Resident
Doctors
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du Canada

Entry Disciplines and Medical Education Reform

CFMS Spring General Meeting: Education Panel

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Role and importance of Entry Disciplines

Entry level disciplines are the training programs medical students enter at the start of residency, where they serve dual roles as trainees and care providers.

Why are they so important?

- 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.
- The mix of disciplines ultimately guides the supply of physicians in different specialties and locations across the country.
- It is therefore incumbent on the PG training system to develop the right mix, type, and distribution of physicians to keep the system functioning efficiently and to deliver the best care.

What led to the current situation?

- Over the six past decades we have seen **significant growth** in the number of residency training disciplines certified by the Royal College and the CFPC:
  - When the Royal College was enacted by Parliament in 1929 only 2 specialty streams were created: General Medicine and General Surgery.
  - In 1954, the College of General Practice of Canada (became the CFPC in 1967) was created with the mandate to establish a PG training program leading to certification in Family Medicine.
- **Today,** the number of disciplines and subspecialities available to postgraduate trainees includes **more than 80** certified Royal College specialties (29), subspecialties (36), and areas of focused competence, **and 19** areas of enhanced skills in Family Medicine.

Why is this a problem?

Continued growth in #s of entry disciplines raises a number of **significant concerns**:

- Lack of coordination and accountability in decision-making
- Not producing the right mix of physicians to meet patient need
- Increased specialization at the expense of generalist training
- Lack of exposure to diverse practice settings
- Emphasis on service demands over educational/future practice needs
- Lack of flexibility for transfers and re-entry to help meet patient needs and career goals.

Of particular concern to residents

- Increased specialization has created a **disconnect** between PGME curricula and the desire to promote versatility and generalism in physician trainees.
- Graduates may not be equipped with the diversity of skills and experiences they need to serve in locations and settings where they are most needed.

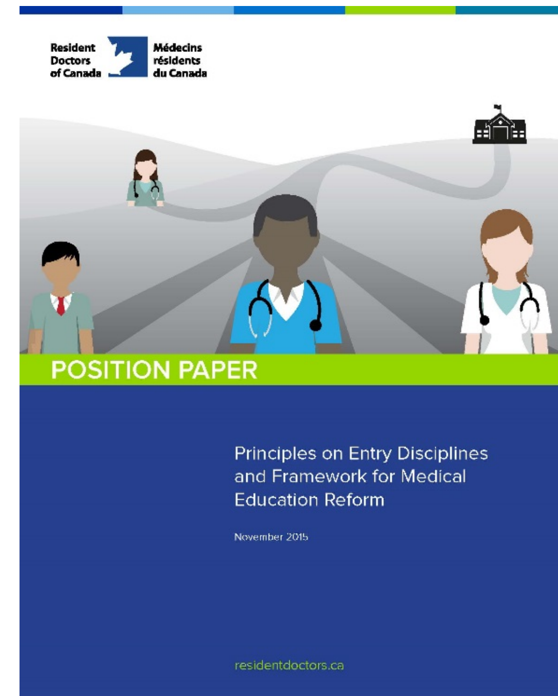
Bottom line: The current system of entry disciplines does not produce a physician workforce that best serves the needs of Canadian patients.

Working towards a solution

- RDoC has developed a **formal position** and **national advocacy** approach to address and influence changes in education delivery that **align with patient needs and support learner transitions** across the education continuum and into practice
- We believe 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 generalist skills, and practice and career flexibility.

Working towards a solution

- Our new position paper, ***Principles on Entry Discipline and Framework for Medical Education Reform*** identifies 4 guiding principles and calls to action for medical educators, health authorities, and governments to consider when discussing entry disciplines and medical education reform.



Principles and Calls to Action

1

Social Accountability

Primary Calls for Action:

- Allocate entry disciplines and residency positions on the basis of societal need.
- Train residents to have a sufficiently diverse skillset that promotes employability and meets the needs of the patient population.
- Establish an evaluative process to regularly assess the capacity of each discipline to meet these criteria.

2 Coordination of Decisions

Primary Calls for Action:

- Establish a national, pan-Canadian task force to examine the current mix of entry and subspecialty disciplines and work in conjunction with national HHR planning.
- Ensure decisions on entry disciplines are made collaboratively among stakeholders so that no single organization mandates their creation, maintenance, or removal.
- Decisions on disciplines should be made independently of (i.e. separate from) the process of designating specialties.

Principles and Calls to Action

3 Versatility

Primary Calls for Action:

- Create more structured and coordinated transfer policies among postgraduate training programs to enable flexibility in residency training and capacity to respond to population need.
- Demand for resident inpatient service should not detract from exposure to generalist/outpatient experiences.

Principles and Calls to Action

4 Relevance to Future Practice

Primary Calls for Action:

- Reform postgraduate training programs so that rotations are determined based on the needs of residents' future practice populations.
- Ensure all residents can access training opportunities in diverse learning environments relevant to future practice, including community and rural settings.
- Support career planning and mentorship programs within PGME to assist residents in identifying career strengths and diverse practice opportunities.

RDoC's continuing role

- Formal position and national advocacy approach to address and influence changes in education delivery that align with patient needs and support learner transitions across the education continuum and into practice.
- Presentations and meetings with stakeholders
- Co-chair National Task Force on Entry Level Disciplines

Questions?

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