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

Réflexions *Nick Busing, président-directeur général*

En 2004, le BMJ Publishing Group et autres intervenants ((http://resources.bmj.com/bmj/readers/academic-medicine) réunissaient des meneurs du milieu universitaire provenant de 14 pays afin de discuter de l'avenir de la médecine universitaire. Selon certains d'entre eux, la médecine universitaire traversait à l'époque une « crise ».[1] Réunis dans le but d'aider à promouvoir et à dynamiser la médecine universitaire, les membres de ce groupe de travail international ont déterminé un certain nombre de préoccupations, notamment, la sous-estimation de l'enseignement, la tolérance face au déséquilibre et au manque de communication entre la recherche en matière de science fondamentale et la recherche clinique et appliquée, le manquement au fait d'insuffler innovation et excellence dans l'exercice clinique et le fait d'ignorer les valeurs essentielles de la responsabilité sociale et globale.[2] Le groupe de travail a adopté une approche intéressante : après avoir procédé à une séance de remue-méninges sur les défis et l'analyse des données probantes, il a présenté cinq scénarios qui n'étaient pas nécessairement conçus pour prévoir l'avenir, mais plutôt pour stimuler la réflexion concernant les options pour l'avenir et encourager la réflexion de manière à potentiellement améliorer la planification à long terme.

Les cinq scénarios élaborés ont été baptisés comme suit : Milieu universitaire Inc., Réforme, Dans l'œil public, Partenariat universitaire global et Engagement total. Ces scénarios partageaient un certain nombre de points communs, certains portant sur la nécessité pour la médecine universitaire de se rapprocher plus efficacement de ses intervenants (public, patients, praticiens, politiciens et décideurs), la nécessité d'opter pour une vision plus globale, les défis liés au maintien

1 Clark J, Smith R. BMJ Publishing Group to launch an international campaign to promote academic medicine BMJ 2003:327:1001-2.

2 The International Campaign to Revitalize Academic Medicine: agenda setting, BMJ, 2001:329787-789.

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des trois volets universitaires (enseignement, recherche et service clinique), l'importance grandissante du travail d'équipe, la compétition globale entre les établissements universitaires, l'augmentation de l'accent mis sur l'enseignement et l'apprentissage dans un milieu concurrentiel et la combinaison de la recherche (de base et appliquée) à la mise en œuvre et à l'amélioration.

Plusieurs des caractéristiques communes des scénarios décrits en 2004 demeurent pertinentes aujourd'hui. Je veux brièvement mettre en lumière nombre de défis auxquels fait face la médecine universitaire au Canada en 2011 et qui se reflètent dans plusieurs des caractéristiques communes des scénarios décrits en 2004.

Dans le cadre du présent éditorial, je me pencherai sur quatre scénarios : 1) le défi du plein emploi pour les chercheurs de talent que nous avons formés et recrutés; 2) la nécessité d'accroître la collaboration, non seulement sur le plan de l'exercice, mais également de la recherche et de l'éducation; 3) le défi consistant à harmoniser la recherche, l'éducation et le travail clinique relativement à la médecine universitaire aux besoins sociétaux et 4) l'établissement de leadership en médecine universitaire afin de s'attaquer aux nombreux défis systémiques dans le domaine des soins de santé.

Le Canada a réussi à recruter ou à former plusieurs chercheurs de calibre international du milieu des sciences fondamentales et des sciences cliniques, mais nous avons besoin de subventions pour leur permettre de travailler. Le nombre de subventions émanant de sources de financement comme les IRSC ne correspond pas à la capacité de notre milieu de recherche. La nécessité d'équilibrer les subventions entre les recherches d'enquête et les recherches plus ciblées complique la situation. Collectivement parlant, en notre qualité de représentants de la médecine universitaire, nous devons, de concert avec nos partenaires tels que les hôpitaux spécialisés dans la recherche et l'enseignement, les organismes de charité axés sur la santé et autres intervenants, unir nos voix afin de répondre au besoin pressant que constitue le fait d'appuyer les talents nationaux sur le plan de la recherche en santé.

La collaboration devrait englober un partage des responsabilités et une reconnaissance des compétences de celles et ceux qui contribuent à la tâche à accomplir. Comme nous le disons souvent, une collaboration efficace consiste à veiller à ce que le bon fournisseur accomplisse la tâche appropriée au bon moment. La collaboration devrait être vue comme une occasion accueillie avec plaisir, non seulement comme un défi. Possédons-nous véritablement suffisamment de modèles significatifs d'apprentissage, de recherche et d'exercice conjoints?

Tenter de répondre aux besoins est un objectif noble et essentiel, difficile à quantifier et encore plus à atteindre. La médecine universitaire occupe une position privilégiée. Nous devons nous demander comment elle peut parvenir à mieux répondre aux besoins des plus démunis, comme les Autochtones et les communautés urbaines marginalisées. La médecine universitaire doit reconnaître plus clairement les défis entourant l'établissement d'environ 250 000 immigrants par année au Canada. Elle doit trouver des partenaires dans tous les milieux – dans la rue, dans les écoles, dans les institutions publiques et au sein du gouvernement. Ces partenariats nous permettront de mieux répondre aux besoins sociétaux et d'intégrer la médecine universitaire dans le tissu urbain de nos communautés.

Les dépenses relatives aux soins de santé, notamment en matière d'éducation et de

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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.

recherche, n'ont jamais été aussi élevées. Nous sommes tous au courant du débat concernant le caractère adéquat du financement afférent au système de soins de santé. La médecine universitaire devrait faire preuve de leadership en testant et en mettant en pratique des moyens d'optimiser chaque dollar dont nous disposons. Nous ne devrions pas être vus comme drainant les finances. La médecine universitaire doit reconnaître et reconnaît que seul un nombre limité de dollars peut entrer dans le système, que nous formons de plus en plus de médecins, que la demande ne montre aucun signe de ralentissement et que nous devons offrir un leadership collectif en travaillant avec ce que nous avons de manière à produire les meilleurs résultats possibles.

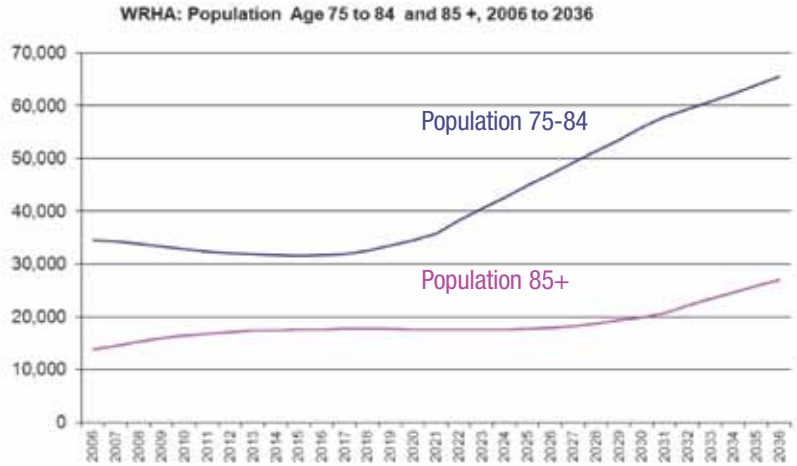
Comme je l'ai souvent dit, la médecine universitaire réunit certaines des personnes les plus talentueuses et les plus engagées au pays. Nous sommes en mesure de nous attaquer individuellement et collectivement à ces défis et de veiller à ce que la médecine universitaire ait un avenir brillant, pertinent et hautement valorisé.

THE DEANERY

The Effects of an Aging Population

Brian Postl, Dean, Faculty of Medicine, University of Manitoba

Demographic data projects an increasing proportion of the Canadian population being greater than the age of 65 more than anytime previously. This likely will result in a small or modest share increase in expenditures within the healthcare sector over the next decade. We know that use of the healthcare system increases with age. From age 65 to 74, use of services from home care begin to increase. The demand for home care, other community services and long-term care services increases dramatically after age 75. The risk of institutional placement increases dramatically after age 85. The impact of population changes in the Winnipeg Health Region in these age cohorts is described below and is not dissimilar with that which will occur in other major centres (see graph).



NOTE: Projection years are based on June 1 to May 31
Data Source: Manitoba Bureau of Statistics (MBS) and are under their file "Regional Health Authority Projections" Rec'd: April 2008

Dr. Brian Postl's five-year term as Professor and Dean, Faculty of Medicine, began July 1, 2010. He is a graduate of the University of Manitoba. He received his doctor of medicine degree in 1976 and the Royal College Fellowship in community medicine and in Pediatrics in 1981 and 1982, respectively. He was the founding president and CEO of the Winnipeg Regional Health Authority (WRHA), a position he held for ten years.

Dr. Postl has served as head of pediatrics and child health and as head of community health sciences at the University of Manitoba. He has also served as director of the J.D. Hildes Northern Medical Unit and division of community and northern medicine and as director of the Faculty of Medicine's community medical residency program.

His research, published works and professional involvement focus on Aboriginal child health, circumpolar health and human resource planning. His contributions in these areas, combined with his experience as a visiting pediatrician to communities in northern Manitoba and Nunavut, contributed to him earning the Canadian Association of Pediatric Health Centre's Child Health Award of Distinction in 2006 and the Inter-Professional Association on Native Employment's Champion of Aboriginal Employment Award in 2007.

Regions across the country have been preparing for these requirements for several years in variable ways. Importantly, there is recognition that services (acute care, housing, transportation, long-term care and community) required in the future may be different than those of the past.

Future changes will include the concepts of keeping elderly in their homes and independent housing environments for longer periods of time. A key future for enhanced programming is, therefore, community-based with expansions in home care, day programming and day hospital care. Self and family managed care programs are increasingly being used as alternatives to institutionalized care. There is increasing need for focused and specialized programming in such areas as post-stroke care.

Finally, at the more supported end of the spectrum, many regions and provinces have increased their stock of personal care home beds (nursing homes), developed with much more attention to space, infection control and aesthetic requirements for elder care. As people are supported longer in the community, it means that people entering the institutional environments like personal care homes are more complex. It has also resulted in a situation where some individuals need specialized environments for managing unique behaviours.

The aging population also impacts upon the way acute care services are being delivered. In Winnipeg, it is estimated that anywhere from 5% to 15% of patient days are ALC (Alternative Level of Care). Other jurisdictions face similar bed use issues. Some of these individuals are elderly individuals who need care but not necessarily hospital-based care. Growth in the aging population means that our health service delivery system will need to be adjusted to reflect this current and emerging reality. This will result in a re-balancing between acute care, community and long-term care services.

However, this isn't only about money….it is about the people who deliver these healthcare services who must shift their attention to this new demand area. Physicians, nurses and allied health professionals will be challenged to re-think how we care for an aging population. So far, health professions have not generally been interested or attracted to geriatric training or service. As public policy and funding shifts to support population demand, those attitudes will need to change.

Physician supports to these program extensions and expansions have been crucial to their success. Much of the physician support has rested with family medicine where primary care physicians play a prominent role in care of this part of the population. Recent improvements in funding have been essential in supporting the role, which now includes expanded roles in case management, bed management and drug review processes.

There are also efforts of multi-disciplinary support with such interventions as geriatric assessment teams, support in emergency rooms and improved access to geriatric nurse practitioners in personal care homes and home care programmes. Nurse practitioners are a recent addition to some personal care homes and have been a valuable adjunct to the role of family physicians.

There remains a profound shortage in specialists with training in geriatrics or geriatric psychology. This is of particular concern considering the increasing recognition of dementia as morbid and co-morbid conditions of many in this age group.

It may be time to consider new ways of training these physicians that allow for entry in later career, and training that can be supported in a part time way that allows practices to evolve in a more organic fashion. The interest in competency-based training may allow creative ways to enhance training in these important areas of both family physicians and specialists in geriatric care.

Advocating for the Needs of Canadians

Irving Gold, Vice President, Government Relations and External Affairs

Over the last several years, the scope and magnitude of AFMC's advocacy activities has increased significantly. This year, we are poised to hold our biggest ever Deans on the Hill lobby event. This annual event brings deans of medicine from across the country to Parliament Hill to meet with members of parliament and senators to discuss specific proposals and identify ways that the AFMC can work with government to improve the health and wellbeing of our healthcare system and all Canadians.

The theme for Deans on the Hill 2011 will be *Canada's Changing Demographics – meeting the needs of Canadians* and will centre on four specific proposals we have developed to better respond to the ever-changing healthcare needs of Canadians.

Our first proposal relates to the lack of diversity that can be seen in our medical schools. In terms of socioeconomic status, while medical students come from all family income categories, they are much more likely to come from higher-income families; almost 45% of medical students report coming from families with an annual income of $100,000 or more, a group which represents only roughly 26% of all Canadians. In terms of visible minority distributions among medical students, while all visible minority groups are represented among medical students, Black, Filipino and Latin American peoples tend to be relatively less present among the medical student population. Canada's Indigenous population is also significantly under-represented in both medical school and the medical profession. Canada's faculties of medicine are taking steps to foster a physician workforce that better reflects our population and is well-equipped to serve its diverse needs, and AFMC is proposing the creation of a Medical Education Opportunities Fund which would significantly reduce the real and perceived costs of attending medical school.

Our second proposal relates to Indigenous youth. AFMC has a long history with projects aimed at improving the ability of Canadian physicians to provide culturally safe care to Indigenous Canadians, as well as increasing their numbers in faculties of medicine. And while the Medical Education Opportunities Fund would be made available to Indigenous youth, the fact remains that many of the barriers keeping these individuals from medical school are far more upstream than simply the direct costs associated with medical school. Indigenous students need programs that will encourage them to complete secondary school and enter the post-secondary system. It is only then that more will be eligible to pursue a career in medicine. To that end, AFMC has been working with the Association of Universities and Colleges of Canada and other stakeholders to develop a proposal for a series of measures that we believe have the potential to significantly increase Indigenous high school completion rates and entry into the postsecondary system.

Our third proposal relates to health human resources and the important role we believe the federal government can and should play in health human resource (HHR) planning. While healthcare delivery falls within provincial jurisdictions, provinces are left with the responsibility to plan their health human resources. The high level of mobility of the physician workforce, which will increase as a result of the Agreement on Internal Trade means that more than ever, that national modeling and HHR planning will become even more essential. AFMC is proposing to conduct a feasibility study and business plan for the development of a national HHR Data and Analysis Centre which would serve as a national facilitator for HHR modeling. The centre would fully respect federal, provincial and

territorial boundaries, but would provide a service to provinces and the federal government as it analyses and incorporates the needs of Canadians into HHR planning.

Finally, AFMC will continue to advocate for increased investments in health and biomedical research, particularly those that that reflect the ever-changing needs of Canadians. We are calling for increased support for CIHR's Strategy for Patient-Oriented Research (SPOR) as well as increased funding in growing areas of need such as northern and Aboriginal health, mental health, and primary care research.

Répondre aux besoins des Canadiens… vieillissants

Pierre J. Durand, professeur titulaire, Département de médecine sociale et préventive, Faculté de médecine, Université Laval

Le docteur Pierre J. Durand est au professeur titulaire au département de médecine sociale et préventive de la faculté de médecine de l'université Laval. Il était doyen de la Faculté de médecine de l'Université Laval entre 2002 et 2010. Il a été formé à l'Université Laval d'abord en médecine familiale et il a œuvré comme médecin de famille au Centre de santé de la Basse-Côte-Nord à Lourdes-de-Blanc-Sablon pendant trois ans avant d'entreprendre deux formations médicales spécialisées tant en santé communautaire qu'en gériatrie. Par la suite, il a œuvré comme médecin gériatre dans le domaine de la gériatrie ambulatoire, des hôpitaux de jour, de la réadaptation et des équipes ambulatoires de psychogériatrie. En 1992, il a fait un virage recherche et a complété une maîtrise en épidémiologie pour ensuite mettre en place l'Unité de recherche en gériatrie de l'Université Laval qu'il a dirigée jusqu'en 1997. Il a successivement été nommé aux postes de chef de service, de directeur de département hospitalier de gériatrie et de directeur du Centre de recherche du Centre affilié université de Québec jusqu'en 2009. Il a occupé le poste de directeur du Département facultaire de médecine jusqu'en 2002.

L'Association des facultés de médecine du Canada s'est résolument engagée dans une réflexion sur l'avenir de la formation médicale pré et post doctorale avec l'intention explicite de transformer la formation médicale pour mieux répondre aux besoins actuels et futurs des Canadiens. Les Canadiens vivent plus longtemps et s'attendent à ce que le système de santé leur procure un accès facile à des soins de santé de qualité, adaptés à leurs besoins et aux maladies chroniques qui caractérisent le vieillissement. Les facultés de médecine canadiennes ont déjà introduit à des degrés divers des contenus de formation sur les grands syndromes gériatriques de même que des stages de formation où les étudiants sont exposés aux aînés en perte d'autonomie. Ils y développent une expertise technique sur l'évaluation et le traitement, la réadaptation et l'accompagnement des aînés en perte d'autonomie et y apprennent l'importance d'une approche interprofessionnelle centrée sur le patient et sa famille. Ils sont de plus exposés à l'omniprésence des octogénaires dans leurs stages de médecine et de chirurgie et finissent par réaliser qu'à part dans les secteurs de la pédiatrie et de l'obstétrique, la clientèle des réseaux de soins, tant communautaires qu'hospitaliers, est déjà très âgée. Parmi les grands défis de l'éducation médicale canadienne mentionnons notre devoir d'éducateurs de rendre attrayante la pratique des soins de continuité aux aînés vulnérables. Nos étudiants ont depuis quelques années délaissé la médecine familiale et les spécialités générales dites « de base » au profit d'une médecine plus technique et sur-spécialisée. Nous devons redoubler d'efforts pour mettre en valeur la pratique médicale centrée sur la personne, la famille et la communauté. Des services de santé adaptés aux besoins des aînés passent d'abord par une première ligne de soins disponible et capable de services de continuité pour l'accompagnement des nos aînés et de soutien aux aidants naturels. Le défi de l'enseignement des compétences portant sur la collaboration intra et interprofessionnelle, la communication et la défense des intérêts des personnes, des familles et des communautés demeure entier. Nous sommes loin de bien nous en sortir dans ces domaines. Nos facultés de médecine sont invitées à innover pour mettre en œuvre dans leurs programmes de formation pré et post doctoraux les situations d'apprentissage pertinentes à l'acquisition de l'ensemble des compétences CanMEDS et CanMEDS-FM. Elles sont à la fois essentielles et incontournables pour doter nos cliniciens des outils nécessaires pour leur permettre de faire face aux défis du vieillissement démographique.

AFMC Awards - Call for Nominations

AFMC is now accepting nominations for the following AFMC awards:

- AFMC Award for Outstanding Contribution to Faculty Development in Canada
- AFMC Young Educators Award
- AFMC - John Ruedy Award for Innovation in Medical Education
- AFMC - May Cohen Gender Equity Award
- AFMC - President's Award for Exemplary National Leadership in Academic Medicine

For more detailed information regarding the awards, please consult our website at **http://afmc.ca/awards-e.php.**

The deadline for submission is November 21, 2011. Electronic submissions are preferred and can be forwarded to cmercier@afmc.ca. The awards will be presented at the Canadian Conference on Medical Education (CCME) in Banff, Alberta from April 14 - 18, 2012.

Prix de l'AFMC - Appel de candidatures

L'AFMC accepte maintenant les nominations de candidatures pour chacun des prix suivants de l'AFMC :

- Le Prix AFMC pour contribution exceptionnelle au perfectionnement du corps professoral au Canada
- Le Prix AFMC des jeunes éducateurs
- Le Prix AFMC - John Ruedy pour l'innovation en enseignement médical
- Le Prix AFMC - May Cohen pour l'équité entre les sexes
- Le Prix AFMC - Prix du président de l'AFMC pour leadership exemplaire en médecine universitaire à l'échelle nationale

Pour de plus amples renseignements concernant les prix, n'hésitez pas à consulter notre site Web à l'adresse suivante : **http://afmc.ca/awards-e.php.**

La date limite de présentation des candidatures est le 21 novembre 2011. Nous vous encourageons à nous soumettre votre candidature par voie électronique à l'adresse suivante : cmercier@afmc.ca. Les prix seront décernés dans le cadre de la Conférence canadienne sur l'éducation médicale (CCÉM) qui se tiendra à Banff, en Alberta, du 14 au 18 avril 2012.

Les facultés de médecine détiennent une responsabilité première dans la formation de la main d'œuvre médicale et professionnelle en santé. Nous partageons aussi avec les décideurs et les intervenants du réseau une responsabilité dans l'harmonisation des services aux besoins de la société. La présence d'une véritable concertation et d'un partenariat étroit entre les universités, les décideurs et les planificateurs est essentielle pour supporter l'implantation d'innovations pédagogiques et optimiser l'utilisation des ressources de formation, tout en répondant mieux aux besoins de la population. Dans le contexte actuel de rareté croissante de ressources, ces partenariats sont devenus incontournables si nous voulons être cohérents dans la conception et solidaires dans la mise en œuvre des réponses aux besoins de la société canadienne vieillissante.

Reflections *Nick Busing, President & CEO*

In 2004, the BMJ publishing group and others ((http://resources.bmj.com/bmj/readers/academic-medicine) brought together academic leaders from 14 countries around the globe to talk about the future of academic medicine. At that time, according to some leaders, academic medicine was "in crisis".[1] This international working group, convened to help promote and revitalize academic medicine, identified a number of concerns including: undervaluing teaching, tolerating the imbalance and lack of communication between basic science research and clinical and applied research, failing to drive innovation and excellence in clinical practice, and ignoring the essential values of social and global responsibility.[2] The working group took an interesting approach: after brainstorming the challenges and analyzing evidence, the group presented five scenarios that were not necessarily meant to predict the future, but were a means to stimulate thinking about options for the future and to encourage thinking in ways that could potentially enhance long-term planning.

The five scenarios developed were labeled: Academic Inc., Reformation, In the Public Eye, Global Academic Partnership and Fully Engaged. These scenarios had a number of common features, some of which are the need for academic medicine to relate more effectively to its stakeholders (public, patients, practitioners, politicians and policymakers); the need to be more globally minded; the challenges in maintaining the "triple threat academic" (teaching, research and clinical service); the increasing importance of teamwork; global competition between academic institutions; increased emphasis on teaching and learning in a competitive environment; and combining research (basic and applied) with implementation and improvement.

Many of the common features of the scenarios described in 2004 are still relevant today. I want to briefly highlight several challenges for academic medicine in Canada in 2011 that are reflected in many of the common features of scenarios described in 2004.

In this editorial I will focus on four scenarios: 1) the challenge of full employment for the talented researchers we have trained and recruited; 2) the need for more collaboration in, not only in practice, but in research and education; 3) the challenge to align the research, education and clinical work of academic medicine with societal needs; and 4) building leadership in academic medicine to address the many system challenges in healthcare.

1 Clark J, Smith R. BMJ Publishing Group to launch an international campaign to promote academic medicine BMJ 2003:327:1001-2.
2 The International Campaign to Revitalize Academic Medicine: agenda setting, BMJ, 2001:329787-789.

Canada has successfully recruited and/or educated many world-class researchers in the basic and clinical sciences to apply their many skills, but grants are required for them to work. The number of grants available from funding sources such as CIHR doesn't match the capacity of our research community. Complicating this is the need to balance grants for investigative research and for more targeted research. Collectively, we in academic medicine, with our partners such as the research institutes, teaching hospitals, the health charities, and others, need to speak with one voice as to the pressing need to support our health research talent in this country.

Collaboration should embrace a sharing of responsibility and a recognition of the skills of all those contributing to the task at hand. As is often said, effective collaboration is about ensuring that you have the right provider at the right time doing the right task. Collaboration with others should be seen as an opportunity, not only a challenge, and something we embrace. Do we truly have enough meaningful models of learning together, researching together, and practising together?

Meeting societal needs is a lofty and essential goal, hard to quantify, and harder to achieve. Academic medicine holds a privileged position. We need to ask how academic medicine, from this vantage point, can better address the needs of the less fortunate, such as many in our Aboriginal and marginalized urban communities. Academic medicine needs to recognize more clearly the challenges of settling approximately 250,000 immigrants a year in Canada. Academic medicine needs to find partners in all communities – on the street, in the schools, in public institutions, and in government. These partnerships will build our capacity to respond to societal need and integrate academic medicine into the fabric of our communities.

Spending on healthcare – including education and research – has never been higher. We all know about the debate regarding the adequacy of funding for the healthcare system. Academic medicine should be showing leadership in testing and applying ways to use every dollar we have more efficiently and effectively. We should not be seen as a drain on finances. Academic medicine should, and does, recognize that there are a limited number of dollars that can enter the system, that we are producing more and more physicians, that demand is not slowing down, and that we have to collectively provide leadership in working with what we have to ensure the best possible outcomes.

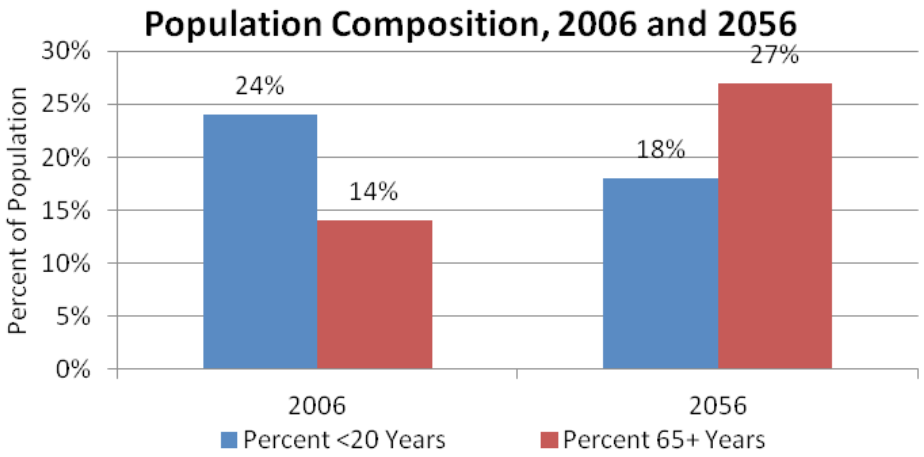
As I have said often, academic medicine brings together some of the most talented and committed individuals within our country. It is within our grasp to individually and collectively tackle these challenges and ensure that academic medicine has a bright, relevant and highly valued future.

The Metrics of Meeting People's Needs

Steve Slade, Vice President, Data and Analysis, CAPER-ORIS

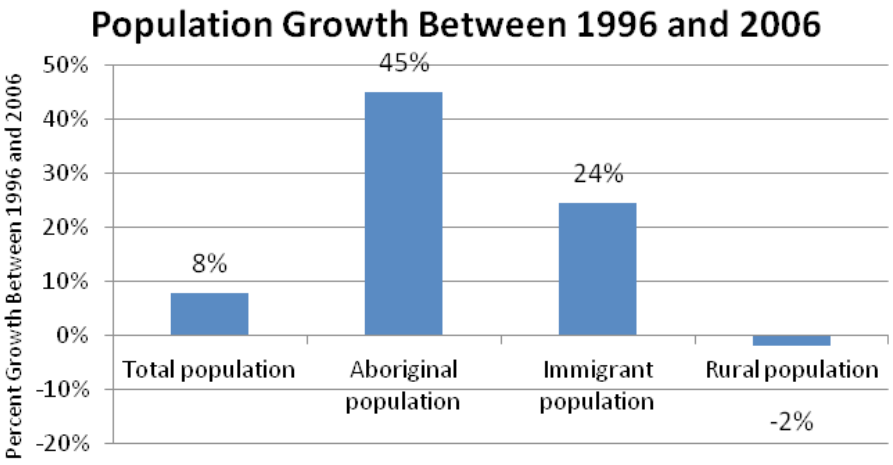
Societal change happens along multiple axes. We see shifts in population density, age composition, urban-rural distribution and migration, birth and immigration rates, and ethnic and language diversity. Focusing on health indicators, we measure life expectancy, infant mortality and birth weight, population dietary patterns and exercise activities, substance use, disease incidence and prevalence, and healthcare utilization. These dimensions are not exhaustive, but merely suggestive of the many axes along which population change and variation are measured.

As illustration, consider the data on population aging and life expectancy. Between 2006 and 2056 the population proportions less than 20 years, and greater than 64 years, are expected to more or less invert themselves. In 2006, 24% of Canadians were under 20 years of age; this is forecasted to drop to 18% by 2056[1]. In contrast, 14% of Canadians were aged 65 years or more in 2006. This segment of the population is forecasted to increase to 27% by 2056[1]. Expected change in our population age composition is largely due to the "baby boom", but is also partly due to changes in life expectancy. Between 1921 and 2005, average life expectancy at birth rose from 58.8 to 78.0 years for males and from 60.6 to 82.7 years for females[2]. On average, we are expected to live two decades longer than our ancestors of less than a century ago.



Source: Statistics Canada

Canada's population is changing in other ways. While the total population grew by a relatively modest 8% between 1996 and 2006, some population subgroups exhibited marked differences from the overall pattern[3]. For example, the population of Inuit, Métis and First Nations peoples increased 45% between 1996 and 2006[3]. Similarly, our immigrant population grew by 24%, three times the rate of growth of the total population[4]. In contrast, the number of rural Canadians decreased slightly (-2%) between 1996 and 2006[5]. Over time, population subgroups may increase or decrease in absolute numbers and/or as a percentage of the total population.



Source: Statistics Canada.

(Endnotes)

1 Statistics Canada. Population Composition. http://www.statcan.gc.ca/pub/82-229-x/2009001/demo/poc-eng.htm. Cited September 22, 2011.

2 Statistics Canada. Life Expectancy. http://www.statcan.gc.ca/pub/82-229-x/2009001/demo/lif-eng.htm. Cited September 22, 2011.

3 Aboriginal Peoples in Canada in 2006: Inuit, Métis and First Nations, 2006 Census. The Daily; Tuesday, January 15, 2008. Statistics Canada. http://www.statcan.gc.ca/daily-quotidien/080115/dq080115a-eng.htm. Cited September 29, 2011.

4 Statistics Canada. Immigrant Population by Place of Birth. http://www.statcan.gc.ca/c1996-r1996/nov4-4nov/imm2a-eng.htm (1996) and http://www40.statcan.gc.ca/l01/cst01/demo34a-eng.htm (2006). Cited September 29, 2011.

5 Statistics Canada. Urban and Rural Population. http://www40.statcan.gc.ca/l01/cst01/demo62a-eng.htm. Cited September 29, 2011.

Even within this relatively brief and recent 10-year period, we see Canada's population changing in important ways. If we were to extend the timeline further back – say 30 or 40 years – the societal transformations would appear even more pronounced. What we know is that today's physicians have, and will, practise through the change we see above; and that really is the crux of the matter. Healthcare providers continually respond to the needs of a changing society.

Not surprisingly, Canada's faculties of medicine are themselves changing. Again, the change is measured along multiple axes. We see new outreach programs and admissions processes, increased undergraduate medical education enrolment and variable growth in post-M.D. training fields, increased numbers of international medical graduates, increased use of technology, movement toward distributed medical education coupled with increased preceptor recruitment and faculty development. This is all occurring against the backdrop of a constantly evolving curriculum designed to impart new skills and competencies to medical students and residents.

The challenge, of course, is in trying to anticipate how society will change, what our future needs will be and to then direct our efforts accordingly. In the sphere of academic medicine, the challenge is taken up by many, including students and residents, medical educators and clinical teachers, program directors, administrators, deans, accrediting bodies and other professional medical organizations as well as government and regulatory partners. To the extent that meeting people's needs is a shared mission, the words of our dean at the Faculty of Medicine at the University of Toronto will ring true:

"The allegiance of our education, research and administrative enterprise is collectively towards making a difference in health outcomes by producing a workforce that meets societal needs, answers our society's health problems and demonstrates accountability and leadership in academic medicine."

- Catharine Whiteside, Dean, Faculty of Medicine, University of Toronto, 2011

Medical School Curriculum Addresses the Needs of Canadians

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

Our faculties of medicine have risen to the challenge of meeting societal needs in a big way; the Future of Medical Education in Canada (FMEC) MD project had social accountability as a major component. FMEC MD implementation was the focus of an invitational workshop held at the 2011 Canadian Conference on Medical Education where each school presented their work on one of the 10 recommendations.

The University of British Columbia described how they are **addressing individual and community needs** by having social responsibility and accountability as a key pillar of their curriculum renewal. Development of a Centre for Aboriginal Health Education was presented by the University of Manitoba. Memorial University of Newfoundland reported on **enhancements to their admissions process** using a mission-based focus on candidates from rural settings while McMaster University reviewed their work on the mini-multiple interview.

Queen's University continues to **build on the scientific basis of medicine** with a revised critical enquiry course and the University of Alberta has established new "schools of thought".

The **promotion of prevention and public health** was highlighted by Dalhousie University as they are integrating population and public health directly into other content as part of their curriculum renewal and the University of Western Ontario has developed the first case-based Masters in public health program.

The Université Laval described their faculty-wide structures and processes **addressing the hidden curriculum** and McGill University presented their multi-dimensional assessment of clinical teachers. Examples of **diversified learning contexts** were given by the Northern Ontario School of Medicine's comprehensive, integrated and Aboriginal community clerkships and the Université de Sherbrooke described its distributed program that includes collaboration with two other universities and two provinces.

A task force on family medicine as a career choice has provided guidance to learners at the University of Calgary on how to **value generalism**. The University of Toronto has a centre for inter-professional education (IPE) and has developed an IPE curriculum for their medical students to **advance inter- and intra-professional practice**.

The Université de Montréal plans to **adopt a competency-based and flexible approach** by developing a new assessment model. **Medical leadership is fostered** at the University of Ottawa with a longitudinal core and elective curriculum including a multi-source feedback tool.

Just published is the *MD Education at the University of Saskatchewan's College of Medicine: Looking to the Future*, a faculty-wide response to the 10 recommendations.

The enabling or overarching recommendations of FMEC MD are to realign accreditation standards, build capacity for change, increase national collaboration, improve the use of technology, and enhance faculty development. These will be the focus of the next wave of activities.

Our physicians of tomorrow will be well prepared to meet the needs of society. The future looks bright!

Le Dr Alain Beaudet, M.D., Ph.D., est le président des Instituts de recherche en santé du Canada (IRSC). À ce titre, le Dr 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 Dr Beaudet occupait le poste de président-directeur général du Fonds de la recherche en santé du Québec (FRSQ) depuis 2004.

Un message des IRSC…

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

Alors que la recherche universitaire a longtemps été considérée comme une noble quête en soi, n'ayant besoin d'autre justification que la curiosité intellectuelle et l'excellence scientifique, ou peu s'en faut, nous assistons depuis les dernières décennies à un intérêt plus marqué pour les répercussions sociétales et économiques de la recherche financée par les fonds publics. Certes, lorsque la recherche ne représentait pas plus qu'une dépense budgétaire symbolique, ni les gouvernements ni le public ne songeaient à ses retombées sociétales ou économiques. Mais maintenant que les investissements publics dans la recherche comptent pour plusieurs milliards de dollars par année, on s'y intéresse de beaucoup plus près.

Le thème du présent numéro de *Gravitas* soulève la question qui suit : la recherche universitaire d'aujourd'hui dans le domaine de la santé répond-elle vraiment aux besoins de la société? Selon moi, la réponse est oui, *mais pas tout à fait*.

On pourrait soutenir que la recherche en santé a toujours été davantage axée sur la société que d'autres domaines de recherche, notamment en raison de l'accent qu'elle met sur l'amélioration de la santé et des soins. De fait, la création des IRSC il y a onze ans visait, entre autres, à s'assurer que la recherche en santé réponde mieux aux besoins de la société. L'objectif a été atteint à bien des égards. D'ailleurs, l'intégration de la recherche sur la santé publique et des populations et sur les services et les politiques de la santé dans le mandat des IRSC en est un exemple. Il en est de même pour la création d'instituts axés sur une population en particulier (p. ex. l'Institut du vieillissement, l'Institut de la santé des femmes et des hommes et l'Institut de la santé des Autochtones). En fait, le mandat des IRSC, selon leur loi constitutive, consiste à « exceller, selon les normes internationales reconnues de l'excellence scientifique, dans la création de nouvelles connaissances et leur application en vue d'améliorer la santé de la population canadienne, d'offrir de meilleurs produits et services de santé, et de renforcer le système de santé au Canada. »

Les instituts des IRSC ont lancé de nombreuses initiatives dans le but précis de répondre aux besoins de la société. Pensons par exemple aux initiatives de recherche stratégique de l'Institut du vieillissement des IRSC et de ses partenaires, fort pertinentes par rapport aux défis que doit relever une population vieillissante, comme la déficience cognitive, la mobilité et les soins. Dans le même ordre d'idées, l'Institut de génétique des IRSC a investi dans d'importants travaux de recherche liés à l'éthique qui joueront un rôle essentiel pour définir les politiques actuelles et futures en matière de médecine personnalisée. En outre, les objectifs de recherche stratégique établis dans le plan stratégique des IRSC permettent d'assurer une pertinence sociale continue.

Toutefois, en dépit des progrès indéniables réalisés dans l'intégration de l'application des connaissances (AC) à bon nombre de leurs possibilités de financement, les IRSC peuvent faire encore plus pour améliorer les résultats cliniques et aider les décideurs à relever les défis auxquels notre société fait face sur le plan des soins de santé. On dispose actuellement de données de recherche importantes, mais le processus visant à traduire ces renseignements en services et en politiques de soins de santé transformateurs est trop long. C'est du moins l'avis du Comité d'examen international, qui recommande des améliorations, entre autres, dans les domaines de la recherche clinique, de l'engagement des citoyens et de la commercialisation des résultats de recherche.

Les IRSC entendent donner suite à ces recommandations, ce qu'ils ont d'ailleurs commencé à faire. Voilà pourquoi ils ont demandé que soit formée une coalition pour la recherche axée sur le patient visant à « améliorer de façon démontrable les résultats cliniques et l'expérience des patients quant

aux soins de santé par l'intégration de données probantes à tous les niveaux du système ». C'est ainsi que notre investissement initial dans le projet pilote Des preuves à volonté – qui favorise l'échange de connaissances entre les chercheurs dans le domaine des services de santé et les utilisateurs éventuels de la recherche – a permis de déboucher sur le programme Meilleurs cerveaux, lequel s'impose de plus en plus aux gouvernements fédéral et provinciaux.

Enfin, pour assurer la réussite à long terme de programmes comme ceux-ci et d'initiatives semblables entreprises ailleurs, j'aimerais terminer en enjoignant les doyens des facultés de médecine du Canada à recruter des candidats possédant les compétences nécessaires à ce genre de travail, des cliniciens-chercheurs, des chercheurs dans le secteur des services et politiques de santé, et des économistes spécialisés dans les soins de santé, par exemple. C'est tout un système de santé qui en dépend, un système axé sur le patient qui répond entièrement aux besoins de la société.

Rising to the Challenge – How postgraduate medical education in Canada is preparing future physicians to look after aging Canadians

Roger Wong, Assistant Dean, Postgraduate Medical Education, Faculty of Medicine, University of British Columbia
With Contributions from Mark Walton, Assistant Dean, Postgraduate Medical Education, Faculty of Health Sciences, McMaster University and Chair, AFMC Standing Committee on Postgraduate Medical Education and Joanne Todesco, Associate Dean, Postgraduate Medical Education, Faculty of Medcine, University of Calgary

Dr. Roger Wong is Clinical Professor in the Division of Geriatric Medicine, Department of Medicine, University of British Columbia (UBC), Assistant Dean of Postgraduate Medical Education of the UBC Faculty of Medicine, and Associate Program Director of the UBC Internal Medicine Residency Program. Dr. Wong is also Consultant Physician and Head of the Geriatric Consultation Program, Vancouver General Hospital.

Dr. Wong is President of the Canadian Geriatrics Society. He founded the state-of-the-art Acute Care for Elders Units (ACE) in Vancouver, which has been implemented nationally and internationally. His clinical research focuses on hospital medicine in vulnerable older adults, including quality improvement in acute care geriatrics. He has received numerous awards of appreciation from the Alzheimer Society of British Columbia to recognize his advocacy work in the community.

More than 13% of Canadians are over 65 years of age, and the first cohort of the baby boomers turns 65 years old this year. These seniors will have increased healthcare needs that require skilled medical care. This poses a substantial challenge for our postgraduate medical education (PGME) system to prepare and empower future physicians to face the aging demographic imperative.

Geriatric care in Canada is currently provided by physicians in a variety of disciplines, especially by those skilled in family medicine (including care of the elderly and palliative care), internal medicine, psychiatry, surgical specialties, geriatric medicine, and geriatric psychiatry (one of the most recently recognized subspecialties). These physicians more than ever require the skills to care for older patients in inter-professional teams in the community, in acute care and in rehabilitation settings.

There is a severe shortage of doctors who provide geriatric care, and this is expected to worsen in the very near future. For instance, as of August 2011, there are 225 registered physicians in geriatric medicine in Canada (based on the Royal College of Physicians of Surgeons of Canada registry) and another estimated 200 family physicians with additional training in care of the elderly. These numbers are substantially below what are required when compared with other developed countries (for instance, in Sweden there are 500 geriatrics physicians serving a population base of 9 million, whereas the 425 geriatrics physicians in Canada currently serve a much larger population base of 34 million), and unfortunately the numbers have not increased over the past decade.

PGME in the faculties of medicine have started a multi-faceted approach to this demographic change in collaboration with other key players in the healthcare system. Clearly, we all have a responsibility to train physicians to meet societal needs in a socially

responsible and accountable manner. A major part of the response involves the national expansion of family medicine and internal medicine PGY-1 entry positions in recent years, including expansion into distributed medical education sites in many jurisdictions across the country. However, expansion is not the only answer and not all positions are being filled. For example in the CaRMS medicine subspecialty match, positions in geriatric medicine increased from 25 in 2010 to 31 in 2011. Eight of these filled in 2010 (32%) and 13 in 2011 (42%). In contrast, many medicine subspecialties had an 85% or greater match rate in both years. Even though general internal medicine and geriatric medicine training positions have expanded and are protected in some provinces to ensure healthy numbers of entry annually, subspecialty training in geriatric medicine has not been sufficiently attractive to internal medicine residents. This is a multifactorial issue that will need to be addressed in collaboration with the ministries of health and other stakeholders. Nevertheless, we have learned from family medicine that it is possible to identify variables in undergraduate and PGME that predict or influence career choice. It is time to start examining those variables for geriatric care and implement them in our medical schools.

In some jurisdictions in Canada, a formal needs-based model for PGME planning has been implemented. The Ontario Ministry of Health, in conjunction with the Ontario Medical Association, recently commissioned a needs-based physician forecasting and modeling system to complement the supply-side modeling. Care of the aging population is seen as a major priority. In many provinces the ministries of heath and the faculties of medicine actively discuss health human resources and focus expansion on areas of need such as the aging population.

There is growing interest in making curricular changes in PGME in order to increase exposure to geriatric care across residency programs. While there are national core competencies in geriatrics at the undergraduate level, they have not yet been developed in PGME. This is an opportunity for national collaboration, which should also include development of an accompanying assessment framework for these postgraduate geriatrics core competencies.

The Canadian Geriatrics Society is leading a number of initiatives to improve the image of aging and caring for seniors among residents. For instance, there is a recently formed national Resident Geriatrics Interest Group (RGIG) that is spearheaded by residents who are interested in the field. This national group comprises of local chapters that actively deliver health advocacy programs to seniors in the community on a volunteer basis. The RGIG also organizes social events to raise awareness and offer peer support among residents who share a common interest in a career of geriatrics.

Meeting the healthcare needs of the aging population should be a priority for the faculties of medicine in Canada. The approach must be multi-faceted and include providing excellent training to meet the needs of aging Canadians as well as making this career attractive to our young doctors.

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.

A Word from CIHR…

Alain Beaudet, President, Canadian Institutes of Health Research

Whereas academic research has long been considered a noble pursuit *per se*, with little or no need for justification other than intellectual curiosity and scientific excellence, we have witnessed over the last few decades a perceptible increase in public demand for societal and economic impacts of publicly-funded research. Admittedly, when research represented little less than token budgetary expenditures, neither governments nor the public thought much about either societal or economic returns. But now that public research investments account for several billion dollars a year, much closer scrutiny is being paid to return on investments.

The theme of the current issue of *Gravitas* raises the question as to whether today's academic health research truly meets the needs of society. The answer in my view is both yes, and a qualified *not yet fully*.

One could argue that health research has always been more socially-oriented than some of the other research fields because of its focus on improving health and healthcare. In fact, one of the reasons for the creation of CIHR eleven years ago was to ensure that health research would better fulfill societal needs. And in many ways, it has succeeded in doing so. The integration of population and public health as well as of health services and policy research to its mandate is an example of this intent. So was the creation of population-based institutes (e.g. Institute of Aging, Institute of Gender and Health, Institute of Aboriginal People Health). In fact, CIHR's mandate, as defined in its founding Act, is clearly "*to excel, according to internationally accepted standards of scientific excellence, in the creation of new knowledge and its translation into improved health for Canadians, more effective health services and products and a strengthened Canadian health care system…*"

Examples abound of targeted initiatives launched by CIHR's institutes with the specific aim of meeting social needs. For instance, CIHR Institute of Aging and its partners have launched a number of strategic research initiatives highly pertinent to challenges faced by an aging population such as cognitive impairment, mobility in aging and caregiving. In the same vein, the CIHR Institute of Genetics has invested in important ethics-related research that will play a major role in defining current and future policies involving personalized medicine. Strategic research objectives articulated in CIHR's Roadmap ensure continued social relevance.

However, despite undeniable progress in integrating knowledge translation into many of its funding opportunities, CIHR still needs to do better in terms of improving health outcomes and helping decision makers meet healthcare challenges currently facing our society. Important research evidence is on the table but the process of transforming this information into truly transformative healthcare policies and service provision is taking too long. This, at least, was the opinion of the International Review Panel, who recommended improvements, *inter alia*, in the fields of clinical research, citizen engagement and commercialization of research results.

CIHR fully intends to respond to these recommendations and has, in fact, begun to do so. Thus, the call for a coalition for patient-oriented research, aimed to "demonstrably improve health outcomes and enhance patients' healthcare experience through integration of evidence at all levels in health care". Hence our initial investments in the Evidence on Tap pilot project – brokering knowledge exchange between health services researchers and potential users of this research – has transitioned into a successful Best Brains program which is gaining increasing traction from both federal and provincial levels of government.

To ensure the long-term success of programs such as these and similar efforts by others, I would like to close this column by calling on Canada's deans of medicine to recruit more of the kinds of skill sets necessary to carry out this type of work, such as clinician-scientists, health services and policy researchers, and healthcare economists. A patient-oriented healthcare system that fully meets the needs of society depends on it.