

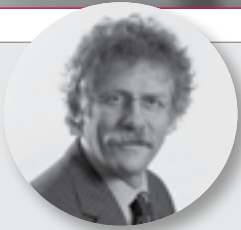
GRAVITAS

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



Reflections *Nick Busing, President & CEO*

The following President's Address entitled "Academic Medicine 2014 and Beyond" was presented by Dr. Nick Busing at the 2011 Canadian Conference on Medical Education in Toronto, Ontario.

I want to talk to you today about academic medicine and where it can apply its many strengths in the years ahead [Slide #1]. I also want to frame the issues in terms of 2014. Although academic medicine may not be at the forefront in terms of the negotiations that should go on between the provinces and the federal government as they make plans to renew the Health Accord, we should be putting our issues forward so they are considered by all parties. We need to emphasize that academic medicine has a stake in these discussions and that we can provide valuable advice and perspectives. I will focus on three issues [Slide #2]. There are many items I could highlight but these three are top-of-the-line for me at the moment.

Firstly, I want to look at the numbers of medical students and residents graduating from our 17 schools. This slide shows that Canada still lags behind OECD countries in the classic doctor to population ratios we all seem wedded to [Slide #3]. I think we need to challenge these ratios, and ask if they are still meaningful and helpful indicators in the context of new models of care, alternate providers, and team-based care. The OECD average includes countries that have a surplus of doctors, so we need to be careful in our interpretation. As well, countries outside the OECD have major surpluses, and in many cases, major shortfalls in physician numbers. For example, Kazakhstan with a population of 16 million persons, takes in 5000 medical students a year. Canada takes in nearly 3000 students with a population of nearly 34 million. Even with a pyramid system in Kazakhstan, 80% of these students graduate, leading to a huge surplus in the physician population. This is a different conversation if we are to look at many of the African countries where the numbers of doctors for

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Managing Editor/Coordonnatrice: Natalie Russ

ISSN: 1913-9616

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the population are very, very small. For example, there are 8 doctors for 100,000 population in Uganda and 3 per 100,000 in Ethiopia.

Here is what has been happening in our medical schools in the past years [Slide #4]. The solid bars show the significant increase in the total numbers of undergraduate and postgraduate students per 100,000 population. If you look at the years from 1994 to 2000 you can see that total enrolment in UG and PG training actually dropped. In that same time period our population grew from 29.2 million to 30.8 million. From 2000 and onwards, the total UGME enrolment has increased 61% and total PGME enrolment has increased 66%. During the same period the population has grown about 10%. We have really accelerated our inputs into medical school and residency programs. Do we know if we are admitting enough students, when to slow down, or when to take in more? We do not have a national planning model and the provinces still think they primarily can and should plan for the healthcare resources they may need within their own borders.

But what I really want to talk about comes next. Let's look more closely at who we are training in the next generation of our physician population. This is a slide showing Canada's aging population [Slide #5]. Currently there are 4.8 million Canadians age 65 and older. By 2036 that will double to 10.4 million and by 2051 one in four Canadians will be 65 and older.

Today, we have 238 certified geriatricians in Canada and a small number of care of the elderly graduates. This slide shows the postgraduate medical education enrollment in care of the elderly and geriatric medicine programs and it should be an embarrassment to all of us [Slide #6]. These are paltry numbers, under any circumstances, but alarming numbers considering the shifting age demographics. In 2010, we had 31 positions to fill in geriatrics and only 18, as indicated on this slide, were in fact taken up. Yes, there are other important ways to help address the needs of this population, such as the use of many other healthcare providers, the use of more well-trained family doctors, more appropriate and adequate home care and so on. But I would still contend that we need a much larger cohort of expert clinicians as well.

Let's look at these numbers in contrast to the postgraduate enrolment in paediatrics, a much needed specialty, but one that is already better served than geriatrics [Slide #7]. This is something we need to reflect on.

Wherein lay the problems and what can academic medicine do to address them?

Geriatricians and practitioners in care of the elderly have less status than many other physicians. We as a population are enthralled with the technical specialties, the interventionists and those that have a particular skill to offer rather than with those disciplines that are more cognitively based. We admire our colleagues in the discipline of geriatrics and care of the elderly, but do we support them, and if so how? We have a hospital-based system, not particularly seniors' friendly, even when the hospital bed is needed by the senior. We don't provide enough resources to community and home care, funds that would enable the practitioners to do their jobs more effectively. Geriatricians are paid very poorly in Canada; this is one of a number of reasons the discipline is not attractive to medical students.

Our strategy to recruit and educate more geriatricians and care of the elderly experts is critical; it is part of our larger challenge that includes addressing the adequacy of LTC facilities, developing inexpensive home care and even providing better drug coverage.

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Vacant

Gravitas is the official quarterly newsletter of The Association of Faculties of Medicine of Canada. 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.

Gravitas est le bulletin trimestriel officiel de l'Association des facultés de médecine du Canada. 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.

I want to look at another perspective on graduates of our profession and how we can best meet the needs of Canadians. Have we arrived at the right mix of visa residents and Ministry of Health-funded residents in our programs? Have we achieved the best balance between Canadian Medical Graduates, International Medical Graduates and visa graduates in post graduate training? This slide shows the percentages of visa residents in five primary and subspecialty disciplines [Slide #8]. I am not so concerned with the number of fellows in the system – many have a different role to play and meet an important service need. This data shows that 20 percent or more of residents training in 2010 in 4 of the disciplines on this slide were visa residents. Residents are here for education, and ultimately to serve the needs of Canadians (recognizing that we have international obligations to train physicians and to provide some of our medical expertise internationally) – I think we need a better balance between training opportunities for Canadian medical graduates, our increasing number of international medical graduates, and visa residents so all our real and perceived obligations are more effectively met.

Linked to my observations about who we are training in our medical schools is a concern with regard to quality in our system. In a recent public poll commissioned for the Future of Medical Education in Canada PG project there was a surprising finding – there was a perceptible shift on the part of the public from concern regarding access to medical care to a concern that focuses on the quality of healthcare services. As a side note to my earlier comments the same poll showed that a majority of respondents said that Canada's aging population and demographic shift is the most important emerging issue for our healthcare system.

There are many aspects of the quality discussion that we can contribute to and I will mention but a few. For example, how confident are we that we are teaching the best evidence to our students and residents? Are we all up to date with our teaching methods and out teaching content? How do we monitor and assure this? What is the outcome of our current curricula? That is certainly an issue that speaks to quality.

Have we developed both at undergraduate and postgraduate levels, accreditation systems for measuring the results of our training or are we too focused on issues related to processes in the context of accreditation? Recognition should lead, over time, to a healthier population. How do we not only make this connection, but also to evaluate it? In the clinical arena, issues like medical errors, inappropriate drug utilization, and poly pharmacy are critical for us to examine. If we do not tackle these issues of quality they can, and do have, a significant impact on the health of our population.

Studies continue to suggest that the Canadian healthcare system is not as healthy as it used to be. What is our role in addressing the system issues? Is the quality agenda front and center with our academic centers? As with our HR planning, I believe it is piecemeal, fragmented, and frequently focused on hospitals and often described in terms of patient safety. We need strategies that apply quality indicators and safety across the continuum and across all geographic areas of care. In the same poll that I cited earlier there was a suggestion that as socioeconomic status and income levels increased in the population so did comfort with access and care. This is not surprising, but in contrast to that, people with a disability and visible minorities were less comfortable with the healthcare system and felt less supported by it. This is a quality issue for us to think about and address.

Comparative effectiveness research, according to the Institute of Medicine [Slide #9] "is the generation and synthesis of evidence that compares the benefits and harms of alternative

Standing Committee and Resource Group Reports Available

AFMC is supported by four standing committees and eleven resource groups. Reports from each committee and resource group detailing the year's activities and accomplishments were presented to the AFMC Board of Directors at the Canadian Conference on Medical Education and can be downloaded from our website here:

www.afmc.ca/about-committees-e.php

Accessibilité des rapports des comités permanents et des groupes de ressources

L'AFMC est épaulée par quatre comités permanents et onze groupes de ressources. Les rapports de chaque comité et groupe de ressources expliquant les activités et les réalisations durant l'année écoulée ont été présentés au Conseil d'administration de l'AFMC à l'occasion de la Conférence canadienne sur l'éducation médicale et peuvent être téléchargés à partir de notre site Web à

www.afmc.ca/about-committees-f.php



methods to prevent, diagnose, treat and monitor a clinical condition, or to improve the delivery of care. The purpose of comparative effectiveness research is to assist consumers, clinicians, purchasers, and policy makers to make informed decisions that will improve healthcare at both the individual and population level”.

It needs to be supported and developed – to ensure we're providing the safest and most effective care in the best setting with the ideal providers. Academic health centers (medical schools, teaching hospitals, and all other participants in the emerging academic health science networks) need to model how we can in fact provide this exemplary care in the best setting with the best providers. If it doesn't start with us and we don't model it with our students and residents, where will it start?

In summary I am looking for leadership from academic medicine on several fronts today [Slide #10]:

- To work collectively to have a more coherent physician resource planning environment;
- To grow our geriatric medicine and care of the elderly programs and graduate more physicians that I – and many of you – will soon need;
- To work towards a better balance for Canadian medical graduates, international medical graduates and visa residents;
- To provide much more leadership to the quality agenda, in all the domains that are relevant to us as educators, researchers and clinicians.

Thank you. 🌹

Evidence-based Medical Education

Irving Gold, Vice President, Government Relations and External Affairs

The term evidence-based medicine (EBM) has become so ubiquitous that it's hard to imagine that the concept really only became a global phenomenon in the early 1990s. To oversimplify, the idea of EBM is that gaps frequently exist between medical practice and the most current available medical evidence. The goal of EBM is to minimize that gap; according to McMaster's David Sackett, one of the movement's “founding fathers”, EBM is about integrating individual clinical expertise and the best external evidence.

In less than a quarter of a century, proponents of EBM have managed to promulgate their ideas to the point where courses on evidence-based medicine are commonplace in faculties of medicine, centres for evidence-based medicine can be found throughout the globe, and organizations have emerged to support physicians in making evidence-based decisions. The Cochrane Collaboration, for example, has the following vision statement: “that healthcare decision-making throughout the world will be informed by high quality, timely research evidence. The Cochrane Collaboration will play a pivotal role in the production and dissemination of this evidence across all areas of healthcare”.

New tools for interprofessional health education accreditation standards

The second phase of the Accreditation of Interprofessional Health Education (AIPHE) initiative is now complete and has launched a new web site (www.aiphe.ca) and resources such as the **Interprofessional Health Education Accreditation Standards Guide** to assist in integrating interprofessional education (IPE) standards into the accreditation programs of health professions and examples of evidence for assessment to support accreditation surveyors.

The following six health professions were involved in the initiative: medicine, physical therapy, occupational therapy, pharmacy, social work and nursing. Before the new resources were finalized, AIPHE partner organizations shared information and consulted with their key stakeholders, including clinical training site managers, regulatory authorities, and government representatives since these groups are critical to enabling education programs to immerse learners and new graduates in collaborative, person-centred health and social care environments. There is evidence to show that interprofessional education enables effective collaborative practice, which strengthens the health system and improves health outcomes.ⁱ

While the second phase of the initiative is complete, the accrediting organizations involved with AIPHE will continue to incorporate their shared principles for IPE into their accreditation standards, pilot test the standards, revise and implement them. Please visit www.aiphe.ca for more information.

ⁱ World Health Organization (WHO), Framework for Action on Interprofessional Education and Collaborative Practice, 2010.

The principles of evidence-based medicine have also come to be applied to other types of decision-making. Organizations such as the Canadian Health Services Research Foundation expanded the notion of evidence-based medicine to the broader concept of evidence-based decision-making and applied it to the world of health policy and planning. Dr. Donald T. Campbell, for whom the Campbell Collaboration was named, believed that governmental reforms could be seen as societal experiments to which scientific rules of evidence can be applied. The Campbell Collaboration works to support evidence-based decision-making by bringing systematic reviews of research evidence on the effectiveness of social interventions to bear on a wide range of social policy and practice areas.

It seems only natural that the concepts of evidence-based medicine and evidence-based decision-making be an integral part of medical education in at least two ways. First, and most obvious, there is a recognized need to ensure that graduates of medical school are equipped with the skills and tools necessary to find, evaluate, adapt and apply the best available evidence. More fundamentally, however, there is also an increasingly recognized need for the pedagogical components of medical education to be evidence-based as well. Evidence-based medical education is a natural progression of the movement.

Evidence-based medical education requires a robust and high quality research base. The Canadian medical education community is recognized internationally; we punch above our weight in terms of educational research, publication and innovation. Problem-based learning emerged here, we are leaders in distributed medical education, IMG training and inter-professional education, to name just a few examples.

But for evidence-based medical education to really take root in Canada, we need to significantly increase funding for research in medical education. We are by no means starting from ground zero; twelve of Canada's seventeen medical schools have developed centres or departments of medical education, seven offer their own graduate programs in health professions education, and there are twelve funded chairs in medical education.

Canada invests heavily in health and biomedical research that informs medical practice and health policy and planning; in other words, the federal government directly supports both evidence-based medicine and evidence-based decision-making. This is not the case in the world of medical education. In fact, the greatest current challenge for evidence-based medical education is that Canada's tri-council structure is designed such that research on medical education is something of an orphan. SSHRC does not fund health research, and CIHR does not fund educational research. In order to receive funding from either of these funding agencies, researchers need to bend themselves into pretzels to shape their research proposals in ways which make them eligible for either of these two agencies. This takes a great deal of time and effort, and often has the unintended consequence of distracting researchers from the real questions they wish to answer.

Canada's investments in health and biomedical research are meant to ultimately improve the health and well-being of Canadians. A solid commitment to funding medical education research will clearly have a similar effect. It's time for medical education research to have a well-funded home. 🇨🇦





Punching Well Above Our Weight

*Kevin Eva, Senior Scientist, Centre for Health Education Scholarship
Associate Professor and Director of Education Research and Scholarship, Department of Medicine,
University of British Columbia
Editor-in-chief, Medical Education*

Dr. Kevin Eva began his appointment as Senior Scientist in CHES and Associate Professor, Director of Educational Research and Scholarship in the Department of Medicine in July 2010. He completed his PhD in Cognitive Psychology (McMaster University) in 2001 and became Editor-in-Chief for the journal Medical Education in 2008. In addition to sitting on four other editorial boards Dr. Eva maintains appointments as Associate Professor in the Department of Clinical Epidemiology and Biostatistics at McMaster University and in the School of Health Education at Maastricht University (The Netherlands) and as Visiting Professor at Bern University (Switzerland).

His current research interests are broadly defined within the context of research into educational practices within the health professions. They include research into (1) The value and limits of subjective judgment, (2) The promotion and assessment of non-cognitive characteristics in professional practice, (3) The context specific nature of performance, (4) The conceptualization, nature, and use of self-assessment, (5) The psychological processes that impact upon one's responsiveness to feedback, and (6) The nature of clinical expertise. Recent awards for this work include an Innovator of Distinction Award from McMaster University, the Canadian Association for Medical Education's Junior Award for Distinguished Contributions to Medical Education, and the Association of Faculties of Medicine in Canada-GlaxoSmithKline Young Educators Award.

Canada is, by every measure, a world leader in the field of medical education research. We publish at a rate that surpasses all other countries (per capita); our researchers have been honoured with a disproportionate number of the field's most prestigious international awards; and Canada is credited with many of the most recognizable innovations in the field. These successes are internationally recognized to the extent that one of the more common questions I field when traveling abroad is "how have Canadian medical education researchers achieved so much success?" I freely admit that my answer is variable and speculative, but I think that reflects the multifaceted nature of the issue rather than simply reflecting my own instability.

I began reflecting on these issues again when charged with writing a brief article for *Gravitas* on the future of the field and the Canadian contribution to it. I'll share some of those thoughts here, anticipating that the sources of past success offer insight into mechanisms through which we can continue to drive the field to new heights. In no particular order, we must acknowledge the foresight of the licensing and certifying bodies, the vision of the medical school leadership, and the collegiality of the scholars working within health professional education research.

The Medical Council of Canada and Royal College of Physicians and Surgeons of Canada are two prominent examples of organizations that have championed medical education research through the various granting programs they offer. Very few countries can claim licensing and certification authorities that give back to furthering the field to the extent granted Canadian medical education researchers. Fewer still can compete in terms of the willingness with which their organizations define their mandate with sufficient breadth to enable real innovation and curiosity-driven research to lead the field in unanticipated directions.

Similarly, the vision of health professional leaders around the country has been demonstrated time and time again by their investment in educational research as a way of invigorating and building capacity for educational practice. New centres have been built in recent years at an astonishing pace and with remarkable diversity of perspectives, disciplinary backgrounds, and expertise. The not-for-profit nature of our healthcare system makes many of these things possible, but the leadership, imagination, and spirit of innovation that abounds throughout our educational leadership ensures that they are realized.

Finally, I think we should be proud of the fact that medical education research in Canada does not embody the cut-throat competitiveness plaguing scholars in some other areas of study. The PhDs, MDs, and other health professionals alike that I have had the good fortune to work with have universally proven themselves willing and eager to treat institutional and epistemological boundaries as opportunities for innovation rather than deterrents. To a person they have demonstrated themselves willing and able to offer advice and support to those trying to break into the field and to engage collegially regardless of academic background. This attitude creates a whole that is greater than the sum of its individual parts and, while I am not generally one for predicting the future, it is the dominant reason that I am confident that the best days of Canadian medical education research lie ahead. 🌱

Medical Women Trailblazers

Nahid Azad, President-Elect, Federation of Medical Women of Canada

The Federation of Medical Women of Canada (FMWC) is hosting their annual meeting in British Columbia: Trailblazers: Catching Our Dreams, in Vancouver from September 16-18, 2011. This is a unique opportunity to be inspired by outstanding medical women, hear about new advances in women's health care and be rejuvenated by taking time to connect with colleagues and students alike!

For those of you who aren't familiar with us, the FMWC is a national medical organization committed to the development of women physicians and to the well-being of all women.

Trailblazer Topics include: Made in BC Solutions; Leadership on Engaging Others; Work-Life/Home-Life Balance; Physician Health; Media and Women's Perspective; Career Advancement/Career Change; Preventative Health; Immunization; Cervical Cancer; and Contraception and Osteoporosis.

BC Women physician leaders participating include: Drs. Nadine Caron, Teresa Clarke, Cathy Clelland, Mary Conley, Alexandra T. Greenhill, Kerstin Gustafson, Diane McIntosh, Shelley Ross and Dorothy Shaw.

For delegates wanting more in-depth training, there are two pre-conference leadership workshops available on Friday, September 16th which focuses on improving management and team-building skills! Healthcare Team Effectiveness and PMI: Managing People effectively are offered for an additional fee to a limited number of delegates.

Networking events on the Friday evening and Saturday afternoon will allow all delegates a chance to connect with one another, which is an important goal of the FMWC. The Awards Lunch on the Saturday is a chance to celebrate women who aptly fit the theme of trailblazer. In the spirit of the West Coast, there will also be Tai Chi and Yoga breaks. In addition to these included social events; delegates with a Saturday Soiree ticket can let their hair down and relax on a sunset dinner cruise! (There will even be dancing under the stars for those so inclined.)

We hope that you will join us in Vancouver for this ACCREDITED event to celebrate the outstanding medical women who have blazed trails within our profession, achieved their dreams and inspire us all! As a delegate, you can expect to gain insight and tools that will help you achieve your personal and professional dreams and improve the life quality of your patients.

Registration is limited to 200 delegates so don't miss out! For information and on-line registration go to:

www.fmwc.ca; Event Email: fmwcmain@fmwc.ca



The 2010 Research Careers Survey: A new and more comprehensive view of health research careers in Canada

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

As AFMC publishes this issue of *Gravitas*, with its focus on scholarship, there has perhaps never been a greater need to reflect on support for health research careers in Canada. To its credit, today's funding environment aims to support the most promising research and the most meritorious investigators. This is largely achieved by coupling the open grants/awards process with peer review involving formal scoring and ranking criteria. Arguably, this formula does well in targeting and supporting research excellence.

At the same time, however, research funding is a limited resource, leading to a highly competitive environment wherein health researchers may find themselves perpetually uncertain of their future. Consider, for example, that of the 3,365 applications to CIHRs 2005-06 Open Operating Grants Program (OOGP), 33% received funding¹. Five years later, in 2010-11, the number of applications submitted to this program increased to 4,416, a 31% jump. Moreover, only 23% of 2010-11 applications resulted in funding¹. As one of Canada's most significant health research funding programs, the OOGP example is highly suggestive of the environment health researchers find themselves in.

Remarkably – and in spite of the incredible social and economic benefits that stem from health research – the data on how research careers are supported has been virtually non-existent. We have not known, for example, how university salaries, research salary awards, clinical care remuneration and other income sources come together to support research careers. We have not known how health researchers divide their time across research, patient care, teaching, administrative and other activities. We've had no useful data on the number of workers supported by health research funding. Nor have we had data that allows us to study career supports in relation to research outputs, such as publications, patents, teaching and peer-review activities.

AFMC's 2010 Research Careers Survey (RCS) was developed precisely to fill these data gaps. For the first time, the RCS asked Canada's university-appointed, biomedical and healthcare researchers to give a comprehensive picture of who they are, where they work, how they spend their time, what they produce and how their careers are supported. While our analysis of the data is just starting, we've already gained new insight from the study.

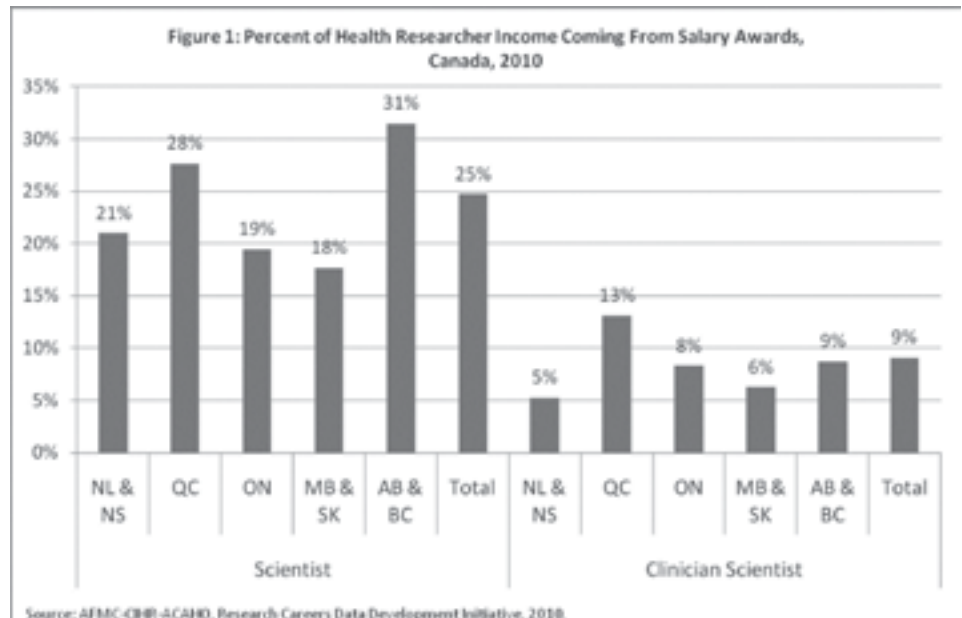
To illustrate, Figure 1 gives a cross-Canada picture of the extent to which clinician and non-clinician scientists are supported by research salary awards. Clinician scientists are those biomedical and healthcare researchers who spend part of their time providing patient care and/or receive part of their income from patient care. As shown in Figure 1, clinician scientists receive considerably less of their personal income from research salary awards, compared to non-clinician scientists. Not surprisingly, this is largely because clinician scientists receive about 37% of their personal income from patient care – a fact that is not illustrated in Figure 1, but which is also based on results of the 2010 RCS.



Hélène Boisjoly est nommée doyenne de la Faculté de médecine

C'est Hélène Boisjoly, professeure titulaire au Département d'ophtalmologie de la Faculté de médecine de l'Université de Montréal, qui assumera les fonctions de doyenne de la Faculté. C'est la première fois dans l'histoire des facultés de médecine du Québec qu'une femme occupera le poste. Médecin, spécialiste de la transplantation de la cornée et maître en santé publique, Hélène Boisjoly a été chercheuse nationale du Fonds de la recherche en santé du Québec (FRSQ) et directrice scientifique du Réseau FRSQ en santé de la vision. À l'Université, elle a mis sur pied plusieurs fonds destinés à la recherche et à l'enseignement, notamment le Fonds de recherche en ophtalmologie de l'UdeM (FROUM), dont elle est la directrice, et deux importantes chaires, la Chaire Léopoldine A. Wolfe et la Chaire Charles-Albert-Poissant en transplantation cornéenne. En plus d'avoir longtemps dirigé les départements d'ophtalmologie de l'UdeM et de l'Hôpital Maisonneuve-Rosemont, elle s'est engagée activement dans la gouvernance et les affaires internes de l'UdeM, en siégeant à l'Assemblée universitaire et au Comité de la planification. Au chapitre de l'enseignement, elle est l'une des architectes du nouveau doctorat en sciences de la vision, élaboré conjointement par la Faculté de médecine, l'École d'optométrie et la Faculté des arts et des sciences, et depuis 2006, elle porte le titre de leader pédagogique du Centre de pédagogie appliquée aux sciences de la santé (CPASS).

L'AFMC souhaite la bienvenue à la nouvelle doyenne de la Faculté de médecine de l'Université de Montréal.



Perhaps more surprising is the regional variation in the extent to which clinician and non-clinician scientists are supported by research salary awards. As shown in Figure 1, Quebec's clinician scientists receive, on average, about 13% of their income from research salary awards. In comparison, clinician scientists in Newfoundland and Nova Scotia receive, on average, about 5% of their income from research salary awards. Similar regional variations exist for non-clinician scientists. On average, non-clinician health researchers in Alberta and BC receive about 31% of their personal income from research salary awards. In Manitoba and Saskatchewan, non-clinician scientists receive only 18% of their personal income from research salary awards.

Results of the 2010 Research Careers Survey show clearly that clinician and non-clinician scientists are supported by research salary awards in variable ways across the country. This finding is, of course, just one thread in a more complex fabric. One must look more closely at time spent on research activity, research outputs and other supports, such as university and research institute salaries, before proclaiming on the overall adequacy of research career supports. Indeed, this is the great strength of RCS data – it allows for a more robust analysis of the many salient factors that contribute to health research productivity. In keeping with the theme of this issue of *Gravitas*, I sincerely welcome readers to contact me sslade@afmc.ca if you'd like to talk about how the 2010 Research Careers Survey can advance our understanding of how health research scholars are supported in Canada. 🌸

¹ Canadian Institutes of Health Research. *Message to the Health Research Community from the Scientific Council of CIHR Regarding the OOG Competitions*. December 16, 2010. <http://www.cihr-irsc.gc.ca/e/42857.html>, cited June 30, 2011.



Educational Scholarship and Practice *Gary Poole, Senior Scholar, Centre for Health Education Scholarship and Associate Professor in the School of Population and Public Health, Faculty of Medicine, University of British Columbia*

Gary Poole is the past-president of the International Society for the Scholarship of Teaching and Learning. He is the co-author of Effective Teaching with Technology in Higher Education, and The Psychology of Health and Health Care: A Canadian Perspective. Dr. Poole is an associate professor in the School of Population and Public Health in the University of British Columbia's Faculty of Medicine and Senior Scholar in the Centre for Health Education Scholarship.

References

Barrow, R. (2006). Empirical research into teaching." *Interchange*, 37(4), 287-397.

Eva, K.W., & Lingard, L. (2008). What's next? A guiding question for educators engaged in educational research. *Medical Education*, 42, 752-754.

Haynes, B., & Haines, A. (1998). Getting research findings into practice: Barriers and bridges to evidence based clinical practice. *British Medical Journal*, 317, 273-276.

Regehr, G. (2009). It's not rocket science: Rethinking our metaphors for research in health professions education. *Medical Education*, 44: 31-39.

Poole, G. (2011). *Valuing Scholarship in Medical Education: Some Current Opportunities and Challenges*. Plenary address to the Canadian Conference on Medical Education, with Batty, H & Fincher, R.M. Toronto, Ontario. May 9, 2011.

Poole, G. (in press). Square one: What is research? In K. McKinney (Ed). *SoTL in and across the disciplines* Bloomington, IN: Indiana University Press.

The nature of decision-making related to educational practice is changing. Intuition is being augmented by evidence. The level of activity presented at the recent Canadian Conference on Medical Education provided ample evidence of this movement.

At the same time, the journey to more evidence-based educational practice is a rocky one. Indeed, all professions experience some of this rockiness. For example, Haynes and Haines (1998) point out that the size and complexity of the research, the access to that research, and the need for more continuing education programs to help practitioners translate research evidence into practice all make evidence-based clinical practice far from simple. These factors apply equally well to educational practice.

Health educational literature features even more challenges regarding its translation to practice. For example, this literature is generated from a wide range of research methods, from randomized control trials to ethnography and grounded theory. The potential impact of this research will depend, in no small part, on the willingness of practitioners to accept a given method as legitimate (Poole, in press). Thus, a clinician who has been accustomed to reading evidence from *Cell* might be required to consider qualitative data in the form of in-depth interviews and focus groups when turning to educational literature. No random assignment. No blinding. No hypotheses.

In addition to the challenges provided by multiple methods, there is the issue of multiple purposes of research. In the health sciences, seeking cause and assessing interventions that may affect that cause are fundamental purposes of research. Regehr (2009) talks about an "imperative of proof" (p. 32) and an "imperative of generalizable simplicity" (p. 31) while also pointing out that educational research embraces a wider range of purposes.

These imperatives relate to the general research purpose of determining if something "works." This is an important purpose for educational research, but it is fraught with challenges, as Barrow (2006) points out, in terms of controlling confounding factors and operationally defining that which we are studying.

We will continue to grapple with these challenges and conduct important research on the efficacy of educational practice. At the same time, we can pursue other purposes that are equally as noble, and should be seen as such (Poole, 2011). These include: defining educational contexts in ways that help us better understand the complexity of such contexts (Regehr, 2009); exploring the characteristics and approaches of our learners; developing educational theory (Eva & Lingard, 2008); and further legitimizing the field of educational research.

In order for educational research to have a more extensive positive impact on practice, this range of methods and purposes must be acknowledged, valued, and explored. This asks a lot of researchers and practitioners, but it is a challenge well worth rising to. 🌟



A Word from CIHR...

Alain Beaudet, President, Canadian Institutes of Health Research

Medical knowledge is only useful to patients if physicians have access to it. Improving the way in which we provide this knowledge has become an increasingly pressing question, as it is currently believed that as little as 15% of all medical acts in Canada are truly evidence-based.

Timely and efficient translation of research innovations from the research setting to patient care settings is at the core of what CIHR's Strategy on Patient-oriented Research is set out to achieve. The strategy also calls for the evaluation and synthesis of existing knowledge and the rapid transfer of this knowledge to the clinical setting.

While a major focus of the strategy on patient-oriented research is on new discoveries, an equally important focus is comparing new discoveries with existing therapies to determine which interventions are most beneficial. This "comparative effectiveness research" complements studies designed to demonstrate the efficacy and safety of new drugs or devices prior to their application in clinical practice.

Physician-scientists form the cornerstone of an evidence-based healthcare system. CIHR has long recognized this and has invested, since 2000, \$10 million in its MD/PhD program, enabling 112 clinician scientists to divide their time between the clinic and the lab. But more needs to be done. Currently, less than 10% of Canada's medical work force is extensively involved in clinical research. While other countries have worked towards building their clinical research communities, Canada lags behind. This is why the strategy calls for increased support of health professionals trained in the core methods necessary to carry out clinical research activities.

But the weight of evidence-based practice cannot be borne solely by physician-investigators. It also needs a body of scientifically-minded physicians, trained to rely on research evidence and determined to maintain their skill sets. With intense demands on their time and an explosion of new information and information sources, tomorrow's physicians will need to develop more effective ways to access information and remain up-to-date.

In the past, the physician was the patient's sole source of health information. But today's doctors work as part of a team, which increasingly includes patients, who often come armed with pages of Internet research on their specific condition – some of it accurate, some of it not. The physician must be prepared to help the patient assess the accuracy of health information gleaned from the Web.

And advances in technology aren't just expanding the amount of information that patients have access to; they are radically changing the way that the doctor's office functions.

Physicians must be introduced to the concepts of e-health early in their education, so that they are prepared to work in an increasingly digital environment.

That's why CIHR has funded the study and implementation of the Medical Office of the 21st Century (MOXXI) project, an e-health record system that has helped connect doctors and pharmacists in Quebec to reduce prescription errors. As part of the project, approximately 70 physicians received Continuing Medical Education (CME) credits for participating in training to implement the MOXXI system. There are now 85,742 patients participating in the MOXXI trials.

CIHR also supports researchers who explore and assess other forms of Internet-based CME. For example, Dr. June Carroll at the University of Toronto and colleagues at McGill University and the University of Ottawa partnered with the Canadian Family Physician (CFP - the journal of the College of Family Physicians of Canada) to disseminate Gene Messengers. Each "messenger" is a critical review of a gene-disease association or genetic test that has received recent media coverage. Physicians receive continuing professional development credits for each Gene Messenger they read and rate. There are currently 16 Gene Messengers on the CFP web site, each of which receives between 300-1,300 views per month. So far, 1,035 family physicians have signed up to review Gene Messengers and give feedback on their relevance, use, impact and expected health benefit as a genetics knowledge translation strategy.

Through this type of research, we can explore new ways to help physicians keep abreast of health research discoveries that are of interest to their patients.

As the demands on physicians increase and evolve, we must continue to examine new strategies and opportunities in medical education. Health research, particularly patient-oriented research, will be vital as we move forward. 🇨🇦

Dr. Alain Beaudet, MD, PhD, is the President of the Canadian Institutes of Health Research (CIHR). As President, Dr. Beaudet acts both as Chair of the Governing Council and Chief Executive Officer of CIHR. Before joining CIHR in July 2008, Dr. Beaudet was the President and Chief Executive Officer of the Fonds de la recherche en santé du Québec (FRSQ), a position held since 2004.



Scholarship in Medical Education

Geneviève Moineau, Vice President, Education and Secretary, CACMS/CACME

Scholarship is a key component to the advancement of medical education. Promotion of research and innovation is part of the AFMC mission to achieve excellence in education.

Scholarship in Medical Education is such an important topic that it was the theme of the Canadian Conference on Medical Education (CCME) in 2011. The CCME is a partnership of the AFMC with the Canadian Association for Medical Education, the College of Family Physicians of Canada, the Royal College of Physicians and Surgeons of Canada and the Medical Council of Canada. We had international leaders in medical education research as plenary speakers and held our first annual research symposium. The quality of the workshops, oral presentations and posters was extremely high. The CCME is also the best Canadian opportunity to meet formally and informally with colleagues and future collaborators over the continuum of medical education. We will, with our partners, endeavor to continuously improve the quality of our world-class conference.

Our faculties continue to broaden the definition of scholarship so that educators, who disseminate work using innovative methods, can be appropriately recognized. Career paths for medical educators should allow promotion in a manner that is equitable to other paths. As our academic environments evolve this should include our clinician teachers at all our teaching sites.


The Future of Medical Education in Canada (FMEC) MD project and the FMEC-PG project triggered extensive reviews of the medical education literature and will help to determine possible new or underrepresented areas of focus in scholarship in medical education. Also, specific outcomes will need to be measured, documented and disseminated for the FMEC work to reach full potential.

We need to find new ways to engage our current medical student, resident and graduate student learners from across the country as they will be the next generation of leaders in medical education research and innovation.

As we envision medical education as a continuum of life long-learning involving healthcare teams we must look at our current education, accreditation, and credentialing structures to facilitate this change. Our scholarly work should increasingly be focused on all health professions and encompass the entire continuum of learning.

The AFMC serves an important role as facilitator in the advancement of scholarship in medical education by supporting committees and resource groups, engaging in liaison activities with partners, collecting and sharing data and in advocacy work.

Canada is fortunate to have an outstanding community of medical education researchers from which we can all benefit. We need to celebrate our successes and continue to strive towards the dissemination and translation of knowledge in medical education for the benefit of learners and ultimately, society.

I look forward to receiving your comments and suggestions at gmoineau@afmc.ca. 

AFMC Guided By New Mission Statement, Values and Strategic Objectives

Following a rigorous strategic review, AFMC is pleased to announce its new mission statement, values and strategic objectives. The updated information can be accessed on our website here: www.afmc.ca/about-mission-e.php

L'AFMC est guidée par un nouvel énoncé de mission, de nouvelles valeurs et de nouveaux objectifs stratégiques

Au terme d'un rigoureux examen stratégique, l'AFMC a le plaisir de vous présenter son nouvel énoncé de mission, ses nouvelles valeurs et ses nouveaux objectifs stratégiques. L'information mise à jour est sur notre site Web ici à : www.afmc.ca/about-mission-f.php



Réflexions *Nick Busing, président-directeur général*

L'allocution du président ci-dessous, intitulée « La médecine universitaire, 2014 et au-delà » a été présentée par le Dr Nick Busing lors de la Conférence canadienne sur l'éducation médicale, à Toronto, en Ontario

Je voudrais vous parler aujourd'hui de la médecine universitaire et de ses nombreuses forces qui peuvent être mises à contribution durant les prochaines années [diapo #1]. Je veux aussi situer divers enjeux dans le contexte de 2014. Même si la médecine universitaire n'est pas aux premières lignes dans les négociations entre les provinces et le gouvernement fédéral alors qu'ils se préparent à renouveler l'Accord sur la santé, nous devrions mettre de l'avant nos revendications pour qu'elles soient prises en compte par les parties concernées. Nous devons insister sur le fait que la médecine universitaire a des intérêts substantiels dans ces discussions et que nous pouvons donner des conseils et des points de vue précieux [diapo #2]. Dans le cadre de ma brève allocution, je mettrai l'accent sur trois enjeux qui méritent selon moi d'être étudiés collectivement et sur lesquels nous devrions fournir des avis [diapo #2]. J'aurais pu insister sur de nombreux points, mais il s'agit pour moi des trois principaux enjeux pour le moment.

D'abord, regardons le nombre d'étudiants en médecine et de résidents qui obtiennent leur diplôme de nos 17 facultés. Dans cette diapositive, on voit que le Canada tire de l'arrière par rapport aux pays de l'OCDE dans les ratios traditionnels de médecin par nombre d'habitants auxquels nous semblons tant tenir [diapo #3]. Je crois que nous devons remettre en question ces ratios et nous demander s'ils sont toujours des indicateurs significatifs et utiles dans le contexte des nouveaux modèles de soins, des autres professionnels et des soins en équipe. Étant donné que la moyenne de l'OCDE inclut les pays où il y a un surplus de médecins, il faut interpréter ces statistiques avec circonspection. De plus, des pays qui ne font pas partie de l'OCDE ont des surplus importants, et dans bien des cas, des pénuries importantes dans leurs effectifs médicaux. Par exemple, le Kazakhstan, qui a une population de 16 millions de personnes, accepte 5 000 étudiants en médecine par année. Le Canada, avec près de 34 millions d'habitants, accepte à peu près 3 000 étudiants. Même avec un système pyramidal au Kazakhstan,

80 % de ces étudiants obtiennent leur diplôme, ce qui entraîne d'énormes surplus dans la population de médecins. Ce n'est plus le même discours quand on regarde de nombreux pays africains où le nombre de médecins par habitant est minuscule. Par exemple, il y a 8 médecins par 100 000 habitants en Ouganda et 3 médecins par 100 000 en Éthiopie.

Voici ce qui s'est passé dans nos facultés de médecine au cours des dernières années [diapo #4]. Les barres de couleur unie montrent la hausse considérable dans le nombre total d'étudiants aux niveaux prédoctoral et postdoctoral par 100 000 habitants. Si vous regardez les années 1994 à 2000, vous pouvez constater que le nombre total d'inscriptions en formation prédoctorale et postdoctorale avait baissé en réalité. Durant cette même période, notre population s'était accrue de 29,2 millions à 30,8 millions. À partir de 2000 et durant les années subséquentes, les inscriptions totales au niveau prédoctoral ont augmenté de 61 % et celles au niveau postdoctoral ont connu une hausse de 66 %. Simultanément, la population augmentait d'environ 10 %. Nous avons réellement accéléré la production de médecins dans les facultés de médecine et les programmes de résidence. Savons-nous si nous admettons assez d'étudiants, quand ralentir les inscriptions et quand en accepter davantage? Nous n'avons pas de modèle national de planification et les provinces pensent encore qu'elles peuvent et devraient être les principales planificatrices des ressources du secteur de la santé dont elles pourraient avoir besoin à l'intérieur de nos frontières.

Mais ce dont je veux vraiment parler vient ensuite. Regardons de plus près qui nous formons dans la prochaine génération de nos effectifs médicaux. Voici une diapositive qui illustre le vieillissement de la population au Canada [diapo #5]. On compte actuellement 4,8 millions de Canadiens âgés de 65 ans et plus. D'ici 2036, ce nombre aura doublé pour atteindre 10,4 millions et en 2051, un Canadien sur quatre aura 65 ans et plus.

À l'heure actuelle, nous avons 238 gériatres certifiés au Canada et un petit nombre de diplômés en soins aux personnes âgées. Cette diapositive montre l'inscription en formation médicale postdoctorale spécialisée dans les soins aux aînés et en gériatrie et ce devrait être un embarras pour nous tous [diapo #6]. Ce sont des chiffres dérisoires, en n'importe quelles circonstances, mais très alarmantes compte tenu de l'évolution des données démographiques. En 2010, nous avions 31 postes à combler en gériatrie et seulement 18, comme l'indique la diapositive, ont été de fait comblés. Pourtant, il existe d'autres moyens importants pour répondre aux besoins de cette population, comme recourir à de nombreux autres professionnels de la santé, faire appel à des médecins de famille bien formés, des centres d'hébergement plus appropriés et adéquats, et ainsi de suite. Mais je

maintiens toujours qu'il nous faut aussi une bien plus grande cohorte de cliniciens experts.

Examinons ces chiffres en les comparant aux inscriptions en pédiatrie au niveau postdoctoral, une spécialité certes très importante, mais qui attire déjà davantage de candidats que la gériatrie [diapo #7]. Il s'agit d'une situation à laquelle nous devons réfléchir.

Où se situent les problèmes et que peut faire la médecine universitaire pour les régler?

Les gériatres et les médecins spécialistes en soins aux aînés ont moins de prestige que bien d'autres médecins. Nous, en tant que population, sommes subjugués par les spécialités techniques, interventionnistes et celles qui demandent une compétence très particulière, plutôt que par les disciplines davantage centrées sur la cognition. Nous avons de l'admiration pour nos collègues spécialisés en gériatrie et en soins aux aînés, mais les appuyons-nous et, dans l'affirmative, comment? Nous avons un système axé sur les hôpitaux, un milieu qui n'est pas particulièrement convivial pour les aînés, même si la personne âgée a besoin d'un lit d'hôpital. Nous ne fournissons pas assez de ressources à la communauté et aux soins à domicile et, pourtant, plus de fonds permettraient aux médecins de faire leur travail plus efficacement. Les gériatres sont très mal rémunérés et c'est là l'une des raisons pour lesquelles la discipline n'est pas attrayante pour les étudiants en médecine.

Il est essentiel d'avoir une stratégie pour recruter et former plus de gériatres et d'experts en soins aux aînés; elle fait partie de notre défi plus large qui comporte aussi d'assurer des établissements de soins de longue durée adéquats, des soins à domicile abordables et même une meilleure assurance-médicaments.

J'aimerais maintenant examiner d'un autre angle les diplômés de notre profession et les façons de mieux répondre aux besoins des Canadiens. En sommes-nous arrivés à un agencement équilibré entre les résidents détenteurs d'un visa et les résidents financés par les ministères de la Santé dans nos programmes? Avons-nous atteint le meilleur équilibre possible entre les diplômés en médecine canadiens, les diplômés formés à l'étranger et les diplômés détenteurs d'un visa dans la formation postdoctorale? Cette diapositive illustre les pourcentages de résidents détenteurs d'un visa dans cinq disciplines primaires et surspécialisées [diapo #8]. Je ne m'inquiète pas outre mesure du nombre de boursiers dans le système – bon nombre d'entre eux ont un rôle différent à jouer et répondent à un important besoin en matière de services. Ces données montrent que 20 % ou plus des résidents en formation en 2010 dans quatre des disciplines

indiquées sur la diapositive étaient des résidents détenteurs d'un visa. Les résidents sont ici pour recevoir de la formation et, en définitive, répondre aux besoins des Canadiens (reconnaissant que nous avons des obligations internationales de former des médecins et de mettre à contribution notre expertise médicale sur le plan international) – alors je pense qu'il nous faut un meilleur équilibre entre les possibilités de formation pour les diplômés en médecine canadiens, le nombre croissant de diplômés formés à l'étranger et les résidents détenteurs d'un visa, de manière à ce que nos obligations réelles et perçues soient acquittées de manière plus efficace.

En lien avec mes observations entourant ceux que nous formons dans nos facultés de médecine, il existe une préoccupation concernant la qualité dans notre système. Dans un récent sondage auprès de la population parrainé par le Projet postdoctoral sur l'Avenir de l'éducation médicale au Canada, une constatation surprenante a été relevée – il y avait un changement perceptible dans l'opinion de la population, passant d'une préoccupation quant à l'accès aux soins à une préoccupation concernant la qualité des services de santé. Pour corroborer mes commentaires précédents, le même sondage a indiqué qu'une majorité de répondants estimaient que le vieillissement de la population et les changements démographiques au Canada étaient le plus important problème émergeant dans notre système de santé.

Nous pouvons apporter beaucoup de contributions à de nombreux aspects de la discussion sur la qualité et je n'en nommerai que quelques-unes. Par exemple, dans quelle mesure sommes-nous confiants que nous enseignons la médecine factuelle à nos étudiants et résidents? Sommes-nous tous à jour dans nos méthodes pédagogiques et le contenu enseigné? Comment exerçons-nous une surveillance et assurons-nous que nous sommes bien à jour? Quels sont les résultats de notre programme d'enseignement actuel? Ce sont toutes là des questions qui concernent la qualité.

Avons-nous développé, tant au niveau prédoctoral que postdoctoral, des systèmes d'agrément permettant de mesurer les résultats de notre formation ou sommes-nous trop axés sur les enjeux liés aux procédés dans le cadre de l'agrément? L'agrément devrait mener, au fil du temps, à une population en meilleure santé. Comment parvenons-nous non seulement à établir ce lien, mais également à l'évaluer? Sur la scène clinique, des questions comme les erreurs médicales, le recours inapproprié aux médicaments et la polypharmacie sont des problèmes cruciaux à examiner. Si nous ne réglons pas ces questions de qualité, elles peuvent avoir et ont effectivement des impacts considérables sur la santé de notre population.

Des études ne cessent de faire valoir que le système de santé canadien n'est pas aussi en santé qu'auparavant. Quel est notre rôle dans la résolution des problèmes du système? Le plan d'action pour la qualité est-il à l'avant-plan des préoccupations de nos centres universitaires? Comme notre planification des ressources humaines, je crois qu'il est fragmenté, épars et souvent axé sur les hôpitaux et fréquemment décrit en termes de sécurité des patients. Nous avons besoin de stratégies qui mettent en application des indicateurs de la qualité et de la sécurité dans tout le continuum des soins et dans toutes les régions. Dans le sondage dont je viens de parler, on laissait aussi entendre que le degré d'aise avec l'accès et les soins augmentait en fonction de la situation socioéconomique et du niveau des revenus dans la population. Ce n'est pas surprenant, mais en vif contraste avec l'avis des personnes ayant une incapacité et les minorités visibles qui se sentaient bien moins à l'aise avec le système de santé et moins bien soutenues par ce dernier. C'est un problème de qualité auquel réfléchir et qu'il faut régler.

Selon l'Institute of Medicine, la recherche comparative sur l'efficacité [diapo#9] est la production et la synthèse de données probantes permettant de comparer les bienfaits et les inconvénients de méthodes alternatives de prévenir, diagnostiquer, traiter et surveiller les problèmes cliniques ou d'améliorer la prestation des soins. La recherche comparative sur l'efficacité a pour but d'aider les consommateurs, les cliniciens, les acheteurs et les décideurs à prendre des décisions éclairées qui amélioreront les soins de santé tant pour les individus que pour la population.

Elle doit être soutenue et développée – pour veiller à ce que nous dispensions les soins les plus efficaces et les plus sécuritaires dans le meilleur milieu avec les professionnels idéaux. Les centres de santé universitaires (facultés de médecine, centres hospitaliers universitaires et tous les autres participants dans les réseaux universitaires émergents en sciences de la santé) doivent incarner la façon dont nous pouvons effectivement offrir ces soins exemplaires dans le meilleur environnement possible avec les meilleurs professionnels. Si tout ne commence pas avec nous et si nous ne servons pas de modèles à imiter par nos étudiants et nos résidents, où cela commencera-t-il?

En résumé, aujourd'hui, je recherche le leadership de la médecine universitaire à plusieurs égards [diapo #10] :

- Travailler collectivement pour avoir un environnement de planification des effectifs médicaux plus cohérent.
- Développer nos programmes de gériatrie et de soins aux aînés et produire plus de médecins dont j'aurai et plusieurs d'entre vous aussi aurez bientôt besoin.
- Travailler pour en arriver à un meilleur équilibre entre les diplômés en médecine canadiens, les diplômés en médecine formés à l'étranger et les résidents détenteurs d'un visa.
- Exercer plus de leadership dans le plan d'action pour la qualité, dans tous les domaines qui nous concernent en tant qu'éducateurs, chercheurs et cliniciens.

Je vous remercie. 



Nouveaux outils relatifs aux normes d'agrément de la formation interprofessionnelle en sciences de la santé

La deuxième étape du projet sur l'Agrément de la formation interprofessionnelle en sciences de la santé (AFISS) a maintenant été complétée. Nous avons procédé au lancement d'un nouveau site Web (www.aiphe.ca) et à la mise en œuvre de ressources telles que le *Guide sur les normes/standards d'agrément de la formation interprofessionnelle en sciences de la santé* pour vous aider à intégrer les normes relatives à la formation interprofessionnelle (FIP) en sciences de la santé au sein des programmes d'agrément des professions de la santé et vous fournir des exemples de données probantes en matière d'évaluation pour aider les évaluateurs chargés de l'agrément.

Les six professions de la santé suivantes sont touchées par l'initiative : la médecine, la physiothérapie, l'ergothérapie, la pharmacie, le travail social et les sciences infirmières. Avant de produire les ressources et outils dans leur version définitive, les organismes partenaires de l'AFISS ont renseigné et consulté des intervenants-clés, notamment des gestionnaires

de centres de formation clinique, des organismes de réglementation et des représentants des gouvernements puisque ces groupes jouent un rôle essentiel pour permettre aux programmes de formation d'intégrer les étudiants et les nouveaux diplômés dans des milieux de soins et de services de santé misant sur la collaboration et centrés sur la personne. Des données scientifiques démontrent que la formation interprofessionnelle permet une pratique efficace qui, en retour, renforce le système de santé et améliore les résultats en soins et services de santé.¹

Même si la deuxième étape du projet est terminée, les organismes d'agrément qui participent au projet sur l'AFISS travailleront à intégrer dans leurs normes/standards d'agrément des principes communs en ce qui a trait à la FIP. Ils mettront à l'essai les normes, les réviseront et les mettront en œuvre. Pour tout complément d'information, veuillez consulter le site : www.aiphe.ca.

¹ Organisation mondiale de la santé (OMS), Framework for Action on Interprofessional Education and Collaborative Practice, 2010 (Cadre conceptuel sur la formation interprofessionnelle et la pratique en collaboration) [traduction].



Un message des IRSC...

Alain Beaudet, Président, Instituts de recherche en santé du Canada

Les connaissances médicales sont utiles aux patients à condition d'être accessibles aux médecins. Améliorer la façon dont nous rendons ces connaissances accessibles est devenu une question de plus en plus pressante, car seulement 15 % de tous les actes médicaux au Canada reposeraient véritablement sur des données probantes à l'heure actuelle.

Le passage opportun et efficace des innovations des centres de recherche aux milieux de soins de santé est au cœur des objectifs de la Stratégie de recherche axée sur le patient des IRSC. La Stratégie prévoit aussi l'évaluation et la synthèse des connaissances existantes, et le transfert rapide de ces connaissances au milieu clinique.

Bien que la Stratégie de recherche axée sur le patient mette fortement l'accent sur les nouvelles découvertes, c'est avec une insistance égale que ces nouvelles découvertes sont comparées aux thérapies existantes pour déterminer quelles interventions sont le plus bénéfiques. Cette « recherche sur l'efficacité comparative » complète les études conçues pour démontrer l'efficacité et l'innocuité de nouveaux médicaments et dispositifs avant leur introduction dans la pratique clinique.

Les médecins-chercheurs forment la pierre angulaire d'un système de soins de santé fondé sur des données probantes. Les IRSC reconnaissent depuis longtemps cette réalité, ayant investi 10 millions de dollars dans leur programme de M.D./Ph.D. depuis 2000, et permis ainsi à 112 cliniciens de diviser leur temps entre la clinique et le laboratoire. Cela n'est pas suffisant, par contre. Actuellement, seulement 10 % du corps médical canadien participe intensivement à la recherche clinique. Le Canada a pris du retard sur d'autres pays qui se sont appliqués à renforcer leurs milieux de recherche clinique. C'est pourquoi la Stratégie demande de mieux appuyer les professionnels de la santé possédant la formation de base qu'exige la recherche clinique.

Néanmoins, le poids d'une pratique fondée sur des données probantes ne peut reposer seulement sur les épaules des médecins-chercheurs. Il fait aussi une armée de médecins à l'esprit scientifique, formés pour se fier aux données scientifiques et déterminés à tenir leurs compétences à jour. Face à d'énormes contraintes de temps et à l'explosion de la quantité et des nouvelles sources d'information, les médecins de demain devront acquérir des façons plus efficaces d'avoir accès aux connaissances et de rester à jour.

Par le passé, le médecin était la seule source d'information sur la santé. Aujourd'hui, il fait partie d'une équipe, laquelle – de plus en plus – compte des patients, qui arrivent souvent armés de pages de recherches faites sur Internet (parfois justes, mais pas toujours) au sujet de leur maladie particulière. Le médecin doit être préparé à aider le patient à évaluer la justesse de l'information glanée sur le Web.

Les avancées technologiques n'accroissent pas seulement la quantité d'information à laquelle les patients ont accès; elles changent radicalement la façon dont le cabinet du médecin fonctionne. Les médecins doivent être initiés aux concepts de la cybersanté au début

de leurs études afin d'être préparés à travailler dans un univers de plus en plus numérique.

Voilà pourquoi les IRSC ont financé l'étude et le projet MOXXI (Medical Office of the 21st Century), système de dossiers de santé électroniques qui a aidé à mettre les médecins en contact avec les pharmaciens au Québec pour réduire les erreurs de prescription. Dans le cadre du projet, environ 70 médecins ont reçu des crédits de formation médicale continue après avoir suivi la formation visant à mettre en œuvre le système MOXXI. À l'heure actuelle, 85 742 patients participent aux essais MOXXI.

Les IRSC viennent également en aide aux chercheurs qui explorent et évaluent d'autres formes de formation médicale continue sur Internet. Par exemple, la D^{re} June Carroll, de l'Université de Toronto, et des collègues de l'Université McGill et de l'Université d'Ottawa se sont associés à la revue *Le médecin de famille canadien* (MFC, publication officielle du Collège des médecins de famille du Canada) pour disséminer la collection de documents intitulés « Gene Messenger », qui se veulent un examen critique d'un lien gène-maladie ou d'un test génétique d'actualité. Les médecins reçoivent des crédits de perfectionnement professionnel pour chaque « Gene Messenger » qu'ils lisent et cotent. Cette collection compte actuellement 16 documents dans le site Web de MFC, et chacun est consulté de 300 à 1 300 fois par mois. Jusqu'ici, 1 035 médecins de famille ont demandé à recevoir les « Gene Messengers » et en commentent la pertinence, l'utilisation, l'impact et les avantages attendus sur le plan de la santé comme moyen d'application des connaissances en génétique.

Grâce à ce type de recherche, nous pouvons explorer de nouvelles façons d'aider les médecins à se tenir au courant des découvertes en santé qui présentent de l'intérêt pour leurs patients.

Comme les exigences auxquelles doivent répondre les médecins augmentent et évoluent, nous devons continuer d'examiner de nouvelles stratégies et possibilités qu'offre la formation médicale. La recherche en santé, particulièrement la recherche axée sur le patient, sera vitale à l'avenir. ❀

Le D^r Alain Beaudet, M.D., Ph.D., est le président des Instituts de recherche en santé du Canada (IRSC). À ce titre, le D^r Beaudet assume les fonctions de président du conseil d'administration et de premier dirigeant responsable des IRSC. Avant d'entrer en fonction aux IRSC en juillet 2008, le D^r Beaudet occupait le poste de président-directeur général du Fonds de la recherche en santé du Québec (FRSQ) depuis 2004.

L to R: Lara Cooke and Tom Feasby



L to R: Ravi Sidhu and Tom Feasby



L to R: David Topps, Kevin Lachapelle, Rachel Ellaway and Tom Feasby



L to R: Catherine Cooke and May Cohen



L to R: Nick Busing, Brian Hodges and Tom Feasby



2011 AFMC Award Winners

AFMC is proud to announce the 2011 winners of five awards celebrating excellence in medical education. These awards were presented on May 10, 2011 at the Canadian Conference on Medical Education in Toronto.

AFMC Award for Outstanding Contribution to Faculty Development in Canada

Dr. Lara Cooke, University of Calgary

AFMC Young Educators Award

Dr. Ravi Sidhu, University of British Columbia

AFMC-John Ruedy Award for Innovation in Medical Education

Dr. Kevin Lachapelle, McGill University, Dr. Rachel Ellaway, Northern Ontario School of Medicine and Dr. David Topps, Northern Ontario School of Medicine

AFMC-May Cohen Gender Equity Award

Dr. Catherine Cook, University of Manitoba

AFMC-President's Award for Exemplary National Leadership in Academic Medicine

Dr. Brian Hodges, University of Toronto

For more information on these awards including nomination procedures, please consult our website at: www.afmc.ca/awards-e.php

Lauréats des prix de l'AFMC en 2011

L'AFMC est fière d'annoncer le nom des lauréats de cinq prix en 2011 décernés en hommage à l'excellence en éducation médicale. Ces prix ont été remis le 10 mai 2011 à l'occasion de la Conférence canadienne sur l'éducation médicale à Toronto.

Le Prix AFMC pour contribution exceptionnelle au perfectionnement du corps professoral au Canada

D^{re} Lara Cooke, University of Calgary

Le Prix AFMC des jeunes éducateurs

D^r Ravi Sidhu, University of British Columbia

Le Prix AFMC - John Ruedy pour l'innovation en enseignement médicale

D^r Kevin Lachapelle, Université McGill, D^{re} Rachel Ellaway, École de médecine du Nord de l'Ontario and D^r David Topps, École de médecine du Nord de l'Ontario

Le Prix AFMC - May Cohen pour l'équité entre les sexes

D^{re} Catherine Cook, University of Manitoba

Le Prix AFMC - Prix du président de l'AFMC pour leadership exemplaire en médecine universitaire à l'échelle nationale

D^r Brian Hodges, University of Toronto

Pour obtenir plus de renseignements sur ces prix, y compris le processus des mises en candidature, veuillez consulter notre site Web à www.afmc.ca/awards-f.php