Executive Summary

On December 12, 2016, the Royal College held its annual National Specialty Societies (NSS) Summit. This year’s dialogue focused on opportunities for collaboration between the Royal College and NSS, the Royal College advocacy approach, and the role of specialists in palliative and end of life care. The Summit program, which was developed with the NSS, kicked off with an update on Royal College medical workforce initiatives including the Medical Workforce Knowledgebase (MWK), the Canadian Physician Database and the Care for the Elderly Project. The Royal College committed to collaborate with the NSS to reflect on and interpret trends observed in the MWK to develop sound workforce policy advice.

This was followed by a presentation on competence by design (CBD). This will be implemented in residency training over the coming years through the articulation of milestones and entrustable professional activities (EPAs). Competency based continuing professional development is planned to begin in 2020. It will align with a physician’s scope of practice, be outcomes oriented and acknowledge interprofessional collaborative practice.

The next session centred on advocacy. It began with an outline of the process undertaken by the Royal College to enable a more focused approach, resulting in the Royal College Advocacy Guide. The highlight of this session was a keynote address by Member of Parliament Dr. Doug Eyolfson, FRCPC (Emergency Medicine). He shared what led him to politics and described his current political experience. He encouraged all physicians to become politically active on issues that affect the health of their patients, identifying concrete actions that can be taken.

A panel presentation and discussion on the need for better palliative and end of life care was the focus of the next topic. Several diverse specialists shared how they have integrated a palliative care approach into their practice. Themes that emerged were twofold: palliative care being the responsibility of all physicians, and the need for mandatory palliative care training in undergraduate and residency training programs.

The final session of the day explored the future of the now defunct Specialist Forum (SF). Participants expressed support for continuation of the Royal College HRH Dialogue and NSS Summit. They suggested the NSS could serve to replace the SF, and encouraged the inclusion of meetings of clustered specialties (i.e. medicine, surgical) focused on specific topics.
Introduction

Dr. Kevin Imrie, President of the Royal College and Dr. Andrew Padmos, CEO of the Royal College, welcomed participants to the annual Summit, emphasizing that the Royal College is committed to strengthening its relationship and continuing its open dialogue with National Specialty Societies (NSS). Their introductory remarks highlighted that the program was developed collaboratively with the NSS to ensure that the topics, such as end of life and palliative care, resonate with their priorities and concerns.

Summit Objectives:

- Explore collaboration on Royal College initiatives: Medical Workforce, Competence by Design, Advocacy.
- Learn about and help define effective strategies to engage with decision and policy makers.
- Discuss the role of specialists in regards to end of life care: Medical Aid in Dying and Palliative/End of Life Care.
- Discuss reinstituting the Specialist forum.

Update on Royal College medical workforce initiatives

Mr. Steve Slade, Director of Health Systems and Policy, Royal College, provided an update on medical workforce efforts underway by the Royal College since the Human Resources for Health (HRH) Dialogue in May 2016. The information is meant to serve as a catalyst for discussion between the Royal College, NSS, and others to transform data into intelligence.
Mr. Slade reported that the Medical Workforce Knowledge (MWK 1.0) is now online with information for the 31 primary specialties, with a plan to add information on subspecialties later this year. He showcased the MWK on the Royal College website, highlighting the following features:

- 2010-2014 supply data for the following indicators brought into one domain:
  - R1 quota from the CARMS R-1 match
  - PGY1 trainees
  - Number of new certificants by both colleges
  - Total licensed physician workforce
- Detailed data and summary data with colour coded change indicators (blue=upward; brown=down; white = no trend)
- Shows emerging trends/patterns in narrative section
- Ability to access and download data in Excel or PDF format

Mr. Slade then showcased some MWK 2010-2014 fast facts:

- 13% increase in residency spots
- 12% increase in new trainees
- 26% increase in medical, surgical, and laboratory certificants
- 37% increase in family medicine certificants
- 13% increase in total licensed medical workforce

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<th>Broad specialty snapshot, 2010-2014</th>
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<tbody>
<tr>
<td>Family Medicine</td>
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<tr>
<td>Residency Spots</td>
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<td>0.22%</td>
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- Family medicine, anatomical pathology and emergency medicine are the highest growth specialties with above average growth on all four indicators
- Emergency med, anatomical pathology, family medicine, psychiatry, dermatology, internal medicine and pediatrics are all trending upward in terms of average annual increases and % growth from 2010
- Those specialties trending downward from 2010-2014 include general surgery, orthopedic surgery, radiation oncology, plastic surgery, otolaryngology, obstetrics/gynecology, neurology, and diagnostic radiology

He showcased age distribution data of licensed physicians for 4 specialties: emergency medicine (RCPSC), radiation oncology, psychiatry and cardiac surgery. Psychiatry is an older specialty with two times as many physicians aged 65+ as compared to under 35. Even more pronounced is cardiac surgery with five times as many physicians aged 65+ versus less than 35.

Mr. Slade then turned attention to the Canadian Physician Database Feasibility Study, a partnership of the Royal College, Canadian Medical Association (CMA) and College of Family Physicians of Canada (CFPC). The goal is to determine the
feasibility of building a pan-Canadian physician database with select data from the medical regulatory authorities. It is designed to fill the gap left by the National Physician Survey. The project evaluation report is expected May 2017.

And finally, he spoke to the Care for the Elderly Project in which the Royal College is trying to go beyond physician headcount and get a sense of what kind of care is being provided, in this case, to Canada’s elderly population. The project is based on a decade of billing data from the Canadian Institute for Health Information (CIHI) National Physician Database examining the types of services (National Grouping System categories) provided by physician specialties to those aged 65 and over in 5 year groupings. Preliminary findings indicate:

- 90% of physicians provide services to elderly patients (age 65+)
- 50% of elderly care is provided by family medicine and internal medicine
- geriatricians provide 0.5% of all services received by the elderly
- 29% of the total services provided my family physicians is directed towards the elderly

Next steps for this project include generation and dissemination of a full report and several shorter, focused reports.

This presentation generated enthusiasm and discussion on how to move forward with this information. Mr. Slade informed participants that version 2.0 of MWK will break down data by region and faculty of medicine and bring in subspecialty data, expressing caution about small numbers in terms of percentage and meaningful indicators. One participant representing emergency physicians noted that there are approximately 478 vacancies for emergency physicians in Canada right now. Mr. Slade clarified that this data does not reflect labour market data including vacancies. It is supply based data only and currently does not examine the health care needs side of the equation. The Royal College is interested to work with NSS who have some of the needs information (including demographics) to inform analysis and discussion. Other specialties expressed caution in that supply infrastructure data is missing, such as radiation machine and operating room time.

Mr. Slade noted that the intent of this initiative is to signal trends in the early stage to promote discussion. The Royal College is interested to collaborate with specialty societies in terms of reflecting/interpreting on these and other data, determining how to respond to these data, and developing sound workforce analysis and policy advice. The NSS were very responsive to this. They also requested the Royal College provide advise on how to develop consistent methodology to determine physician specialty workforce needs.

**Competence by Design**

This session was co-presented by Dr. Ken Harris, Executive Director and Dr. Craig Campbell, Director of Continuing Professional Development, of the Office of Specialty Education at the Royal College. Dr. Harris described the construct and process for competence by design (CBD) for the educational continuum and then focused on residency education. He began with the principles of competency based medical education:
1. Focus on outcomes: graduate abilities
2. Ensure progression of competence
3. Time is a resource, not framework
4. Promote learner centredness
5. Greater transparency & utility

He focused on two key concepts: milestones and entrustable professional activities (EPAs). Milestones are the abilities expected of a health professional at a stage of development (e.g. intubate an airway under supervision); EPAs are the key tasks of a discipline that a practitioner needs to be able to perform (e.g. run a clinic). Typically, each EPA integrates multiple milestones. Both concepts are specialty specific and thus the Royal College will be staging workshops with the specialty committees over the coming to develop. A number of disciplines have been working on creating their educational designs and Otolaryngology – Head and Neck Surgery, and anesthesiology will be the two inaugural specialties to proceed.

Dr. Harris noted that a robust assessment strategy is needed, comprised of multiple observations with formative feedback. The eportfolio will facilitate this and it, combined with the EPA assessment form, will be key constructs of the program.

Dr. Campbell followed with a presentation on competency based continuing professional development (CPD) which is planned to begin in 2020. He began with the need to move to this model given the challenges with the current CPD system. He then outlined educational principles of competency based CPD:

- Use a set of competencies to guide learning and assessment relevant to each specialists practice.
- Embrace learning and assessment of individuals, groups and health teams.
- Enable achievement of meaningful educational outcomes – the progression of competence and performance in practice.
- Contribute to achievement of meaningful clinical outcomes – continuous enhancement to quality, safety and health outcomes.

The intent is to use education in a much more positive way to produce measurable outcomes to improve how physicians perform in delivering quality health care to patients. It will achieve a better balance between autonomy and accountability by putting physicians at the centre of their own learning and surrounding them with the resources to do so.

Dr. Campbell focused on four premises of competency based CPD:

1. In competency-based CPD learning and assessment must be relevant to a physician’s scope of practice.
2. Competency-based CPD will require physicians to use multiple external sources of data with feedback to demonstrate meaningful outcomes.
3. Competency-based CPD must focus on demonstrating improved patient care outcomes.
4. Competency-based CPD must focus on individual and collective competence (focus more on interprofessional collaborative practice).
This strategic direction is deemed by stakeholders as the ‘right thing to do’. Among other benefits, it supports the integration of CPD with continuous quality improvement in the workplace, and leverages the commitment, motivation and professionalism of Fellows. The Royal College will be further developing this new system through workshops with each of the specialty committees. Further details on the program will be released over time.

Comments in the discussion that ensued focused on:

- The challenge of accessing and using external data to support CPD
- The need to be realistic in regards to CPD and measuring outcomes – don’t place undue responsibility on physicians for something they cannot be accountable for or control
- The need for valid tools to assess competencies
- The importance of strengthened relationships (including enhanced communication) between the Royal College, NSS and RC specialty committees

Dr. Harris concluded by emphasizing the need for NSS to participate on Royal College specialty committees, with NSS positions often remaining vacant, given the important role of these committees in the transformation to a competency-based model for both PGME and CPD.

**Keynote Address – Making a difference together: Effective strategies to engage with decision makers**

Member of Parliament Dr. Doug Eyolfson, FRCPC (Emergency Medicine) shared his medical career experience that led him down the path of federal politics. He noted it is a challenging time to be a physician, always trying to adapt in a stressed, strained and unsustainable health care system. As a physician he experienced the unique challenges of emergency medicine on a daily basis. He felt he could add his voice to the table of decisions being made in regards to the needed changes to the health care system. He then shared some reflections from his role as a politician, most notably that policy making and change is a slow arduous process. He is only one of a many large number of voices yet he is able to contribute the medical perspective to patient and provider experiences in policy discussions. Dr. Eyolfson outlined what physicians can do to contribute including recognizing the social determinants of health and their impact on the health of Canadians. Physicians are a credible, powerful tool that can advocate for issues such as poverty reduction programs and affordable housing. He concluded with “We not only have the ability to advocate but an obligation to advocate and it begins with each of us.”
In the discussion that followed, participants raised a number of policy issues with Dr. Eyolfson including integrated homecare, dental care coverage, opioids, pharmacare, medical assistance in dying (MAID), cuts to health research funding and the role of the federal government in research. He welcomed and responded to all comments. In particular, he noted that in regards to health research, the federal government has invested an additional $167 M into health research, including mental health. The mandate is to increase funding in basic scientific research, changing direction away from the commercialization/industry focus of research from the previous government.

He concluded by expressing a sense of gratification that his voice, particularly as a physician, is heard on the Hill. He encouraged physicians to become politically engaged on issues, suggesting a number of means to do so, including communicating with himself, local MPs, and the Minister of Health's office.

6 Royal College advocacy

Mr. Steve Slade shared the process undertaken by the Royal College to enable a more focused advocacy approach. It began with extensive discussions at the Royal College Council table, with specialty committees, NSS, and sister organizations. Then in April 2015 the Royal College conducted a member survey. A one-time email invitation was sent to 40,575 Fellows with 2,429 respondents. The results of the discussion and this survey have culminated in the Royal College Advocacy Guide to be used by all involved in Royal College advocacy activities (staff, committees/Council and others). It sets out the Royal College advocacy role, domains and processes.

Mr. Slade then described advocacy efforts with respect to opioid prescribing, one of the priority items identified by members in the survey. The Royal College is determining what educational resources are available for its members. An environmental scan summary report will be shared, along with the creation of a section on the Royal College website to highlight these resources and others. These efforts are designed to complement that of pan-Canadian collaborative led by the CFPC. The Royal College will also be developing a self-assessment module on prescribing to help specialists determine if their pattern is consistent with leading practices and national guidelines. He also spoke briefly about advocacy efforts in regards to MAID, noting that the Royal College is deferring to CMA to take the lead in a partnership model but is developing new online bioethics modules.

Participants expressed an interest in training for advocacy, given that this is one of the CanMEDS roles. It was noted that CMA is active in this area too, and thus the need to avoid duplication, but rather, foster collaboration. Suggestions were put forward on advocacy training at a provincial/territorial level and that advocacy could be integrated as an EPA/milestone as part of new CBD program.

Survey Questions:
1. What should RC advocate about?
2. What role should RC fill?
3. What activities should we carry out?
4. How should RC advocate?
End of Life and Palliative Care – PART I: it’s everyone’s responsibility

Dr. Stephanie Connidis and Dr. Susan MacDonald, palliative care physicians, kicked off a discussion on end of life care and palliative care. They began by defining a palliative care approach. They provided an overview of why palliative care is everybody’s business, encouraging physicians in the room to reflect on their perceptions, thoughts, experiences. They set the context for why it is important given an aging population and the growing burden of disease. Although the leading cause of death is still cancer more Canadians will die as a result of non-cancer related illness.

They presented two palliative care models:

1. the Palliative Healthcare System According to Need
2. The Bowtie Model.

Both models reinforce that subspecialists/specialists can and do play a vital role in the delivery of palliative care. They linked this to the CanMEDS framework which reflects the competencies of a palliative approach to care. Many models exist across Canada which demonstrate the benefits of palliative care for patients and families, including the INSPIRED program for COPD patients.

This introduction was followed by three presentations in which physicians shared how they have incorporated palliative care into their specialized field of medicine.
**Dr. David Carroll (Internal Medicine)**

Dr. Carroll began by describing the current state of congestive heart failure in Canada. The common disease trajectory often results in the patient dying in a hospital bed, alone. He noted this is due to a lack of planning & conversations regarding end of life. He stated there is always something we can do for our patients; we need to engage them earlier. Dr. Carroll stressed the need for mandatory palliative medicine education, recognizing that palliative care can be hard emotionally at times but rewarding. He pointed to a trial study which found that people who were referred to palliative care experienced a better quality of life. He concluded by sharing a touching personal experience in providing palliative care to an elderly woman in her final days.

**Dr. Shalini Nayar (Respiratory Medicine)**

Dr. Nayar shared how she integrates palliative care into her respirology practice. She began by noting that the pulmonary disease trajectory is hard to prognosticate given the disease is linked to many other diseases. The Bowtie Model is one that she uses to guide her practice, including her collaboration with other healthcare professionals. She shared a challenging case study, demonstrating how she was able to improve the quality of life of one of her COPD patients through a palliative care approach. In her experience, patients are willing to discuss end of life issues but they are often waiting for physicians to begin discussions. And it is important for these discussions to be private as caregivers are often inaccurate and patients put on a brave front for their family. She concluded that palliative care affirms life and seeks to minimize total suffering. It is an important element of care in non-malignant diseases. However, there are care gaps and we must all seek to fill the gaps.

**Dr. Chandra Thomas (Nephrology)**

Dr. Thomas began by sharing several profound clinical experiences with negative patient outcomes and how they could have been better managed by employing a palliative care approach. She then recounted how she learned about palliative care. As a resident, she noticed the suffering of individuals on the nephrology unit. She was part of a group of individuals that started consulting the palliative medicine service for assistance. She learned so much from watching their interactions with patients, expertly run family meetings, and the recommendations for symptom management in their consults. This led her to spend the last rotation of her nephrology training in palliative medicine. Now she has been tasked with leading and improving palliative care within her nephrology program. She shared ways in which she is constantly trying to build palliative care capacity within her specialty. She concluded by advocating for the inclusion of palliative medicine experience in training programs so that all physicians are provided the opportunity to learn the skills necessary to improve quality of life and relieve suffering for patients.
End of Life and Palliative Care – PART II: additional insights and possible next steps

This panel session with the previous speakers from Part I enabled an open and informative interactive dialogue with participants.

Themes that emerged from the discussion include:

- There are many misconceptions about palliative care
- There are not enough palliative care specialists – other specialists will also need to provide palliative care
- Better communication/collegiality between family physicians and other specialists is needed
- New subspecialty program of the Royal College validates the specialty
- Need to educate and inform the public and MPs about palliative care
- Support expressed for mandatory training on palliative care training in all undergraduate and specialty training programs

The Specialist Forum: Where to now?

Dr. Andrew Padmos, CEO of the Royal College, led a discussion on the future of the Specialist Forum (SF), led by CMA and sunset in 2015. The Royal College currently has two events with the NSS - HRH and this one.
He posed questions to participants regarding the utility of the SF, the idea of resuming it and how it should take place. He also questioned participants regarding the role of the Royal College, noting that the Royal College is open to shared leadership. Themes that emerged include:

- The best discussions are those that occur in person which support networking/making connections and hearing about common struggles/issues
- Focusing on key topics is more engaging and useful
- May be useful to explore meetings of all NSS for cross cutting issues combined with meetings of clusters of specialties (i.e. medical, surgical, etc.) to focus on specific issues
- The Royal College should continue with its two meetings (HRH Dialogue and NSS Summit) which are gaining momentum
- This Summit could serve the purpose of the SF
Dr. Padmos summarized next steps – the Royal College will resume its annual meeting of NSS in addition to HRH meeting and will address issues/concerns of specialist societies and their collaborators. The CEOs of NSS will discuss and the Royal College will come back with a plan.

10 Closing remarks

Dr. Kevin Imrie, President of the Royal College, concluded by providing a recap of the day. He also thanked the presenters and participants for their time and thoughtful input, hoping everyone found the day useful. He reiterated the Royal College’s commitment to better communicate and collaborate with the NSS.