Ministers of Health established the National Coordinating Committee on Postgraduate Medical Training (NCCPMT)⁹ with representation from provincial and federal governments as well as national medical organizations. Its mandate was to examine several issues in HHR planning, including portability of training and the perceived oversupply of specialist physicians. More recently, HHR concerns have led the federal and provincial governments to create and fund the Physician Resource Planning Task Force (PRPTF), which includes medical stakeholders and government representatives.¹⁰ The PRPTF is actively working on a variety of issues in HHR, including modeling the supply of physician human resources in Canada.

Generalism in Entry Disciplines

In medicine, generalism is defined as

“... a philosophy of care that is distinguished by a commitment to the breadth of practice within each discipline and collaboration with the larger health care team in order to respond to patient and community needs.”¹¹

New medical technologies and the growing body of medical information and knowledge have made health care more complex. This growing complexity has been accompanied by increased specialization and

4 Carraccio, Carol. Shifting Paradigms: From Flexner to Competencies. *Academic Medicine*. 2002; 77: 361-7.

5 Canadian Medical Forum. Report of the Working Group on the Common PGY-1. Co-Chairs: Dr. Sarita Verma and Dr. James Clarke. Approved by the Canadian Medical Forum for Discussion, June 2004.

6 Verma S, Birtwhistle M. Letter to Dr. Mikhael and Dr. Kline, June 4, 2003.

7 Canadian Medical Association. Adapting To The New Reality. First Invitational Conference On Flexibility In Career Choice. Preliminary report. Ottawa, 1997.

8 <http://www.caper.ca>

9 Appendix 3, Building Momentum for Change in the Postgraduate Medical Training System, CMA Backgrounder 2015

10 Conference of Deputy Ministers of Health, June 2012

11 The Royal College of Physicians and Surgeons of Canada. Report of the Generalism and Generalist Task Force, July 2013.

12 The Royal College of Physicians and Surgeons of Canada. Report of the Generalism and Generalist Task Force, July 2013.

subspecialization within the medical profession and in the medical education system. Concerns have arisen that this degree of specialization in medical training does not allow physicians to optimally serve the needs of Canadian patients, as generalism ensures coordination of care.¹²

Recognition that entry disciplines should be promoting skills in generalism among postgraduate trainees is not a recent development. In 1998 the Royal College released the Langer Report, “A Re-Examination of the Royal College Specialties and Subspecialties,” which advocated for an approach where “specialties are grouped in generic categories where there are areas of strong commonalities of principles and approach.” The report cited “improved flexibility for career choices among trainees” as a benefit of such a model. National medical organizations have also expressed publicly their willingness to encourage and foster a culture of generalism among practising physicians, which Resident Doctors of Canada (RDoC) believes should also relate to residency training.

Currently there appears to be a disconnect between postgraduate medical education curricula and the desire to promote versatility and generalism in physician trainees. PGME curricula are shaped by the mandatory rotations that physicians must complete in order to be deemed competent and eligible for the licensing (certification) exam and independent practice in their chosen field. This is determined by the CFPC and the Royal College, and guides the training and future practice of resident physicians. Certain rotation structures emphasize concepts and skills that encourage continued subspecialization over the course of residency, which can hinder development of generalism in practice. A loss of generalism in favor of specialization may not equip graduates with the diversity of skills and experiences they need to serve in locations and settings where they are most needed.

A Resident Doctor’s Dual Roles

As the number of subspecialties increases, residents are distributed among a greater number of subspecialty rotations. However, because residents serve a dual role as trainees and health care providers, some programs may wish to maintain training positions for present service requirements, such as call shifts and assisting with procedures, rather than for longer-term objectives, such as meeting population needs or preparing residents for future practice opportunities. Having residents complete a rotation simply for the purpose of providing service hinders their ability to perform rotations that can better prepare them to meet the diverse needs of Canadian communities. The responsibility to the Canadian public needs to supersede considerations such as filling the service requirements of individual programs.

Entry Disciplines Today

There is growing concern that the current system of entry disciplines does not produce a physician workforce that best serves the needs of Canadian patients. Access to medical care is a fundamental human right, and it is the responsibility of our publicly funded health care system to serve the needs of all Canadians. It is therefore incumbent on the postgraduate training system to develop the right mix, type and distribution of physicians to keep the system functioning as efficiently as possible in order to deliver the best care.

Resident Doctors of Canada (RDoC) has developed a set of principles for medical educators, health authorities, and governments to consider when discussing entry disciplines and medical education reform.

RDoC believes that the mix of PGME entry disciplines, and their ability to serve the needs of the Canadian health care system, must be continually re-evaluated to ensure they are aligned with societal and patient needs, adequate generalism skills, and practice and career flexibility.

Principle 1

Social Accountability

Rationale

Canadian society helps fund medical education with the expectation that postgraduate trainees will practise medicine and provide medical services that best serve the needs of patients. It is not clear that the increase in number of entry disciplines and subspecialization have facilitated better health care for Canadian patients, nor is there any system in place to assess this now or in the future.

Call for Action:

1. Entry disciplines and residency positions should be allocated on the basis of societal need.
2. An evaluative process should be established to regularly assess the capacity of each discipline to meet the needs of Canadian patients.
3. Decisions around entry disciplines should be explicit about their effect on physician workforce planning.
4. Residency programs should train physicians to have a sufficiently diverse skillset that promotes employability and meets the needs of the patient population.
5. The mix of entry disciplines or residency spots in academic centres should not be determined by service requirements (see Principle 4).
6. Universities and governments should strive to maintain an adequate ratio of undergraduate to postgraduate training positions, while allowing flexibility for transfers between programs.

Principle 2

Coordination of Decisions Regarding Entry Disciplines

Rationale

Despite the fundamental importance of entry disciplines to HHR planning, the right mix of entry disciplines and subspecialties has not been a topic of discussion at national tables like the PRPTF. Decisions regarding specialties and subspecialties remain the sole jurisdiction of the Royal College and the CFPC, with little oversight or input from other stakeholders and few, if any, metrics of success.

Call for Action:

1. A national, pan-Canadian task force should be established to examine the current mix of entry and subspecialty medical disciplines and work in conjunction with the PRPTF so that no single organization mandates their creation, maintenance or removal. Task force membership should include medical student and resident organizations, national medical stakeholders, the Royal College and the CFPC, and federal/provincial/territorial governments.
2. This conjoint task force on disciplines should review national data sources to prepare recommendations on entry disciplines. Decisions on entry disciplines should be made collaboratively among stakeholders.

3. Decisions to create, maintain or remove entry disciplines should be made independently of (i.e. separately from) the Royal College process of designating specialties.
4. The National Physician and National Resident Surveys should continue their effort to determine whether undergraduate medical students utilize available data on population need when they are making decisions about residency programs and future intended practice locations.

Principle 3

Versatility in Residency Training

Rationale

Whereas previously all medical graduates would begin postgraduate training with a common “rotating internship,” medical students and residents now are required to decide on their career path during the early years of medical school, often before being exposed to all fundamental clinical rotations. This prevents trainees from making a truly informed decision. There are limited options to re-enter or change specialties, and these opportunities are not guided by the needs of Canadian patients.

Call for Action:

1. Transfer policies of postgraduate training programs should be more structured and coordinated to enable flexibility in residency training, particularly for residents who wish to transfer into areas of medical practice that respond to population need.
2. Residents should have the opportunity to train in generalist and community settings throughout their training, including in rural and remote settings.
3. Practising physicians should be permitted to enter second residency programs or to challenge examinations that would facilitate their entry into the workforce in areas of population need.
4. Demand for resident inpatient service should not detract from exposure to generalist/outpatient experiences.
5. Medical schools should promote generalist curricula that do not encourage early streaming into residency disciplines.

Principle 4

PGME Curricula Most Relevant to Future Practice

Rationale

While some residency programs have innovative curricula designed to facilitate transition into practice, other programs may require all residents to complete a fairly consistent set of rotations. It is rare for residency programs to allow residents to stream their training toward a particular practice environment. For example, a general surgery resident interested in a broad, community-based practice may still be required to complete a large number of rotations in subspecialized, tertiary academic settings but may not gain the training needed (e.g., obstetrics) to facilitate his or her career goals.

Call for Action:

1. Service requirements at academic centres should not be used to determine either entry discipline positions or mandatory residency rotations.
2. Postgraduate rotations should be determined with an education focus that serves the needs of residents' future practice populations. Every rotation during the course of a resident's postgraduate education should have specific educational goals.
3. Postgraduate training programs should ensure all residents can access training opportunities in diverse learning environments relevant to future intended areas of practice, including community and rural settings.
4. Postgraduate training programs should support career planning and mentorship programs within PGME to assist residents in identifying career strengths and diverse practice opportunities.
5. A process and schedule to regularly evaluate PGME curricula that considers national workforce data, population needs, and resident career goals should be established.



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