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POSITION PAPER

Resident Principles on Physician Health Human Resources to Better Serve Canadians

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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.

RDoC and Physician Health Human Resources

Proper management of physician health human resources (HHR) is an essential component of quality health care. In a publicly funded system it is critically important to achieve value, effectiveness and efficiency in the utilization and expenditure of health care resources. The fact that Canadian residency graduates from many specialty groups are experiencing difficulty in finding full-time employment¹ should therefore be of major concern to governments, hospitals, and students contemplating a career in medicine, and residents close to or currently looking for independent practice opportunities. Most important is the impact of this trend on Canadian patients and their access to health care.

To develop a comprehensive, multi-pronged approach to understand the HHR situation, build awareness of residents' concerns, and effect change, RDoC, as the national leader in Canadian resident advocacy, brought residents together on the RDoC Standing Committee on Health Human Resources. Policy issues that are founded on the input and collaboration of residents drive RDoC's advocacy.

The Role of Residents on Physician HHR

Residents are physicians who have completed their undergraduate medical school education and are now undertaking postgraduate training in diverse specialty areas. Residency training involves providing direct, hands-on health care services to patients in teaching and non-teaching hospitals, and in settings that range from urban academic teaching centres to remote communities in the north. Twenty-four hours a day, seven days a week, residents are working on the front lines in all areas of the health care system, providing highly skilled and sophisticated services to patients.

In most major hospitals, a resident is the first physician a patient encounters when seeking care and the last face the patient sees on discharge. RDoC brings to the HHR discussion a commitment to enhancing Canada's publicly funded health care system for all patients and an intimate understanding of the training needs of tomorrow's staff doctors. RDoC's members are uniquely positioned to engage with national stakeholders and policy makers to provide the resident perspective on physician health human resources, and to shape our health care system's overarching plan to train, employ and retain Canada's future physicians.

Resident Principles on Physician HHR to Better Serve Canadians

The Resident Principles on Physician Health Human Resources to Better Serve Canadians (the Principles) were developed through an iterative and consultative process by resident members on the RDoC Standing Committee on HHR and serves as the resident perspective on physician health human resources. While the Principles are not exhaustive, they represent a coordinated, concerted approach to physician health human resources. The Principles also reflect the evolutionary nature of physician HHR planning and the multiple factors that should be a constant consideration for HHR planners and medical educators alike. The Principles comprise of three components: the statement of Principle, rationale, and calls for action.

¹ Results of the 2013 RDoC National Resident Survey (March-April 2013), show that one in four residents plan to undertake a fellowship. When asked what prompted that decision, three in ten cited future employment/career goals, one in four cited personal interests and less than one in four mentioned wanting more training/skills/specialization. In addition, one in five respondents felt that undertaking a fellowship will help them find employment in a staff position.

The 6 Principles are:

1. Effective, evidence-based workforce planning for Canadian patients and physicians.
2. Distribution/allocation of residency training positions that accords with population needs and job availability.
3. Recruitment and retention of graduating physicians.
4. Career counselling throughout medical training.
5. Promotion of social accountability via changes to the formal curriculum and culture building.
6. Succession planning and transition of retiring physicians' practices.

Principle 1

Effective, Evidence-Based Workforce Planning for Canadian Patients and Physicians

Rationale

Effective, evidence-based workforce planning is essential if Canada is to meet the future health care needs of the population and put in place the health human resources required to meet those needs. Since a successful strategy will employ smart health care solutions based on reliable data, accelerated efforts by federal, provincial and territorial health ministers are critical. Meaningful models that forecast physician supply and demand based on population needs should be utilized consistently and comprehensively in all regions so that medical students and residents are better informed during decision-making about their careers and specialties.

CALLS FOR ACTION

- 1.1** Develop a national strategy for the collection, synthesis, analysis and communication of reliable data on the health care needs of the Canadian population and physician resource requirements.

Canadian society's requirements for health care are constantly changing. Factors such as the size and distribution of the patient population, changing demographics, innovation and technological developments and policy shifts associated with multiple levels of ministerial and organizational responsibility contribute to this. Information on physician resource requirements, analyzed according to specialty and scope of care relative to local or national needs, is critical information for medical trainees who are making choices about what specialty to pursue, where to train, and where to practise. While gathering information on the specific care provided by physicians is complex, it is important that trainees have some broad understanding of physician resource requirements in each area of medical specialty. It will require investment to acquire sufficient reliable data to guide a sustainable health human resources plan. This data would be the foundation of a strategy to align health human resources to meet health care needs across the entire country.

Accordingly, the critical first step in the development of any strategy for health human resources is to understand the needs of the Canadian population for physician care. Forecast models, using existing population and health service utilization data, could be used or adapted to describe current needs and to project future health care needs. This can be supplemented by data provided by individual specialty societies regarding job trends and unmet health care needs in various specialty areas.

1.2 Establish a pan-Canadian health human resource observatory and regional units at each of the Canadian medical schools and postgraduate medical education institutions.

To support the development of a national strategy for the collection and synthesis of data on health care needs and physician resource requirements is the establishment of a pan-Canadian health human resource observatory and regional units at medical schools and postgraduate medical education institutions. Medical education and the job situation in Canada have changed significantly over the past few years. Medical students make career decisions very early in the medical education continuum, having had limited exposure to more than 70 Royal College specialty and subspecialty disciplines and family medicine. Consequently, when these decisions are made, it is difficult to predict the long-term viability and employment prospects of a particular specialty, or to understand the breadth of opportunities that different specialties offer.

The pan-Canadian observatory would independently review health data from various sources to identify important HHR trends that would help medical students and residents make informed decisions about their specialty, sub-specialty, and practice choices. Examples include working patterns of graduating physicians, including employment data, and data on retiring physicians. The observatory would work with ministries of health on a national scale to collect data on local health care needs that would reflect current job prospects and trends in various specialty areas. It would also ensure that the management of physician numbers occurs at the beginning of the medical training continuum so that the number of yearly medical school and residency positions correspond, are reasonably predicted and calculated, and align with forecasted jobs in all specialties. This information should be communicated to all relevant stakeholders in a robust and standardized way.

1.3 Accelerate development of a pan-Canadian strategy for health human resources that emphasizes federal/provincial/territorial collaboration.

A national strategy for data collection on the health care needs and physician resource requirements requires national, multilevel health human resources planning and considerable collaboration by the federal, provincial and territorial governments as well as many key stakeholders, who include educational institutions, licensing and accreditation bodies, trainee representative groups, and regulatory health authorities. RDoC calls upon the federal government, in collaboration with provincial and territorial governments, to recommit to the national strategy for health human resources as laid out in the ACHDHR² framework with specific emphasis on accountability moving forward.ⁱ RDoC acknowledges the work currently underway by the Council of the Federation and the guiding principles on health human resource management as outlined in the first report of the July 2012 Health Care Innovation Working Group.ⁱⁱ RDoC supports the call to improve the exchange of health human resources information among provinces and territories. The result will be informed decision-making and greater coordination and collaboration by the government ministries responsible for medical education and the delivery of health services to Canadians.ⁱⁱⁱ

² A Pan-Canadian body called the Federal/Provincial/Territorial Advisory Committee on Health Delivery and Human Resources (ACHDHR) was created in 2002 with the mandate “to provide policy and strategic advice on the planning, organization and delivery of health services, including health human resources.”

Principle 2

Distribution/allocation of residency training positions that accords with population needs and job availability

Rationale

The distribution/allocation of residency training positions according to population needs and job availability calls for the development of national standards for the allocation of residency training positions. The allocation of residency training positions is an essential mechanism in assigning physician human resource capacity. Training spots, and by extension the physician workforce, should reflect both job opportunities for physicians and patient care needs. The current system of residency training allocation varies widely among provinces and universities, and may differ depending on the location and needs of the community. In Québec, for example, each health region develops a health human resource plan that sets targets for physician specialties according to population need. Health authorities in other provinces have varying degrees of involvement in determining funding for residency specialty programs and training locations.

Given the valuable contribution of International Medical Graduates (IMGs) to health human resources and health care provision in Canada, once granted entry into the Canadian postgraduate training system, there should be appropriate integration of IMGs into the Canadian medical education and training system.

With increasing undergraduate enrollment at Canadian medical schools, it would be important to ensure that Canadian medical graduates are afforded every opportunity to match to a postgraduate position.³ Within this framework, there should be flexibility in the allotment of residency positions, based on specialty, to account for population needs and job availability.

CALLS FOR ACTION

2.1 Allocate residency positions based on population need and employment capacity per specialty, as well as with regard to personal and professional interests.

The guiding principle for the allocation of residency training positions should be the preparation of physicians who can work meaningfully to better the health of the Canadian public. Training capacity should be weighted toward medical specialties where there is a large unmet health care need while, similarly, physician trainee positions should be controlled in specialties that offer limited employment opportunities. The tasks of residents and others involved with patient care may need to change in response to the allocation of residency positions that accords with population need and employment capacity. For example, the number of trainees available to cover call schedules and other responsibilities that have traditionally been part of the residency experience will need to be re-assessed.

³ In 2003, RDoC, along with other national medical organizations, supported recommendations that at the very least there should be a 1:1.2 ratio between medical students entering residency training and residency positions. This RDoC statement is under review.

2.2 Re-evaluate residency position allocation on a regular basis.

The health care needs of the Canadian population are changing with the aging of the baby boomer generation. At the same time, many physicians are approaching retirement and changing their practices to accommodate this transition. The increase in the number of Canadian medical graduates and international medical graduates (IMGs) entering the physician workforce also requires regular re-evaluation of residency positions to ensure that our HHR system adapts to evolving health care needs and to changes in specialty areas where training capacity is needed. Many specialty residencies are five or more years in duration; over this elapsed time the population's health needs – and the required number of physicians to meet these needs – can change.

2.3 Use the right criteria to determine residency capacity, not institutional (staff or administrator) self-interest.

A frequently-cited justification for maintaining residency capacity is the institution's need for trainees to cover call and provide a broad spectrum of medical services. The reality of residency training is that many academic centres rely heavily on residents to provide a significant quantity of health care in their institutions. While service provision is a critical component of residency training, the dependency of departments on residents can be an artificial incentive to create or maintain positions, and is a deterrent to proper reassessment of positions. Institutions' desire to maintain such coverage must not play a major role in decisions about residency position allocation.

2.4 Facilitate the transition into the health care system for international medical graduates (IMGs) selected for Canadian training positions.

IMGs who have been selected for Canadian training positions should have orientation and training as well as access to faculty and clinical teachers in residency programs who can mentor and work with IMGs. The Canadian Psychiatric Association, for example, has developed a formal national mentorship program; one component of this is an IMG mentorship program that links interested psychiatrist mentors with IMGs who are in Canadian psychiatry training programs.^{iv} Formal or informal transition support within residency is important.

Principle 3

Recruitment and retention of graduating physicians

Rationale

How graduating physicians are recruited and retained within a community is of utmost importance. An increasing number of specialist physicians do not have meaningful full-time employment after completing residency. Many are underemployed or have to take further training that often includes additional and/or multiple fellowships. However, there is no guarantee that further training will secure future employment in a particular geographic area or even within their specialty. This has a direct impact on the mix and distribution of physicians across the country, and ultimately on how well the physician supply meets the needs of Canadian society.

In addition, recruitment and retention strategies to meet patient care needs in rural areas should be enhanced. Rural and remote training experiences increase the likelihood of residents choosing to practise in such a region after graduation, because exposure to a new setting during training builds familiarity and interest.^{v,vi} A supportive and positive clinical workplace environment – where one is already aware of available resources, has established relationships with colleagues, is familiar with the patient population, and has gained practical knowledge of the common pathways through a local medical system – eases the transition from training into practice.

Being welcomed into a new site or community for an extended period of time during training allows trainees to establish the roots and relationships that may influence their decisions in the long term. The Northern Ontario School of Medicine, for example, develops and delivers an innovative model of distributed medical education that is community-based and socially accountable to the communities of Northern Ontario. Similar incentives must be put in place to attract specialty trainees to other areas of need. To make maximum use of new physicians' skills and meet patient demands, appropriate levels of investments in health human resource infrastructure such as operating rooms, long-term care institutions, chronic care facilities and community clinics, is required.

CALLS FOR ACTION

3.1 Establish a national recruitment/job match program.

A national, coordinated recruitment/job match program – for example, A Transition into Practice service for residents – would be a consistent, reliable way to communicate physician employment opportunities across Canada to new graduates and those contemplating a career change. Recent reports suggest that in physician recruitment, the interests of hospitals and physicians may be divergent, particularly when senior doctors are given control over recruiting new physicians.^{vii, 4} A national resource/database could identify, coordinate and collect regional and specialty-specific job opportunities through the National Specialty Societies or through HHR recruiter organizations such as the Canadian Association of Staff Physician Recruiters.

3.2 Improve the work environment in rural areas to attract and retain new physicians in local communities.

RDoC believes that professional and academic support is essential for physicians in rural areas and a strong contributor to physician retention, healthy lifestyles, and positive attitudes towards the patient population. For residents, a welcoming environment with enthusiastic preceptors, adequate access to online resources, sufficient exposure to a range of clinical problems and specialties, appropriate housing, opportunities for the trainee and partner/family to integrate into a new community, and orientation to a new region are just a few factors that contribute to a positive academic experience. The following should be considered:

- Consolidate services into larger districts to allow for expanded practice groups and help decrease professional isolation.
- Improve laboratory and specialty referral networks to enhance clinical support and decrease stress and potential burnout.

⁴ Dr. Robert Bear, a former University of Toronto professor who now works as a health care consultant, notes that “in many specialties, a hospital physician’s annual income depends on the number of colleagues he or she shares patients with – the more doctors in a department, the less each one earns through government billing. As a result, even in departments where there might be room to hire, some choose not to.” Dr. Bear notes that this is the case for nephrologists practising in Ontario.

- Improve academic support through such means as telemedicine conferences (e.g., grand rounds).
- Improve access to library support and increase availability of continuing medical education opportunities.
- Improve the practice environment through access to online resources, sufficient exposure to a range of clinical problems and specialties, appropriate housing, opportunities for the trainee and partner/family to integrate into a new community, and orientation to a new region and preceptors.
- Develop attractive locum tenens programs and larger clinic groups to provide province-wide coverage.

3.3 Develop innovative strategies to meet patient care needs in rural areas.

Encouraging resident physicians to train in rural/remote areas or designated underserved areas could recruit more physicians to these areas over the long term. The following should be considered:

- Provide incentives for residents to seek clinical exposure in areas that need specific medical services. Non-salary compensation (such as housing and access to amenities during a placement away from home) will greatly enhance potential for personal development and the overall attractiveness of practice in underserved areas.
- Residents who work in rural, remote and underserved areas could represent a pool of positions in the CaRMS match that is separate from those designated for new Canadian graduates.
- Provide incentives for rural and remote sites to seek residents and physicians in the specific specialties that will meet local health care needs. Innovative ways to attract new physicians might include working with particular specialty groups to advertise spots, or funding travel to introduce physicians to the community and practice and make them familiar with the support systems that exist for their families.

3.4 Invest in healthcare infrastructure, such as operating rooms and staff support, to better meet patient demands and make maximum use of new physicians' skills.

Investment in a variety of health care settings such as hospital emergency and operating rooms, long-term care institutions, chronic care facilities and community clinics is required to improve patient access to care now and in the future, as well as to attract, retain and accommodate new trainees, physicians and health care workers. While improvements in public health care and distribution of health human resources can be achieved through adequate infrastructure development, health care design also plays a critical role. An emphasis on preventative, community-based care will result in more efficient use of resources and minimize reliance on high-cost, personnel-intensive resuscitative acute care.

Principle 4 Career counselling throughout medical training

Rationale

According to the 2012 RDoC National Resident Survey, 42.3% of residents were unsatisfied with career counselling resources available within their program, while 35.3% were satisfied. In addition, 31% of resi-

dents expressed that they did not have a formal or informal mentor. Accreditation standard B3.6 states that the “residency program committee must establish and maintain mechanisms by which residents receive ongoing career counselling.”^{viii} While career counselling is addressed in diverse ways in different residency programs, the process should be consistent and structured. Mentorship is a key component of the education, training and professional development of resident physicians. Residents often regard mentors as essential resources for advice and guidance pertaining to topics outside the regular academic curriculum including research, career planning, networking, maintaining a healthy work-life balance, and transition into practice. Mentorship, as an element of career counselling, is universally important to residents.

CALLS FOR ACTION

4.1 Establish formal or informal mentorship structures within the residency programs and as part of the residency curricula at all postgraduate medical education offices.

The Royal College formally adopted the CanMEDS Physician Competency Framework in 1996. This framework, which describes the core knowledge, skills and abilities of specialist physicians and is oriented to optimal health and health care outcomes, has become a cornerstone of postgraduate medical education in Canada.^{ix} Mentorship is an integral component of the framework. That the most commonly cited barrier to effective mentorship is the perceived lack of time due to increasing clinical, research and administrative responsibilities^x speaks to the importance of creating a working environment that fosters mentorship.^{xi} To be successful, mentoring programs must create a culture of mentorship that is supported by both the faculty and administration.

4.2 Include career counselling as a component of mentorship within residency programs.

Mentoring and exposure to mentors in all disciplines is critical to the success of residents in the competitive academic environment of modern medicine. Mentorship assists three areas of development: professional, personal and educational. Career counselling is one aspect of mentorship that encompasses all three areas, supporting the resident in his/her personal and professional development to become a compassionate and confident physician. Career counselling, as an element of mentorship, should:

- Connect physicians who are phasing into retirement with new medical graduates.
- Offer information on scope of practice (including community practice, subspecialty fellowship, and academic medicine) as well as lifestyle and career satisfaction.
- Provide guidance on transitions within residency (from junior to senior, or when transferring programs), and the transition from residency into independent practice.
- Offer guidance regarding opportunities and challenges within residents’ areas of interest.
- Outline the year-to-year goals and milestones for the resident to achieve in preparation for practice, examinations and licensure: information on employment and different career paths; options for further training; building a network of potential advisors; exposure to research and other opportunities; perspectives from a variety of specialty areas and training locales; and identification of areas of strength.
- Mentor residents during the career transition process. Support for program transfers would entail mentoring while residents are going through career transitions.

4.3 Promote informed career counselling throughout the lifecycle of a trainee.

Medical students are required to make career choices early on in their training. These choices will have a great impact for years to come as they progress through their residency training and into medical practice. By providing medical students with mentoring and career advice that includes information on where there is need and where job opportunities are more likely to be found, medical students will be better equipped to make informed training and career choices.

Principle 5

Promotion of social accountability via changes to the formal curriculum and culture building

Rationale

Social accountability lies at the heart of medicine and is central to Canada's publicly funded health care system. A quality, patient-centered approach to health care is one of the primary goals of the medical education and training environment, and this culture of social responsiveness has been echoed by medical education organizations and training institutions across the country. The Association of Faculties of Medicine of Canada, which represents all 17 Canadian faculties of medicine, has endorsed the social accountability mandate of the World Health Organization.^{xii} The mandate states that medical schools have an "obligation to direct their education, research, and service activities towards addressing the priority health concerns of the community, region, and/or nation they have a mandate to serve. The priority health concerns are to be identified jointly by governments, health care organizations, health professionals, and the public."^{xiii}

The University of Saskatchewan College of Medicine's Social Accountability Committee, developed the CARE model (Clinical activity, Advocacy, Research, Education and Training) as a guiding tool for social accountability initiatives.^{xiv} The goal of this initiative is aligning medical education curriculum, clinical activities, advocacy, research, education and training efforts to be more responsive to changing community health care needs. It also encourages learners to be more aware of their social responsibility in addressing the priority health concerns of their community, and of their professional responsibility to help meet those needs. Other medical education institutions that have implemented similar programs are McGill University, University of Ottawa, University of Manitoba, University of Alberta, Northern Ontario School of Medicine, and the University of British Columbia.^{xv}

While medical schools have made great strides in incorporating social determinants of health into formal curricula, there is a pervasive culture in medical education that socializes learners to certain values that are not explicitly taught. This "hidden curriculum" promotes sub-specialization and practice in an academic centre as the only route for the best and brightest medical learners.^{xvi} However, medical education needs to empower learners to practice in response to the needs of the population. It should also instill a culture of social responsibility that encourages learners to seek opportunities to better serve society. A shift in culture to embrace the value of general, community-based practice is the best means of reducing the burden of disease and ensuring long-term health rather than resuscitative care for the Canadian population.

Postgraduate medical education and resident physicians have a central role in embracing the social accountability mandate of medical schools and addressing health inequalities and physician maldistribution. This mandate is inherent in the CanMEDS and CanMEDS-FM framework under the Health Advocate role,⁵ which encompasses a broad range of competencies that help physicians “recognize their duty and ability to improve the overall health of their patients and the society they serve.”^{xvii} It is important that this role and associated competencies be fully recognized and valued in postgraduate medical training.

CALLS FOR ACTION

5.1 Incorporate regular rotations in community and in rural and remote locations, with opportunities for exposure to population and public health role models in these environments.

Rotations should include exposure to Aboriginal health, primary care, urban and rural underserved areas, immigrant populations and global health. One of the learning outcomes should be to increase residents’ perception and value of the Health Advocate and social accountability role. A second outcome would be to provide trainees with a broad perspective on health care and health equity so that their choices regarding subspecialty and practice locations reflect the needs of the population.

5.2 Expand the social accountability mandate to emphasize the responsibility of learners to make career choices based on societal needs, thereby initiating a shift in the cultural environment of medicine.

This should include evidence-based education on population and physician needs. The current “hidden curriculum” that epitomizes sub-specialization and tertiary care practice must give way to a culture that empowers learners to provide broad-based generalist and primary health care services. This cultural environment must be flexible to respond to changing patterns in patient and physician demographics, and should be built on the tenet that learners strive to practice to serve the needs of the population.

Principle 6

Succession planning and transition of retiring physicians’ practices

Rationale

Physician HHR planning must consider both the supply of new physicians and the departure of practising physicians. Like the overall Canadian labour force, the physician workforce is aging. Until the mid-1990s there was a significant trend in Canada toward early retirement; however, in 1997 this trend reversed.^{xviii} Approximately 1 in 10 Canadian physicians is aged 65 years or older, and although the intensity of their clinical practice may lessen, many physicians continue to work after reaching the traditional retirement age.^{xix, 6} Physician retirement is therefore quite difficult to track as data on physicians’ self-reported intentions

5 Definition (Health Advocate): As Health Advocates, physicians responsibly use their expertise and influence to advance the health and well-being of individual patients, communities, and populations. (CanMEDS, 2005)

to retire or reduce their workload are not particularly strong indicators of future behaviour.^{xx, 7, 8} In addition, the physician labour market is not contracting. Between 2007 and 2011, growth in the number of physicians outpaced population growth threefold because of a significant increase in medical school enrolment and the number of new physicians entering the workforce.^{xxi} These trends, along with the low attrition rate, make it necessary to implement strategies for appropriate succession planning and transition into retirement.

CALLS FOR ACTION

6.1 Partner physicians who are close to retirement with new physician graduates who can eventually assume the practice.

A program that identifies physicians who are close to retirement and pairs them, as mentors, with new graduates who can eventually assume the practice is a strategy that should be considered. This will bridge the gap in particular for communities that rely on a small number of physicians for comprehensive health care services. Partnering would introduce the new graduate to the community and, since the intensity and scope of clinical practice changes as a physician nears retirement,⁹ make the transition to a new practitioner smoother for patients.

6.2 Develop robust longitudinal data on physician retirement.

Because physicians scale back their practices as they age, estimating the impact of transition into retirement is important for determining future practice patterns and physician resource needs. However, incorporating data into any forecasting model is challenging. As more physicians move from fee for service to alternate funding plans, billing information will provide far less granular data on the practice patterns of individual physicians. In future it will be important to consider several factors that will impact this apparent imbalance in physician supply, including:

- Different practice patterns of new physicians
- Different practice patterns of older physicians
- Urban and rural/remote divide
- Family practice vs. specialist postgraduate positions
- Contributions of older physicians to administration, education and research

6 Based on Scott's Medical Database, "over a period of two decades, the proportion of physicians age 55 and older increased from 25.4% in 1987 to 33.2% in 2007...conversely, the proportion of those younger than 35 dropped from 21.9% in 1987 to 9.8% in 2007" (Statistics Canada, 2011).

7 The National Physician Survey in 2007 and 2010 asked physicians if they intended to retire within the next 2 years. The survey showed that 6.2% (2007) and 7.2% (2010) of family physicians/general practitioners and 6.5% (2007) and 7.5% (2010) of specialists reported their intention to retire. These numbers were not supported by either Scott's Medical Database or the CMA Master File Data, both of which showed substantially lower actual rates of retirement: 0.54% per year (2005–2007) and 0.79% per year (2005–2007) respectively.

8 Assuming an annual retirement rate of approximately 3.5% (based on the National Physician Survey 2007 and 2010), this would give an annual retirement of 2,538 physicians; however, using Scott's Medical Database or CMA Master File Data would give an annual retirement of 392 or 573 physicians respectively.

9 This is echoed by Dr. Raymond Pong, author of the 2011 Canadian Institutes of Health Information study *Putting Away the Stethoscope for Good? Toward a New Perspective on Physician Retirement*. Dr. Pong notes: "In the physician workforce, retirement is not a sudden event. Instead, we see a transition to retirement, with doctors progressively taking on less work and carefully choosing the work that they do take on. It's a process that can extend over months and, in some cases, years."

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